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

Guide to Your Healthcare Benefits

FOR ACTIVE MEDICAL PLAN MEMBERS

PLEASE NOTE:

While this booklet has been updated for 2021, it does *not* reflect important Medical Plan provisions in place due to the COVID-19 pandemic.

Please visit the coronavirus resources page on pensions.org to learn about updates to the Medical Plan in response to the COVID-19 health crisis.

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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 guide addresses highlights of our Medical Plan, principally administered by Highmark Blue Cross Blue Shield, Express Scripts, and Cigna. Triple-S and GeoBlue enrollees should consult their plans' provisions for information about covered services.

Welcome

Dear Member,

The Medical Plan of the Presbyterian Church (U.S.A.) is one of the most comprehensive healthcare plans in the church benefits community. This Guide to Your Healthcare Benefits can help you understand — and get the most out of — your healthcare coverage by providing essential information on

- eligibility for coverage;
- covered services;
- potential costs; and
- your rights and responsibilities under the plan.

If you need detailed information on specific plan provisions, please refer to The Benefits Plan of the Presbyterian Church (U.S.A.), the official plan document, available on pensions.org.

The Board of Pensions has three goals in its role overseeing this plan for you, your family, and other members: (1) encourage you to take care of your health; (2) support your efforts to be a wise consumer of healthcare services; and (3) steward plan resources for the benefit of all those who serve the Church. We hope you'll take advantage of the preventive care, medical screenings, and wellness benefits available through the plan, as these can help identify health risks, limit complications, and improve your health and well-being.

I invite you to participate in Call to Health, which promotes all aspects of wholeness: spiritual, health, financial, and vocational. Participating in Call to Health from December 1, 2020, through November 12, 2021, also enables you to lower your individual and family deductibles for 2022. Look for information about Call to Health on **pensions.org** and at **calltohealth.org**.

If you have questions about your coverage after reading this guide, visit pensions.org for further information, call 800-773-7752 (800-PRESPLAN) to speak with a service representative, or contact one of the service providers listed in the Contact Information section of this guide.

We wish you the very best of health!

Executive Vice President & Chief Benefits Officer

Overview

The Medical Plan, a key component of the Benefits Plan of the Presbyterian Church (U.S.A.), is a self-funded church plan designed to care for and protect a community of members. These members are employees of churches and organizations affiliated with the Presbyterian Church (U.S.A.), and their families. The Medical Plan plays a key role in the care of this community, encouraging both community and member responsibility for healthcare costs — and your health.

Your employer may offer one or more of three medical options through the Medical Plan: a preferred provider organization (PPO), an exclusive provider organization (EPO), and a qualified high deductible health plan (HDHP). The types of services that are covered under each of the options are largely the same, although how much you pay out of pocket when you receive care differs.

Unless otherwise specified, the benefits described in this guide are included as part of your medical coverage, regardless of which option you choose: the PPO, EPO, or HDHP.

Under all medical options, you'll have comprehensive healthcare coverage, which includes

- preventive care;
- hospital and medical/surgical coverage;
- behavioral health and substance use disorder benefits;
- prescription drug coverage; and
- special benefits and resources to improve your health and well-being, including:
  - Centers of Excellence;
  - Livongo for Diabetes;
  - Employee Assistance Plan (EAP); and
  - Call to Health.

The Board of Pensions of the Presbyterian Church (U.S.A.), an agency of the Church, administers the Medical Plan. The Board contracts with service providers, which are companies that specialize in health and wellness benefits, to provide network access, claims processing, and other support services. The service provider for medical benefits is Highmark Blue Cross Blue Shield (BCBS). Express Scripts, a leading pharmacy benefits manager, is the service provider for prescription drug benefits. (For a complete listing of service providers, see Contact Information.)

This guide summarizes these benefits and explains how to access them. It also provides general information about cost and eligibility.

ABOUT THE PLAN

The Benefits Plan, a church plan under §414(e) of the Internal Revenue Code, is not subject to the Employee Retirement Income Security Act of 1974 (ERISA). Under the Church Plan Parity and Entanglement Prevention Act of 1999, it is exempt from state insurance licensing, solvency, and funding requirements.

The Medical Plan of the Presbyterian Church (U.S.A.) is self-funded, which means its benefits are not provided through an insurance company. The plan's ability to pay claims depends on continued contributions, claims experience, and market performance.

