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

Healthcare Coverage (EPO) – 2019

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 and their eligible family members through one of three medical coverage options: a preferred provider organization (PPO), an exclusive provider organization (EPO), or a qualified high deductible health plan (HDHP). The services covered under each option are largely the same, although the cost-sharing provisions differ.

This Benefits Overview covers the benefits for the EPO. For information about the PPO and HDHP, see the applicable Healthcare Coverage Benefits Overviews on pensions.org.

Important! Employees who have the option of choosing coverage under two or more medical coverage options should closely compare the provisions of each option. The option with the lowest contribution costs may have the highest out-of-pocket costs when care is received.

Eligibility

The EPO is available, at the employer's choice, in menu options to employees, including ministers not in installed positions, who are regularly scheduled to work at least 20 hours a week, and to ministers in self-employed validated service 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 are covered under the plan before they reach age 26 also are eligible.

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, including 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 EPO also provides resources to improve health and well-being.

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

Medical and Behavioral Health

Blue Cross Blue Shield (BCBS) is the network of physicians, hospitals, and other healthcare providers available to eligible plan members. Highmark provides access to the provider network nationally, and is responsible for processing claims for all eligible medical expenses. (OptumRx administers the prescription drug program; for details, see the applicable 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 the 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 healthcare 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 2019 maximum annual amounts, or out-of-pocket limits, are

- $7,900 for Member-only coverage;
- $15,800 for family coverage.

PRESCRIPTION DRUG COST COMPARISON

Prescription Drugs	Retail (30/90 days)	Mail order (90 days)
Preventive generic	$6/$18	$15
Preventive formulary brand	$30/$90	$75
Preventive non-formulary brand	**Not covered**	
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	**Part of the combined maximum out of pocket**	
Combined maximum	$7,900/member*; $15,800/family*	

* Includes in-network deductible, office visit copays, copayments, and prescription drug copays.

There are separate copay requirements for the vision benefit (see Benefits Overview: Vision Benefit 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.

Enrollment

Employees may enroll for benefits within 60 days of starting employment or 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 benefit group.

To elect coverage for a spouse, the member must provide the Board of Pensions with a copy of the marriage certificate; for children, the member 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.

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