KINGSTON TRUST FUND

2025 KTF RETIREE MANUAL

This manual provides general information.
Please refer to your plan documents, Parts A, B, & C
for specific benefits provided by your plan.

IMPORTANT CONTACT NUMBERS

♦ Compliance, Appeals, and COBRA Information	844-KTF-FUND
♦ Eligibility and Benefits (MagnaCare)	800-352-6465
♦ Medical Prior Authorization (MagnaCare)	800-352-6465
♦ Claim Status (MagnaCare)	800-352-6465
♦ Medical Network Including Behavioral & Mental Health	800-352-6465
♦ Rx Issues & Prior Authorizations (Four Corners Health)	866-443-9331
♦ Manifest Pharmacy (Mail Order)	888-770-4009
♦ CVS Caremark (Specialty Pharmacy)	800-237-2767

Medical Portal: **My Create Health App; or www.mycreatehealth.com**

PBM Rx Website: **www.fourcornershealth.myrxplan.com**

Rx Mail Order: **www.ManifestPharmacy.com**

PPO Websites: **KTF at www.ktftrustfund.com or call 844-KTF-FUND**

MagnaCare at www.ktftrustfund.com and then click "Providers"

First Health Network at www.ktftrustfund.com and then click "Providers"

Medicare Website: **www.medicare.gov**

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RETIREE QUESTIONS AND ANSWERS

This manual has been prepared to assist retirees and members planning to retire by addressing questions and concerns which should be addressed prior to retirement. We have answered typical questions posed by retirees in the following question and answer format. This manual is not intended to replace your Summary Plan Description. We encourage you to refer to your Summary Plan Description for specific rules as they may vary from plan to plan. Plan rules will govern in the event of any discrepancy or difference between this manual and your plan. You may access your current plan and recent amendments or modifications as well as important notices online 24/7 at www.ktftrustfund.com.

Q 1. Will the new health plan cover everything my old plan covered?

Answer: Yes. Your coverage as a retiree is identical to the coverage you had as an active employee, with the following exceptions:

1. If you are also covered under your spouse's group health plan, you are subject to the coordination of benefits (COB) rules to determine which plan is primary and which plan is secondary. Your KTF Plan will always be primary for you until you are eligible for Medicare; then, Medicare will become primary unless your spouse remains actively employed and you are also covered under their group health plan. *(See Medicare Primary Chart.)*
2. If your spouse is retired and does not have their own retiree coverage, this plan is the primary plan for you and your spouse until you are Medicare eligible; then, Medicare will be your primary medical plan. This plan will be your primary Rx plan and your secondary medical plan.
3. If your spouse is covered by their own plan as an employee or retiree, this plan will be the secondary plan for your spouse. Your spouse's plan will always be primary for him/her unless the Medicare Secondary Payor (MSP) rules apply.
4. Once you or your spouse become eligible for Medicare, your status changes. Medicare Secondary Payor rules apply in all cases when the primary member is actively employed and has group health coverage; that coverage will be primary to Medicare as long as the primary member is active at work.
5. Dependent coverage will always be based on the "*Birthday Rule"* to determine which parent's plan is primary and which plan is secondary. The plan covering the parent born earliest in the year, without regard to the year of birth, is considered the primary plan. Example: If the mother was born April 27 and the father was born October 12, the mother's plan would be the primary plan for any covered dependent; the father's plan would be the secondary plan for the dependent.

Q 2. Will the new health plan cover my existing condition?

Answer: Absolutely. There are no pre-existing rules or conditions under this plan. Should your coverage be terminated, you will need to provide your new plan with a copy of a HIPAA Certificate of Coverage. The KTF Compliance Office will prepare the HIPAA

Certificate of Coverage to protect you from any pre-existing condition rules under your new plan. You may also elect COBRA coverage for up to 36 months.

Q 3. What is Out of Area (OOA) Coverage?

Answer: OOA enrollment is limited to retirees who PERMANENTLY reside out of the area by more than 75 miles and full-time students who attend college outside the primary coverage area. OOA status is not permitted for a temporary change in address (e.g., temporary residence or vacation in Florida or Texas for the winter).

KTF has selected MagnaCare as the primary PPO Network. In addition to having access to MagnaCare's expanded network of providers and the existing KTF Network, members will also have access to the First Health Network outside of the state of New York effective 01/01/2020. PPO contact numbers are located on your ID card and on the front page of this manual.

You should make every effort to use PPO providers within the above PPO Networks when you are temporarily out of area.

Q 4. What is the advantage of Out of Area (OOA) Coverage?

Answer: *Please refer to your Summary Plan Description to see if your plan has OOA coverage and the specific OOA benefits*. OOA coverage is especially important for early retirees not covered by Medicare or another plan (spouse's plan). Once you enroll for OOA coverage, if you go to an out-of-network provider, typically the out-of-network deductible is waived and then benefits will be paid either under the PPO Schedule or the NPPO Schedule, depending on the particular plan. Any special benefits take effect AFTER you enroll as an OOA member.

You are still liable for excess usual, customary, and reasonable charges (UCR) if the out-of-network provider's charges are higher than allowed charges. While special benefits may be provided for OOA members, your out-of-pocket limit may be higher if you use out-of-network providers. You should review the Out of Area Benefits section in your plan for additional information.

Q 5. Will I have to satisfy new deductibles when I enroll OOA?

Answer: No. Limits are computed separately, and all charges accumulate throughout the calendar year and are not affected by a change in status. All deductibles and out-of-pocket amounts carry forward. *Please refer to your schedule of benefits*. If there is a PPO or NPPO deductible, the deductible must be met before any benefits are paid under the applicable schedule (PPO, OOA, or NPPO schedule) EXCEPT for preventative benefits provided with NO copay or when the deductible is specifically waived.

Example: If your plan has a PPO deductible of $155 and you go to the hospital, only the hospital copay will apply. Deductibles as of July 1, 2010, apply only to outpatient services. After the PPO hospital copay, hospital charges are paid at 100% of the allowed charges. If you go to an out-of-network hospital, the NPPO hospital copay applies; then, the NPPO coinsurance applies on the charges in excess of the hospital copay, until you

meet the NPPO out-of-pocket limit. The NPPO out-of-pocket limit applies to coinsurance for both inpatient and outpatient NPPO services on a combined basis.

Deductibles and out-of-pocket limits are listed in your plan. Remember, plan and information about providers is always available online at **www.ktftrustfund.com**.

Q 6. How much are the copays I have to pay?