The terms *out of network* and *non-network* refer to healthcare providers that do not participate in the PPO, EPO, or HDHP.

A NETWORK-DRIVEN PLAN

The Medical Plan provides access to a broad network of physicians, hospitals, and other medical facilities with which your service provider has a contractual relationship; these are called *network providers*. All members are encouraged to use network providers. The contracted rates established with network providers result in savings to both you and the plan, and you can receive services from any network provider without a referral from a primary care physician.

Locating network providers

Visit highmark.com/pcusa and click on **Doctors** to find participating network physicians and other healthcare providers.

PPO medical option

Under the PPO option, you may receive treatment from a provider who is in network or out of network; however, seeing an out-of-network provider when you have access to network providers will cost you more. Emergency services provided at an out-of-network provider are the only exception. See Emergency and Urgent Care Services.

> **The term *out of network* refers to healthcare providers that do not participate in the national Blue Cross Blue Shield (BlueCard PPO) network.**

EPO medical option

Under the EPO option, you must use network providers (the same provider network as the PPO). Unlike the PPO, the EPO does not cover care received from out-of-network providers except for emergency services. If you visit an out-of-network provider when you have access to a provider that participates in the network, you are responsible for all costs incurred.

HDHP medical option

The HDHP option provides access to the same provider network as the PPO and EPO, and, like the EPO, it does not cover care received from out-of-network providers except for emergency services. You are responsible for all costs incurred if you visit an out-of-network provider when you have access to network providers.

Non-network area

If you live in an area not served by the plan's network — a *non-network area* — and therefore cannot access a participating provider, your medical costs under the plan will be the same as if you were using a network provider. When you see a non-network provider, you may need to submit your own claims for reimbursement by the plan.

Whether you reside in a network or non-network area is determined by whether network providers are available within a certain travel distance.

In the rare instance where a particular specialty is not available in your area through the plan's network, out-of-network expenses may be approved for reimbursement at the network rate. Contact your service provider or the Board in advance for this approval.

Your service providers

Be familiar with the service providers that administer benefits on behalf of the Board of Pensions for all three medical options. (See the Appendix for a list of the plan's service providers and their contact information.)

Medical and behavioral health services

Highmark Blue Cross Blue Shield (BCBS) oversees most of your healthcare benefits. Call them to precertify all inpatient medical, surgical, and behavioral health services or to reach the 24-Hour Nurse Line. Other services provided are described in the section Other Well-Being Benefits.

> **YOUR PASSPORT TO MEDICAL BENEFITS**
> **Show your medical ID card at your healthcare provider or hospital admissions office to identify yourself as a plan member. The back of your ID card lists services that require advance approval, or precertification, along with the numbers to call for EAP services (provided by Cigna) and telemedicine (provided by Teladoc), and your service provider's 24-Hour Nurse Line. Whenever you receive new ID card, shred the old one.**

Cigna administers the Employee Assistance Plan (EAP). You don't need an ID card to access EAP services. (See the section Other Well-Being Benefits for information on the EAP.)

Telemedicine

You also have access to a telemedicine benefit with Teladoc through Highmark BCBS. (See Use the Telemedicine Option under Emergency and Urgent Care Services.)

Routine vision services

Your healthcare coverage includes access to the VSP Choice network, a broad network of optometrists and ophthalmologists administered by VSP, for routine annual eye exams. (The VSP Choice network is distinct from the BlueCard PPO network of physicians.)

You don't need an ID card to access VSP services under the Medical Plan.* (See Routine Vision Exam in Other Well-Being Benefits.)

Prescription drug services

As part of your healthcare coverage, you have access to prescription drug benefits, both at participating local retail pharmacies and through mail order. These benefits are administered by Express Scripts, the plan's service provider for prescription drugs. See the section Your Prescription Drug Benefits.

You will receive separate prescription drug ID cards from Express Scripts (in addition to your medical ID cards). Use your Express Scripts card when you fill prescriptions at a participating pharmacy, or order directly from Express Scripts for delivery by mail. You can also use this card to get routine vaccines, such as flu shots, at a participating pharmacy at no cost to you.

