THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

Healthcare Coverage (EPO)

The Board of Pensions administers the Benefits Plan of the Presbyterian Church (U.S.A.), offering retirement, healthcare, death, and disability benefits to qualifying members. The Board also provides financial and vocational grants through the Assistance Program.

Summary

The Medical Plan provides healthcare coverage for enrolled employees of the Presbyterian Church (U.S.A.) and their eligible family members through one of two medical coverage options: a preferred provider organization (PPO) or an exclusive provider organization (EPO). The services covered under each option are largely the same, although the cost-sharing provisions differ.

This Benefits Overview covers the benefits and cost-sharing provisions for the EPO. For information about the PPO, see the Healthcare Coverage (PPO) Benefits Overview.

Important! Employees who are given the option of choosing coverage under either the PPO or the EPO should closely compare the provisions of both options. Although the contribution costs may be less for the EPO, the out-of-pocket costs may be higher.

Eligibility

The EPO coverage option is available, at the employer's discretion, in menu options to non-installed employees who are regularly scheduled to work at least 20 hours a week in eligible church or church-related service, and to ministers of the Word and Sacrament who do not have an installed pastoral relationship, regardless of the number of hours they are regularly scheduled to work.

Enrollment is by coverage level:

- Member-only
- Member + Spouse
- Member + Child(ren)
- Member + Family

Children younger than 26 may be enrolled for coverage, regardless of their financial dependency, student status, marital status, or residency. Dependent, totally disabled children who were covered under the plan before they reached age 26 also may be enrolled.

Medical coverage waiver

Under the EPO, members may waive medical coverage for themselves or their eligible family members. If they waive medical coverage for themselves, their family members are not eligible for coverage. (See Waiving Medical Coverage Offered through Menu Options in *Guide to Your Healthcare Benefits 2018*.)

Contributions

Employees and other ministers offered EPO coverage may be asked to contribute up to 50 percent of the cost of Member-only coverage and up to 100 percent of the incremental cost of coverage for their eligible family members.

Medical Plan coverage

The EPO requires use of network physicians and hospitals to access

- preventive care benefits;
- hospital and medical/surgical coverage;
- behavioral health benefits; and
- prescription drug coverage.

The plan also provides resources to improve health and well-being.

Services provided by out-of-network providers are not covered.

Medical and Behavioral Health

BlueCard, administered by Highmark Blue Cross Blue Shield (BCBS), is the primary network of physicians, hospitals, and other healthcare providers available to eligible plan members. Highmark provides access to the BlueCard network nationally, and is responsible for processing claims for all eligible medical expenses. (OptumRx administers the Prescription Drug Program; see the Prescription Drug Benefits Overview on pensions.org.)*

* Triple-S and GeoBlue enrollees should consult their plans' provisions for information about covered services.

Deductibles, office copays, and copayments

The medical deductible is the amount a member pays annually before the plan pays its portion for certain services. Members with covered spouses and/or children are responsible for two medical deductibles, one for themselves and one for all other family members combined. (For deductible amounts, see Key Provisions: EPO chart on pensions.org.)

Except for preventive care, members are also responsible to pay a fixed copay for each office visit: $40 for primary and behavioral health care visits, $60 for specialists. You also pay a copay when you use your telemedicine benefit with Teladoc or seek care at an urgent care center. Copays do not count toward the plan deductible. For other copay amounts, see the Key Provisions: EPO chart on pensions.org.

After reaching the deductible amount, members are still responsible for paying a copayment — 20 percent of the allowable charges for certain services — up to a maximum annual amount for essential health benefits, as determined by the federal government. The 2018 maximum annual amounts, or out-of-pocket limits, are

- $7,350 for member-only coverage;
- $14,700 for family coverage.

There are separate copay requirements for the vision benefit (see Vision Benefits Overview on pensions.org) and prescription drugs (see Prescription Drug Cost Comparison chart below).

Members can reduce their costs by completing Call to Health and using generic drugs and prescription mail-order services. See Guide to Your Healthcare Benefits 2018 on pensions.org for further information.

PRESCRIPTION DRUG COST COMPARISON

Prescription Drugs	Retail (30/90 days)	Mail order (90 days)
Generic	$12/$36	$30
Formulary brand	35% of cost; 30 days: $35 min to $150 max 90 days: $105 min to $450 max	35% of cost; $85 min to $375 max
Non-formulary brand	**Not covered**	
Prescription copayment maximum	**Does not apply**	
Combined maximum	$7,350/member*; $14,700/family*	

* Includes in-network deductible, office visits copays, copayments, and prescription drug copays (reflects Affordable Care Act maximums).

Enrollment

Employees may enroll for benefits within 60 days of starting employment or on an initial benefits eligibility date set by the employer, if it is later. Retroactive enrollments are not permitted. Coverage is effective upon enrollment.

Employees may also enroll or change benefits elections during annual enrollment, in the fall. The only other time a member may enroll or make changes is if he or she experiences a qualifying life event, such as a marriage or birth of a child. Changes must be made within 60 days of the qualifying life event.

Enrollment is via Benefits Connect, accessible from the pensions.org home page. Employees elect benefits from those the employer has selected to offer their employment classification.

To elect coverage for a spouse, you must provide the Board of Pensions with a copy of your marriage certificate; for children, you must provide a copy of the birth certificate, legal documentation for wards, or a letter of intent or decree for adoption.

This is not a full description of benefits and limitations of the plan. If there is any difference between the information presented here and the provisions of the Benefits Plan of the Presbyterian Church (U.S.A.), the plan terms will govern. Visit pensions.org or call the Board at 800-773-7752 (800-PRESPLAN) for a copy of the plan document.

THE BOARD OF PENSIONS OF THE PRESBYTERIAN CHURCH (U.S.A.)