Answer: Your copays will remain the same as they were prior to retirement. *Please refer to your Summary Plan Description for specific copays for various procedures when you use PPO providers*. Most out-of-network benefits are not subject to copays but are subject to the NPPO deductible and coinsurance unless you are an enrolled Out of Area member. You must pay the out-of-network deductible first; then, eligible charges are reimbursed at the coinsurance rate provided in the plan, until you are eligible for Medicare.

Q 7. Do I have to preauthorize my procedures?

Answer: *Please refer to the prior authorization rules under your plan*. You are required to preauthorize listed procedures when the KTF Plan is the primary plan, the same as when you were an active employee. The prior authorization department number and general requirements are listed on your ID card. Always present your current ID card to the hospital or provider whenever you go for treatment. You must comply with the prior authorization rules that apply to the primary plan. Generally, your provider will take care of obtaining prior authorization for most treatments. You may want to verify with the provider, in advance of treatment, that they have obtained approval for any surgical or inpatient services, complex testing, physical therapy, or chiropractic treatment. **Remember, as of July 1, 2010, you must preauthorize any provider visits in excess of six (6) with the same provider.**

If you fail to preauthorize benefits in advance of treatment, as required by the KTF Plan, the plan benefits will be reduced. *Refer to the Penalty Chart in your plan for failure to preauthorize a benefit and/or for late filing of a claim*. In some instances, treatment may be retrospectively approved through the appeals process and documentation of reasonable cause for failure to obtain prior approval, based on medical necessity. *Please refer to your plan for the rules governing appeals or you may contact the KTF Compliance Office for assistance*.

Once Medicare is primary, procedures will have to be pre-authorized when Medicare benefits are exhausted or if you are not using a Medicare provider. *Please see your KTF Plan for details*.

Q 8. What happens when my dependents are no longer eligible?

Answer: Under the Health Care Reform Act of 2010, children ages 19 to 26 may be covered as dependents. *(Refer to the eligibility rules for dependents in your plan.)* Any dependent that is no longer eligible to be covered as a child/dependent can continue coverage under COBRA for up to 36 months, provided the plan is timely notified (within 60 days) of the

dependent's change of status due to age, employment, dependent status, etc. This also applies to a spouse who loses eligibility due to divorce or legal separation.

You may also apply for continued coverage for any child (including married children) aged 26 to 29 under the Young Adult Option, if they are not eligible for Medicare or other health coverage. Enrollment must occur within 60 days of the event (loss of other coverage, etc.) *(See your plan for details.)*

Q 9. What about disabled dependents covered by Medicare or Medicaid?

Answer: Medicaid is always the last payor to any other individual coverage. KTF will be primary; however, you must notify the plan of any dependent who is disabled and enrolled in Medicaid or Medicare (a copy of the ID is required by the plan). You must enroll your child as a disabled dependent prior to age 19. *(Refer to your plan for specific rules governing disabled dependents.)* After a child reaches the maximum age to be covered as a dependent and is Medicare eligible, continued coverage as a disabled dependent is no longer permitted. You must immediately enroll a disabled dependent in Medicare Part A and B when they become eligible for Medicare. After your child attains the maximum age for coverage as a disabled dependent, you must also immediately enroll your dependent in Medicare Part D for prescription drug coverage. Failure to timely enroll for coverage may result in an increased premium under Medicare rules.

Generally, Medicare becomes effective the first day of the 25th month after the individual is permanently disabled according to Social Security. It is important providers be advised of all coverage, including Medicare coverage, and which coverage is primary and which coverage is secondary. Be sure to update your providers whenever coverage status changes, including changes on where to file claims.

You are required to enroll your dependent in Medicare when Medicare would become primary for that dependent. Any disabled dependent should be enrolled with Social Security for the disability after their 19th birthday as coverage for children ends the later of age 26 (per plan rules) or when the disabled dependent becomes eligible for Medicare.

Medicare is secondary when the dependent or spouse is covered under an active employee's plan. The plan of the employee who is actively working is always primary to Medicare. **Once you or your spouse retire and are covered solely under retiree coverage, the Medicare coverage for a disabled dependent becomes primary, regardless of whether or not you or your spouse are Medicare eligible**.

Q 10. What are the copays and deductibles for prescription drugs?

Answer: *Please refer to your Summary Plan Description*. If your spouse has their own coverage, either as an employee or retiree, they may not use KTF for prescription drugs, unless they do not have prescription coverage under their primary plan. Out-of-pocket Rx charges in excess of the deminis copay specified in your plan or when you pay a percentage of Rx charges may be submitted to the plan for payment as Major Medical Rx. Eligible Rx charges will be reimbursed at 80% and your 20% coinsurance will be subject to the PPO out-of-pocket limit. Once your out-of-pocket limit is met, all eligible charges are reimbursed at 100%. Your prescription coverage, as an enrolled diabetic, changes once Medicare becomes primary. *(See Q 20, Enrolled Diabetics.)*

Members are responsible for paying all Rx copays and coinsurance under the primary plan while KTF is the secondary plan. Then, the members must timely submit their out-of-pocket charges directly to KTF for payment as the secondary plan. Generally, your local pharmacy or prescription plan can give you a statement of all charges for each quarter, which will make it easier to submit Rx charges for payment. Claims must be timely filed to be eligible for reimbursement, within 90 days of the date of service or payment.

If your spouse's health coverage changes, you must immediately notify the plan no more than 60 days after the change. You must also provide the plan with a copy of their HIPAA Certificate or another document that indicates when your spouse's coverage terminated before any change can be made in the coordination of benefits for your spouse or dependent.

The KTF Rx Plan provides prescription drug coverage that is comparable to or better than Part D Rx coverage under Medicare.

Q 11. Is there a limit on my Rx copays?

Answer: Yes. The Rx out-of-pocket limit, as specified by your plan, is separate from and in addition to your medical out-of-pocket limit. Only prescriptions filled under your prescription drug card are subject to the out-of-pocket limit. If your spouse is covered by their own medical plan, and KTF is secondary for Rx coverage, any Rx copays or coinsurance not covered by the primary plan may be submitted to KTF as a Major Medical expense. The Rx out-of-pocket limit applies solely to retail and mail order Rx when filled by this plan as the primary Rx plan. The KTF ID card may only be used for prescriptions when this plan is primary. Medicare Secondary Payor rules also apply to Rx coverage.

Q 12. Which plan pays for my prescription drugs?

