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

Healthcare Coverage (HDHP) – 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 costs differ.

This Benefits Overview covers the benefits for the HDHP. For information on the PPO and EPO, 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. Although the contribution costs may be less for the HDHP coverage option, the out-of-pocket costs may be higher.

Eligibility

The HDHP option is available in menu options, at the employer's choice, 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 HDHP, 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 offered HDHP 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 HDHP 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 HDHP 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.

Health savings account

A health savings account (HSA) is available for those who elect the HDHP, allowing members to pay for certain healthcare expenses, including deductible and copayment amounts, with money free from federal taxes. Employers frequently use funds generated from the premium cost savings of offering a high deductible health plan to contribute to HSAs on behalf of employees. See Benefits Overview: Health Savings Account (HSA) on pensions.org for more information.

Deductibles 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 the entire family deductible amount.

Except for preventive care, members pay out of pocket for all covered healthcare services, including network office visits and when using the telemedicine benefit with Teladoc or seeking care at an urgent care center, until their expenses reach the deductible amount.

PRESCRIPTION DRUG COST COMPARISON

Benefit	Retail 30 days/90 days	Mail order 90 days
Preventive generic	$6/$18 (Not subject to deductible)	$15 (Not subject to deductible)
Preventive formulary brand	$30/$90 (Not subject to deductible)	$75 (Not subject to deductible)
Preventive non-formulary brand	**Not covered**	
Generic Formulary brand	After deductible, 30% of cost; 30 days: $150 max. 90 days: $450 max.	After deductible, 30% of cost; $375 max.
Non-formulary brand	**Not covered**	
Prescription drug copayment maximum	**Part of the combined maximum out of pocket**	
Combined maximum	$6,750 member* $13,500 family*	

* Includes network deductible, copayments, and prescription drug copays (reflects Affordable Care Act maximums for 2019).

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. Unlike the deductible, if any one covered family member's expenses reach the Member-only copayment maximum before the family copayment maximum is reached, the plan will pay 100 percent of allowable charges for that family member for the rest of the year.

There are separate copay requirements for 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 through 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.