Answer: Your primary plan must be used for any prescription drug. If your spouse's plan is primary, then they may not use the KTF card for Rx. If your spouse's plan is primary for you, under the Medicare Secondary Payor (MSP) rules, then you must use your spouse's Rx card for all prescription drugs. You may not use the KTF card for prescription drugs.

The only time your KTF Plan will be primary for your spouse, if they have their own medical coverage, is under the Medicare Secondary Payor Rules (MSP). These rules apply when one member is actively at work (AAW) and the other is retired and eligible for Medicare. Medicare requires the coverage of the individual who is actively at work primary for that individual and any dependents. Otherwise, an individual's coverage as an employee or retiree is primary to their coverage as a dependent. Medicare Secondary Payor rules apply to your Rx coverage, the same as medical coverage.

Once you or your spouse becomes eligible for Medicare, you will not need to sign up for a Medicare Part D Prescription Drug Plan. You may continue to use the KTF Plan as your primary plan for Rx unless you choose a Medicare Part D Drug Plan. Your spouse will also use the KTF card for Rx UNLESS your spouse has their own Rx coverage as an employee or retiree. In that case, your spouse must use their own plan for prescription drugs.

If you or your spouse elect Medicare Part D drug coverage, you are responsible for notifying the plan, paying the Part D premium, and you will have no prescription drug coverage under the KTF Plan. Certain low-income individuals, individuals on Medicaid, or confined to a nursing home may be eligible for subsidized Part D coverage. To request additional information, contact Medicare via 1-800-MEDICARE. If confined to a nursing home or on Medicaid, an individual may be enrolled in Medicare Part D by the nursing facility. *(See Q 22.)*

Members are responsible for providing their local retail pharmacy with explicit instructions as to which card is primary for each member of your family. **The member is responsible for reimbursing the plan for any Rx charges incurred using the KTF card when KTF is not the primary plan for prescription drugs. If you have Rx problems or questions, contact the KTF Compliance Office, at 844-KTF-FUND, for assistance**.

Q 13. Do I have to use the mail order program for my prescriptions?

Answer: Yes. After your third (3rd) refill, you must use mail order for most maintenance medications. The Pharmacy Benefit Manager (PBM) must approve any exceptions or vacation overrides. Please be sure to contact us at least two weeks prior to your vacation to allow sufficient time to process your request. Certain controlled substances may not be eligible for more than one 30-day refill. Many pharmacy chains have your records online and can refill prescriptions when you are out of the area. **If you fail to use mail order for maintenance drugs, your copays will be doubled**. Certain drugs are not eligible for mail order, e.g., controlled substances. The RRA list of drugs is maintained by the Pharmacy Benefit Manager, based on clinical guidelines.

Q 14. Are there additional plan costs when I am living out of area?

Answer: Benefits will be paid according to the type of provider you use. If you are unable to go to a network provider, your cost will be greater until you are eligible for Medicare. Even though you may live outside the primary area, the MagnaCare, KTF, and First Health PPO Networks have many network providers throughout the United States, and you may use any of the PPO providers listed in your plan. There is always the potential for additional costs any time you use out-of-network providers. Once you become eligible for Medicare, you are required to enroll when first eligible and then any Medicare provider is deemed to be a network provider for purposes of this plan. Once you are eligible for Medicare, most Medicare covered expenses will be paid at 100% as your KTF Plan will cover the portion of the cost not covered by Medicare. The only exception to this is the portion of any deductible, including the Medicare Part A and B deductible that must be met annually.

Your KTF Plan will pay what it would have paid if it were the primary plan up to the difference between the Medicare Allowed Charges and the actual Medicare payment. *(See your plan for these rules.)*

Q 15. If I live in a different state for several months, how will the plan cover me?

Answer: If you temporarily live out of state for a few months of the year, benefits will depend on whether you use PPO or NPPO providers and/or specialists. We recommend you first determine if there are any PPO providers in the area. If you use a network provider, you will not incur any additional out-of-pocket costs. If you go to an out-of-network provider, the NPPO Deductible and Benefit Schedule will apply. *(Refer to your Summary Plan Document for additional details.)* The KTF Plan has a unique category of coverage for retirees who live outside the primary coverage area on a permanent basis. It is called Out of Area (OOA) status. You must enroll prior to receiving special benefits provided by this coverage. *(For details, see Q 4 and refer to your plan.)*

Q 16. If I move out of the country, will the plan cover me?

Answer: Depends. You will have full coverage as long as you reside in the US, Canada, Mexico, or one of the U.S. Territories (*Guam, Puerto Rico, U.S. Virgin Islands, or American Samoa).* Special rules apply for foreign coverage. Prior approval must be granted for coverage outside the US, Canada, or Mexico. One very important consideration is once you are eligible and covered under Medicare, you are required to elect Medicare Part A and B; then, KTF pays as the secondary plan for medical coverage and primary for Rx coverage.

Additional Considerations: Medicare does not provide coverage outside the U.S. or U.S. territories. This means that your KTF benefits, which require coordination with Medicare, will only pay up to 35% of the allowable charges, the same as though Medicare had paid their portion of the charges.

- Prescriptions cannot be shipped outside the U.S., nor does the pharmacy benefit manager accept prescriptions from a foreign provider unless they are also licensed in the U.S.
- Any services provided outside the plan's primary coverage area will be paid as an NPPO benefit, subject to the NPPO deductible and coinsurance. Out of Area rules do not apply to individuals receiving services outside the U.S. coverage area.
- Additionally, a $250 copay applies for foreign provider services except in the case of an emergency. Any medical bills must have a full explanation of services provided in English with an appropriate explanation, procedure codes, and charges must be converted into American dollars.

Q 17. Will the plan cover me when I travel out of the country?

Answer: Charges for services provided outside the U.S. are limited to emergency care. Treatment outside the U.S., U.S. territories, Canada, or Mexico, will not be covered, except for emergency treatment, while traveling "temporarily" for a period not to exceed six (6) weeks in any one country or three (3) months in total. Any service provided outside the U.S, Canada, or Mexico is subject to a $250 copay plus the normal NPPO plan deductible before any payment. Non-emergency treatment of a chronic illness that requires hospitalization outside the United States will not be covered, unless such treatment is pre-authorized within 24 hours of admission (48 hours, or next business day

for weekend admissions). Otherwise, charges for medical services rendered outside the U.S. will not be covered. *(See Q 16.)*

Retirees living permanently outside the U.S. will be covered according to the NPPO Schedule of Benefits, as long as proof of residency is provided, and non-residence status is approved by the plan in advance. Once you are eligible for Medicare, by reason of age or disability, the Medicare coordination of benefit rules apply. If you live outside the U.S. or U.S. territories, your eligible benefits for Medicare coverage will be limited to what would have been paid had Medicare actually paid for such benefits.

Approval will be at the sole discretion of the plan based on all relevant facts and circumstances, including the country in which the retiree resides. Coverage in countries considered "high risk" areas may not be approved. Students on exchange-type programs will not be covered. Parents are advised to secure special travel and medical insurance through a travel or insurance agent, through their school, for extended travel, if the member or a dependent intend to live abroad for an extended period.

Important: Any receipts for care outside the United States that do not include the patient's name, date of service, and services provided will not be accepted for processing. This also applies to drug store receipts. You must request a printout in English from the pharmacy or provider that includes detailed information on the patient and services provided.

Q 18. What if I become Medicare eligible while covered under my spouse's plan?

Answer: Once you or your spouse become eligible for Medicare, you must immediately notify the plan, update the plan on any other coverage in effect for your spouse, and provide a copy of your Medicare ID card. If you are covered under your spouse's plan, Medicare does not become primary until your spouse is no longer actively employed. Once your spouse is no longer actively employed, this plan would be primary for you until you become Medicare eligible. Medicare is ALWAYS secondary to any coverage as a member or dependent under an employee who is actively at work, according to the Medicare Secondary Payor (MSP) rules. Both you and your spouse must be retired before Medicare becomes primary when you have coverage with your respective employers.

Q 19. Can I go out-of-network to any provider and how is that covered?

Answer: The KTF Plan is an open access PPO plan with out-of-network access. This means you are free to choose any provider you wish to go to without a referral. However, the benefits paid by the plan will be less when you go out-of-network. When you use an out-of-network provider for any service, other than a bona fide emergency, you must first meet the NPPO deductible or hospital copay before any benefits will be paid. Then, you will be responsible for the NPPO coinsurance. There are several exceptions you need to be aware of if you use an out-of-network provider. *(See your Benefit manual.)*

You are responsible for excess charges for NPPO providers: whenever you go to an out-of-network provider, the plan will limit their charges to the "allowed charges," according to plan rules. If your provider's charges exceed the allowed amount, you will be responsible for the excess charges. There are NEVER any excess UCR charges for network providers. All PPO providers are paid based on the contractual rate. The PPO

fee (eligible expense) will be shown on your Explanation of Benefits (EOB) and the PPO discount is the difference between the actual charges and the eligible expense or allowed charge. Members are NEVER responsible for paying the provider for any charges in excess of either the PPO fee or the Medicare allowed charge (including the additional 15% providers are permitted to charge and who only bill Medicare).

If a provider attempts to bill you for this, contact the provider and advise them that they are a PPO provider, they are not permitted to balance bill you. You should refer them to the Explanation of Benefits (EOB) which will indicate the member responsibility (deductible, copay, or coinsurance). If you need further assistance, contact the KTF Compliance Office to appeal how the claim was processed or to answer questions you may have regarding the EOB or the provider's billing.

When Medicare is Primary: Once Medicare is primary, it makes no difference if you go to an in-network or out-of-network provider for Medicare covered services as long as you go to a Medicare provider who either accepts assignment or who will bill Medicare. Medicare providers are limited by law as to what they can charge (*except contract providers who do not accept Medicare*). For additional information on Medicare providers ***see Q 24***. Non-Medicare covered services are subject to plan rules regarding prior authorization, etc. All surgeries or inpatient procedures need to be pre-authorized.

Q 20. What happens when I become Medicare eligible, and MSP Rules apply?

Answer: When you or your spouse become eligible for Medicare, the Medicare Secondary Payor Rules apply. At age 65, you are automatically enrolled for Medicare Part A if you are drawing Social Security Benefits. **You, your spouse, and any disabled dependent must enroll for Medicare Part B once the individual becomes Medicare eligible, unless the MSP rules apply due to coverage as a dependent or an employee due to Active at Work (AAW) status**. You or your spouse may defer enrollment in Part B as long as you are covered under a plan where the primary member is actively employed. Any coverage as an employee or dependent of an active employee is deemed to be primary to Medicare coverage, even if you are age 65 or older.

All benefits payable under this plan are conditioned on and paid as though the member, spouse, or disabled dependent had enrolled for Medicare when first eligible and/or coincident with the retirement of the member and/or their spouse (i.e., cessation of coverage under a group health plan of an active employee).

Under the Medicare Secondary Payor (MSP) rules, coverage under an active employee's plan (including coverage as a dependent) makes that plan primary and Medicare the secondary plan, regardless of the age of the employee or any covered dependent. Medicare Part B enrollment may be deferred until you are only covered as a retiree or dependent of a retiree. **Disabled dependents are no longer eligible to be covered, as a child or disabled dependent, once they become Medicare eligible and are no longer eligible for coverage as a child (age 19-26), as stated in your plan.**

Enrolled Diabetics: Once Medicare is your primary coverage, you must get some of your diabetic supplies through Medicare Part B. If you are on an insulin pump, you must get your insulin from Medicare. Medicare covers 80% of these items under Medicare Part B. You may then submit the balance of the charges to KTF for reimbursement. *(Refer to your Summary Plan Description for diabetic supplies and Rx coverage.)*

Q 21. What will Medicare cover & where do I order diabetic supplies if Medicare is primary?

Answer: **Medicare covers the following for diabetics:**

- Screenings for people at risk
- Diabetes Self-Management Training
- Medical Nutrition Therapy Services
- Hemoglobin A1c tests
- Glucose monitors, test strips, lancets, insulin, some insulin pumps
- Glaucoma tests
- Foot exams and treatment, therapeutic shoes
- Flu and pneumonia shots
- Cholesterol and lipid checks

For a free copy of "Medicare Coverage of Diabetes Supplies & Services," visit www.medicare.gov/Publications/ and enter 11022.

If you have access to a computer, search for diabetic supplies. There are a number of companies that will bill Medicare directly. Please contact Medicare for a list of these providers.

Q 22. What about prescription drug coverage under Medicare Part D?

Answer: The KTF Plan will continue to be the primary plan for prescription drugs instead of Medicare. **You do not need to enroll in Medicare Part D.** The prescription coverage under the KTF Plan is considered "comparable coverage" and is actually better than coverage under Medicare Part D. Whether or not the KTF Plan is primary for prescription drugs for your spouse, or any dependent will depend on whether or not your spouse has coverage under their own retiree plan. If your spouse has separate coverage as a retiree, and that plan provides prescription drug coverage, prescription drugs will not be available with the KTF card. KTF would only cover prescription drugs as a major medical expense as the secondary plan. The primary plan for dependent children is based on the Birthday Rule. *(See Q 1.)*

Once you or your spouse is Medicare eligible, the MSP (Medicare Secondary Payor) rules will apply to your prescription drugs. The Rx plan under the coverage of a member who is active at work will be primary to an Rx plan of a retired member's plan.

If Medicare Part D is elected, it will be your sole prescription drug plan. There is no coordination of benefits with this plan. A member, spouse, or dependent may only have one Rx plan under Medicare Part D rules. You are required to notify the plan if Medicare Part D is elected for any member or dependent.

Q 23. What if I go to work with another district or another employer after retirement?

Answer: If you or your spouse go to work with another employer after your retirement AND elect health or dental coverage with that employer, your coverage as an active employee with that employer is primary to your KTF coverage as a retired employee. If you are Medicare eligible and enrolled in Medicare, the MSP rules dictate that any coverage under a plan of an active employee is primary to Medicare.

If you have questions on how this works, contact the KTF Compliance Office. You are required to follow the coordination of benefits (COB) rules under the plan for purposes of determining which plan is primary and which plan is secondary. If KTF is the secondary plan, your benefits under this plan will be computed as though the primary plan paid the benefits, even if you do not go to a provider that is covered by the primary plan. You are required to maximize your benefits under the primary plan.

Q 24. When we are both Medicare eligible is Medicare my primary plan?

Answer: Once you or your spouse is covered by Medicare, Medicare becomes the primary plan if your only coverage is as a retiree or as a dependent of a retiree. If you or your spouse are covered under KTF as a retiree and you are also covered under your spouse's plan as a retiree, Medicare is primary for both of you. KTF is secondary for you as the retired member and tertiary for your spouse. Your spouse's retiree coverage is secondary to Medicare and KTF would be tertiary for your spouse. Should you have dependent coverage, the primary plan is based on the Birthday Rule for dependents. *(See Q 1.)*

Q 25. What happens if I go to a provider who does not accept Medicare?

Answer: It is especially important to determine whether or not your provider is a Medicare provider PRIOR to obtaining any services. Any service covered by Medicare must be submitted first to Medicare for reimbursement prior to payment by the KTF Plan as the secondary plan. There are some services and providers that are not covered by Medicare but are covered under the KTF Plan. For services not covered by Medicare, the KTF Plan covers such services as though it were the primary plan. For example, some acupuncture is not covered by Medicare but is covered by KTF. Acupuncture visits will be paid based on whether or not you use a KTF provider. There are three (3) categories of providers under Medicare as shown below. You want to avoid contract providers.

Provider who accepts Medicare Assignment: This is the most common Medicare provider who agrees to bill Medicare for all charges. You need to verify with each provider whether or not they will also bill the secondary plan (KTF) after Medicare pays. If they do not bill the secondary insurance, it is your responsibility to submit a copy of the Medicare explanation of benefits (EOB) and a copy of the actual charges from your provider. Do not submit a "balance due" statement that does not include the date of service, service details provided, procedure codes, charges for each service, and the EOB. All claims to be covered must be timely filed within 90 days of the Medicare payment.

Provider who does not accept Medicare Assignment but will bill Medicare for you: Medicare recognizes this type of provider; however, the provider will expect you to pay for all services in advance and you will be reimbursed directly by Medicare for their portion (generally 80%) of what Medicare allows. This type of provider is permitted to bill the patient 115%, 15% more than what Medicare allows.

Example: If the Medicare allowed charge is $100, the provider may bill you $115. Medicare will only reimburse 80% of the allowed charge ($80) and you are responsible for the difference ($35) instead of $20, which would be the case if the provider accepted Medicare Assignment. You will be responsible for submitting the Medicare explanation of benefit (EOB) with the initial charges to KTF for reimbursement as the secondary plan within 90 days of the date you receive the Medicare EOB.

Under the KTF Plan, you will be reimbursed up to 35% of what Medicare allows in this instance. This means you will have no out-of-pocket expense provided you timely file your claim with KTF with the Medicare EOB statement within 90 days of the Medicare payment. Any Medicare provider is limited by law as to what they can charge for services covered by Medicare. It makes absolutely no difference if you go to an in-network or an out-of-network provider once Medicare is the primary plan. Medicare providers are considered PPO providers.

Contract Provider who does not accept Medicare and is not recognized by Medicare: This type of provider is not recognized by Medicare and Medicare will not cover any services provided by a Contract Provider. If you use a Contract Provider after Medicare is your primary plan, you will be responsible for the majority of the charges since the benefits under the KTF Plan as the secondary plan are limited to what would have been paid if you used a Medicare provider (which is 35% of the allowable charges). You will be personally liable for the balance of the charges unless there are additional benefits due under a tertiary plan. Example: Contract Provider charges $150 for an office visit, the allowable charge is $100. KTF will reimburse you $35 (35% of the Allowable Charge). You will be responsible for the balance of $115.

Q 26. Does the plan cover medical services not covered by Medicare?

Answer: Yes. If, those services would otherwise be covered under the KTF Plan. Any benefit covered by the KTF Plan and not covered by Medicare will be covered as though the KTF Plan were Primary, subject to KTF prior authorization and the timely filing of claims. We recommend you become familiar with your Medicare Benefits. There are several excellent booklets published by Medicare that are available online, they can be ordered by phone or picked up at your local Social Security Office. Everyone aged 64 or older should have the following booklets on hand as a reference: *Medicare and You* and *Your Medicare Benefits*. Go online to **www.medicare.gov** to get the most current version of these booklets, they are usually updated annually. For general Medicare information and assistance, to order Medicare booklets and information about health plans, contact 1-800-MEDICARE 24 hours a day, 7 days a week. English and Spanish-speaking customer service representatives can answer questions about the Original

Medicare Plan and provide up-to-date information regarding health plans available in your area.

Q 27. If my spouse also has retiree coverage, which plan pays for the drugs?

Answer: It depends on whether your spouse's retiree plan covers prescription drugs. If it does, then your spouse's plan is primary for their prescription drugs. Your spouse may not use the KTF card for prescription drugs. A dependent's Rx coverage will be based on the Birthday Rule to determine which parent's plan is primary and which parent's plan is secondary. *(See COB Chart.)* The Medicare Secondary Payor (MSP) rules apply to prescription drugs the same as for medical once an individual is Medicare eligible.

If your spouse has their own retiree coverage, but that coverage does not cover prescriptions, we must be notified and receive documentation of this so your spouse or dependent(s) Rx coverage under KTF can be activated.

Q 28. What is the most I will have to pay per year for my family and me?

Answer: Once you are Medicare primary, the basic out-of-pocket limit will be for Rx copays and a portion of your Medicare deductible. Prior to becoming Medicare eligible, there are various limits. Separate limits apply to PPO providers and NPPO services and providers. Plan limits may be amended at any time. Your total out-of-pocket is dependent on whether you choose to use PPO and NPPO providers and, of course, the extent of your utilization. If you use NPPO providers, total out-of-pocket costs will be significantly higher. Copays, penalties for late filed claims, failure to preauthorize benefits and excess, usual, customary, and reasonable charges are not credited toward your out-of-pocket limit. Infertility coinsurance and coinsurance for ancillary benefits (vision, hearing aids, etc.) are also not credited to your out-of-pocket.

Please refer to your plan for the following limits:

Rx Out-of-Pocket Limit: Limits your Rx copays for retail and mail order drugs when KTF is the primary plan.

PPO and NPPO Out-of-Pocket Limit is a limit that applies to copays, including hospital copays, deductible (if any), and coinsurance. There is a separate limit for PPO and NPPO.

PPO Deductible (if any) and NPPO Deductible is the amount that must be paid before any benefit will be paid under the plan, except for preventive benefits paid at 100%. Deductibles are credited toward your out-of-pocket limit.

Q 29. In the case of an emergency, can I go to any hospital?

Answer: Yes. In the case of a bona fide emergency condition or accident you should go directly to the nearest hospital worldwide. Your emergency room copay is the same for both in-network and out-of-network providers. The ER copay is waived IF you are admitted within 24 hours, but then you will be responsible for the normal hospital copay and coinsurance for inpatient care. For a non-acute situation, higher emergency room copay

applies, and the remaining benefits will be paid at 80% instead of 100%. All inpatient services must be pre-authorized within 24 hours (48 hours, or next business day for weekend admissions).

Q 30. Is there a difference in benefits for early retirees vs. Medicare retirees?

Answer: Yes. Early retirees are not eligible for Medicare; therefore, unless they have additional coverage under their spouse's plan, most early retirees will want to enroll for Out of Area (OOA) coverage if they are going to permanently reside outside the primary area. Also, it will be important for early retirees to use in-network providers whenever possible to minimize out-of-pocket expenses. **The period following retirement, until you reach age 65, is typically the most expensive period in terms of health care costs, both for the plan as well as for individuals.**

Q 31. If I am retired and my spouse is still working, which plan is primary?

Answer: KTF will always be your primary plan until you are covered by Medicare. Once you are covered by Medicare, your spouse's plan will become your primary plan, as long as they are actively employed. Medicare would be secondary and KTF would be tertiary in this situation. This will change once your spouse retires. *(See Q 19.)* Dependent coverage is always determined based on the Birthday Rule. *(See Q 1.)*

Q 32. If I die, is my spouse still covered under my plan?

Answer: Your spouse's coverage is continued for 30-90 days without charge following the month during which death occurs. *(See your plan for the rules.)* COBRA coverage is available for the first 36 months for any spouse who would lose coverage on account of a legal separation, divorce, or death.

Extended COBRA Coverage After 36 months: If your plan provides for extended COBRA coverage, a widowed spouse of a RETIREE may continue COBRA coverage *(Extended COBRA)* for their lifetime at COBRA rates, provided the spouse was covered and married a minimum of five (5) years under this plan. *(Refer to your Summary Plan Description.)* However, the Trust reserves the right to amend any provisions related to extended benefits, as well as other benefits, under your plan, at any time.

If your widowed spouse remarries, they cannot add any additional dependents or a new spouse to this coverage after the initial COBRA period of 36 months expires. During the initial COBRA period, the spouse may add a new spouse or dependent(s), but they may only be covered during the initial COBRA period and are not eligible for Extended COBRA coverage beyond the initial COBRA period. They are not qualified beneficiaries.

COBRA rules, with respect to payment and lapse of coverage, will continue to apply to extended COBRA coverage. The member must request continued coverage under this option and payments must be made to retain coverage, subject to COBRA rules. Dependent children covered at the time of the event would be eligible for continued

coverage after the initial COBRA period, only if family coverage is maintained. *(Refer to your options under Q 33.)*

Q 33. What are Medicare options for surviving spouses of members in lieu of COBRA?

Answer: Your KTF coverage terminates if the primary insured member dies, as provided by the plan, unless COBRA is elected following the death of the primary member. *(See your plan for coverage.)* **Your surviving spouse has the following options to choose from:**

Elect COBRA and *(if eligible)* extended COBRA: If you lose your coverage due to a KTF retiree dying following retirement, or if you lose coverage due to a legal separation or divorce, after age 55, and have been covered and married a minimum of five (5) years under this plan, you may be eligible for extended COBRA benefits. A spouse is always eligible for COBRA up to 36 months under COBRA rules, provided the plan is timely notified of the COBRA event *(legal separation, divorce, or death)*, within 60 days of the event.

Cost: The COBRA rate for the coverage elected (single or family) is based on the same cost of coverage for an active employee.

If extended COBRA rules do not apply, then the following options apply only if the surviving spouse is eligible for Medicare. There are no benefits available after your COBRA benefits expire under KTF. You must then rely on your own coverage through your employer or through individual coverage.

Other Options: The loss of coverage due to death is a *"Special Enrollment"* situation under HIPAA and Medicare. You are permitted to change existing Medicare elections or make new elections within 63 days of the loss of coverage. In lieu of electing COBRA, you may want to consider one of the following:

a. A Widowed Spouse has their Own Retiree coverage: The majority of time, if you have your own retiree plan, you will not need COBRA or continue the KTF Plan, unless there are significant cost or coverage considerations, including Rx. However, you must enroll in Medicare Part A and B, and you must also enroll in a Part D prescription drug plan, if your retiree plan does not have comparable drug coverage.

   Cost: Whatever the cost is for your retiree coverage.

b. Traditional Medicare Part A and B with a Part D Plan: You must also elect a standalone Medicare Part D Prescription Drug Plan. If you fail to enroll in a Part D Plan when first eligible, at any later date, you will be assessed a penalty for your lifetime of 1% for each month that you could have elected coverage. You may only change your Medicare elections during the Annual Enrollment Period, each October 15 to December 7. Certain changes are permitted during Open Enrollment, January 1 to March 31, but you may not add or terminate a Part D Prescription Plan.

   Cost: Medicare Part B Standard Premium ($185.00 for 2025), plus the cost of your Part D Prescription Drug Plan.

c. Medigap or Medicare Supplement Plan (optional): If you purchase a Medigap Plan within 63 days of the date you lose your coverage, it must be issued on a guaranteed insurability basis. For additional information, contact Medicare at 1-800-

MEDICARE or go online to **www.medicare.gov**. When you have retiree coverage plus Medicare, you DO NOT NEED OR WANT a Medigap Plan.

Cost: You must pay the Medicare Part B and D premium, plus the premium for a Medigap Plan.

d. Medicare Advantage Plan with Prescription Drug (MAPD Plan): This is a plan managed by an insurance company that covers the same benefits that are covered under Medicare Parts A, B, and D. You will typically be required to use only doctors in that insurer's network (HMO or PPO). If out-of-network providers are covered, typically your cost sharing will be considerably higher (35% vs. copays or 20%), etc. You can go online to **www.medicare.gov** to find out which plans are available in your area. The website allows you to access Part D Prescription Drug Plans in your area**.**

Cost: Some Medicare Advantage Plans have no additional cost other than the Medicare Part B cost, which you will continue to pay. Other plans may charge an additional premium.

Note: Medicare Advantage Plans must be approved by Medicare and authorized by Congress. The rules may be changed from year to year.

If you have retiree coverage through a former employer, generally, you must make a change within 30 to 60 days of the event. You should check with your benefits administrator or insurer for your retiree plan.

Q 34. What if my spouse dies and I remarry?

Answer: As a primary member, if you remarry, you may add your new spouse and any dependent(s) within 60 days of the date of acquiring new dependents. Otherwise, new dependents can only be added during Open Enrollment or due to a Special Enrollment situation (loss of spousal or dependent coverage, spouse retires, etc.) *(If the Primary Member dies, see Q 32 for surviving spousal rights.)*

Q 35. When must I notify the plan of changes?

Answer: The plan must be notified as soon as possible and within 60 days of any event. Failure to notify the plan may result in the loss of COBRA benefits. COBRA coverage must be paid from the coverage termination date, even if a notice is untimely provided. Coverage will be terminated retroactively whenever the plan becomes aware of any change/event. Members will be responsible for reimbursing the plan for ineligible expenses or COBRA premiums. Notice must be provided for the following:

If you are soon to be or are divorced or legally separated from your spouse. Spousal coverage terminates at the end of the month in which the first event occurs. A copy of the legal document is required by the plan.

If a covered dependent is soon to reach the age limit or ceases to be an eligible dependent. You may continue to cover your child (including a married child) until age 26, as provided by the plan.

In the event of the death of an insured member, coverage ends as of the end of the month in which death occurs, unless otherwise provided by the plan.

Extended coverage may be available for surviving spouses of retired members, as provided by the plan.

Any time your employment status or the employment status of your spouse or a dependent change.

Any time your spouse's health coverage changes, including any coverage for you or any dependent(s), or any situation where your spouse acquires, loses, or changes health coverage. A copy of the HIPAA Certificate is required by the plan.

Any time you, a spouse, or covered dependent(s) has an address change, timely notice within 60 days is required by the plan.

A member or spouse elects Medicare Part D or becomes eligible for Medicare, notice is required within 60 days of the event. A copy of the Medicare ID, Part A and B, is required by the plan.

Q 36. Where do I go for additional information?

Answer: Online go to: **www.ktftrustfund.com**

Call 844-KTF-FUND for various KTF Departments (compliance, appeals, COBRA as well as basic plan information such as, deductibles, copays, and coinsurance for your plan). Check the cover page of this manual for all other contact numbers.

Important phone numbers and the claims office address are on your ID Card.

Q 37. What do you mean by "timely filing of claims"?

Answer: Claims must be filed within 90 days of service or within 90 days of the payment by the primary plan. If a provider is a PPO provider, or if the provider requested that you sign an "Assignment of Benefits" form, the provider is responsible for the timely submission of claims, provided they have been given a current and correct ID card by the member. Claims not filed within 90 days are subject to a late filing penalty. As a member, you are also responsible for timely follow-up on all unpaid claims and to ensure the provider has a current copy of your ID card and correct information on the primary and secondary coverage. *(See the Penalty Chart.)*

Q 38. Are there penalties for failing to preauthorize benefits or filing claims late?

Answer: Yes. *Please refer to the Penalty Chart in your Summary Plan Description*. Members are responsible for following up with the provider and KTF on any unpaid bills or if there is any question as to whether or not a claim has been filed. Members should always get a complete copy of the charges and services provided at the time of service and members may always file claims directly with the claims office. **Members are responsible for filing all claims directly when they pay for benefits in full at the time of service.**

Members are cautioned to always follow up immediately with the provider and the claims office upon receipt of any unpaid bill that is more than 30 days old. Always obtain a complete copy of the claim from the provider at the time of service indicating all charges and services provided.

Q 39. Can I add dependents to my coverage when I retire?

Answer: If a retiree is single at retirement, they may add spousal and/or dependent(s) coverage within 60 days of the date of acquiring a new dependent; otherwise, a new dependent may only be added during Open Enrollment or due to a Special Enrollment situation. Extended COBRA is available to divorced spouses if they are over age 55 and have been covered and married for a minimum of five (5) years. *(See your Plan for COBRA rules and special rules regarding the addition of a spouse or dependent once you are retired.)*

Q 40. What happens in the event of a legal separation or divorce?

Answer: The former spouse can only continue coverage under COBRA for 36 months. Extended COBRA coverage may be available to divorced spouses who are age 55 or older and who have been married to the member for at least five (5) years and covered under the KTF Plan for five (5) or more years. *(Refer to your plan for details.)* The retired member may add a new spouse or dependent(s) after retirement. The KTF Plan provides extended COBRA coverage for divorced and widowed spouses or retirees, provided they have been married and covered by this plan for at least five (5) years.

Q 41. Wellstone-Domenici Mental Health & Addiction Equity Parity Act of 2008

Answer: Mental Health and Addictive treatment are to be given parity with medical treatment in terms of copays, deductibles, out-of-pocket limits, etc. by 2014 Medicare will cover 80% of mental health benefits, the same as it does for medical benefits. *(Refer to the Mental and Addiction Benefits under your Summary Plan Description for additional information on behavioral and addictive benefits.)*

Medicare Mental Health and Addiction Benefits under Mental Health Parity					
Medicare benefits for mental health/addictive treatment are per the following chart. This plan will pay the difference between allowable charges and what Medicare covers. The benefits paid by KTF will be determined by whether or not you see a Medicare provider only, an in-network provider, or an out-of-network provider. See the chart to determine the KTF percentage. • Medicare pays 80% of allowed charges					
Benefit Year	Medicare Benefit % for any Medicare Provider	When Medicare provider is NOT used – KTF benefit/percentage reimbursed to member if the provider does NOT accept assignment		When Medicare provider is used – KTF benefit/percentage reimbursed to member if provider does NOT accept Medicare assignment	
		Out-of-Network Provider (4)	In-Network Provider (3)	Medicare Provider Accepts Assignment for Medicare Payment (1)	Medicare Provider Who Only Bills Medicare for any Medicare Covered Benefit (2)
2014 and forward	80%	20%	35%	20%	35%

1. A Medicare provider who accepts assignment is limited to the Medicare Allowed Rate. If KTF is secondary, KTF will cover the portion of the allowed charges not covered by Medicare.
2. A Medicare provider who does not accept assignment but will bill Medicare (you must pay the provider up front), may charge 115% of the Medicare allowed charges but Medicare still limits its payment to 80%, or the basic Medicare percent for behavioral and addictive services, of Medicare allowed charges. Normally, the member would be responsible for 35% (20% + additional 15%) of the Medicare allowed charges, but the KTF Plan will cover up to 35% of the Medicare allowed fee when you use a Medicare provider who only bills Medicare.
3. When you use an in-network provider, even though they are not a Medicare provider, we will cover the benefit the same as if you used a Medicare provider who only bills Medicare.
4. Out-of-network providers for behavioral health and addiction benefits, reimbursement or benefits are limited to what the plan would have paid had you used a Medicare provider who accepts assignment from Medicare.

Members are REQUIRED to have both Medicare Part A and Part B in effect once they are eligible for Medicare and Medicare would be their primary plan. In all situations, a member is expected to elect Medicare Part A at age 65 or the beginning of the 25th month if they become Social Security Disabled, even if Social Security Benefits are deferred. There is no charge for Medicare Part A. In all situations, the benefits paid will take into account what "should have been paid by Medicare."

Medicare Primary Chart

- **Medicare Secondary Payor (MSP)** rules apply to **Medical and Rx Coverage** and require that coverage as an employee or dependent under an Active at Work individual is primary to Medicare Part A, B and D coverage.
- **Spousal Coverage:** If your spouse has other medical coverage (as a retiree or employee) that plan will be primary unless the individual is eligible for Medicare. Coverage as an **employee** is always primary to coverage as a dependent/spouse or coverage as a retiree (except when MSP rules apply). If Medicare Part D Prescription Drug Plan is elected, this will be your SOLE Rx plan as there is no COB for Rx per Medicare rules.
- **Status Changes:** Due to disability, Medicare eligibility, retirement must be immediately reported to KTF**.**

Medicare Supplement, Medigap, or Medicare Advantage Plans should not be sold to anyone who has full group health coverage as a retiree. Do not enroll in these plans as long as you have KTF coverage. You may want to consider alternative coverage if you are a widowed spouse of a deceased KTF member and can only continue this coverage under COBRA rules. Contact the KTF Compliance Office for additional information on your options.

You have family coverage with KTF and are also covered under your spouse's plan.	**KTF Plan is primary for KTF member, except for when Medicare rules apply.**	**Spouse's plan is always primary to KTF for your spouse when Medicare Secondary Payor rules apply.**
1. You are both actively employed.	KTF is primary for you and secondary for your spouse.	Primary for your spouse and secondary for KTF member.
2. You are actively employed, and your spouse is retired and not Medicare eligible.	KTF is primary for you and secondary for your spouse.	Retiree coverage is primary for your spouse and secondary for you, if your spouse has their own coverage.
3. You are actively employed; your spouse is both retired and Medicare eligible.	KTF is primary for both you and your spouse; Medicare is secondary for your spouse.	For spouse, KTF is primary, Medicare secondary and their retiree plan is tertiary. Spouse's plan is secondary for you.
4. You are both retired, you are both Medicare eligible.	Medicare is primary and KTF is secondary for you and tertiary for your spouse.	Medicare is primary for your spouse; spouse's retiree plan (if any) is secondary, and KTF tertiary.
5. You are both retired and only your spouse is Medicare eligible.	KTF is primary for you; your spouse's plan is secondary. KTF is tertiary for your spouse (secondary for Rx).	Medicare is primary for your spouse's medical. Spouse's plan is secondary for both of you for medical and primary for spouse's Rx. KTF is tertiary for your spouse.

You have family coverage with KTF and are also covered under your spouse's plan.	**KTF Plan is primary for KTF member, <u>except</u> <u>for</u> when Medicare rules apply.**	**Spouse's plan is always primary to KTF for your spouse when Medicare Secondary Payor rules apply.**
6. Your spouse is actively employed, and you are retired and Medicare eligible.	Your spouse's plan is primary for you under MSP rules and Medicare is secondary, KTF is tertiary (secondary for Rx.)	Primary for <u>both</u> you and your spouse for medical and Rx under MSP rules. KTF is secondary for your spouse.
7. Your spouse is actively employed, and you are retired and are <u>not</u> Medicare eligible.	KTF is primary for you and secondary for your spouse. (MSP rules do not apply until you are Medicare Eligible.)	Spouse's plan is primary for your spouse and secondary for you until you are Medicare eligible.
8. Spouse has Medicare and his retiree coverage is a Medicare Supplement Plan with <u>no Rx</u> coverage.	KTF is primary for Rx for both of you. KTF is primary for you and tertiary for your spouse for services covered by Medicare and secondary for medical benefits not covered by Medicare.	Medicare is primary and Medicare Supplement Plan is secondary only for benefits covered by Medicare for spouse. KTF is tertiary for spouse or secondary for benefits not covered by Medicare. KTF is primary for spouse's Rx.
9. Member retired and Medicare eligible and spouse is retired with retiree coverage and not Medicare eligible.	Medicare is primary for you. KTF is secondary for both of you. Your spouse's coverage is tertiary for you.	Spouse's retiree coverage is primary for him and tertiary for you.