> **WHERE TO GO WHEN YOU NEED TO KNOW**
> **The phone numbers and web addresses of the Board of Pensions and its service providers are listed in the Contact Information section, in the back of this guide.**

**Individuals enrolled in the HDHP will be automatically enrolled in the VSP vision exam benefit. The vision exam benefit is not considered part of the HDHP.*

EMERGENCY AND URGENT CARE SERVICES

If you need emergency care, call 911 and seek care from the nearest provider or hospital emergency room (ER), regardless of network participation. ERs are the most prepared and best equipped facilities to handle serious, potentially life-threatening medical needs.

The services provided in an ER are subject to the plan's deductible and coinsurance provisions.

Notification of inpatient admissions

To maximize your benefits, you must notify Highmark Blue Cross Blue Shield (BCBS) within 48 hours of an inpatient emergency admission for:

- physical illness or injury
- behavioral health or substance use disorder treatment

If you go to an ER and are admitted to an out-of-network hospital or other facility, once the emergency is addressed, you may need to transfer to a network provider.

A visit to an ER *without an inpatient admission* does not have to be certified — that is, you do not have to notify Highmark BCBS.

Alternatives to the ER

If unsure whether you really need emergency care when your symptoms are not life-threatening, consider these alternatives (applicable copays, deductibles, and/or coinsurance apply):

- **Contact your primary care physician**. Your primary care physician is generally best suited to treat non-life-threatening conditions and manage your care over time.
- **Use the telemedicine option**, provided by Teladoc through Highmark BCBS, at 800-835-2362. This care option can be especially helpful when common, acute issues, such as ear infections, sinusitis, or the flu, develop in the middle of the night or while traveling.
- **Call the Highmark BCBS 24-Hour Nurse Line**. Always available, including weekends and holidays, the Nurse Line is staffed by experienced nurses, who will help you to assess the problem and consider the most appropriate place for treatment. (See 24-Hour Nurse Line in Other Well-Being Benefits.)
- **Go to an urgent care center**. A freestanding healthcare clinic, an urgent care center generally is staffed by physicians who can treat serious but non-life-threatening accidents and injuries, such as burns, cuts, and sprains, or common illnesses like the flu, allergic reactions, and infections. No appointment is necessary.
- **Visit a retail medical clinic** (typically in a pharmacy). Use a retail medical clinic — generally staffed by certified registered nurse practitioners — for minor, uncomplicated ailments, such as colds, rashes, bumps, and scrapes.

COPAYS AND COINSURANCE

Your deductibles, copays, and coinsurance responsibilities depend on whether you are covered under the PPO, EPO, or HDHP and the type of service you receive. See the Key Provisions chart in the Appendix or on pensions.org.

UNDERSTANDING YOUR BENEFITS

The Board of Pensions is here to help you understand — and make the best use of — your benefits. The Board provides several key resources to help you with all your benefits under the Benefits Plan and the Medical Plan in particular:

- **Pensions.org**: Features guidance on using your benefits and other important information. Visit pensions.org/members whenever you have a benefits-related question.
- **Benefits Connect**: Provides secure, online access to your personalized benefits information. Available 24/7 from the homepage of pensions.org, this site lets you
  - enroll in and review key benefits coverage, including medical coverage, and certain additional benefits online;
  - report a qualifying life event and/or change/elect benefits coverage;
  - update contact information if your address, phone number, and/or email changes;
  - view dependent information; and
  - simplify logins to the websites of many of the Board's service providers.
- **Board of Pensions service representative**: Helps you with your questions about plan benefits and is focused on ensuring you receive excellent service, tailored to your needs. Speak with a service representative when you have
  - eligibility, dues, or payment questions;
  - a work-situation or salary change; or
  - concerns that arise with a service provider.

WAYS TO CONTACT THE BOARD

- **Log on to Benefits Connect for medical coverage information (including coverage levels), resources, and support.**
- **Call 800-773-7752 (800-PRESPLAN) Monday-Friday, 8:30 a.m. to 7 p.m. ET.**
- **Email memberservices@pensions.org.**

Eligibility and Coverage Contributions

Eligibility for Medical Plan coverage and any coverage contributions are determined by your employer following the broad parameters of the plan.

Employers may offer medical coverage to

- ministers of the Word and Sacrament not in an installed pastoral relationship who are regularly scheduled to work 20 or more hours per week; and
- employees other than ministers who are regularly scheduled to work 20 or more hours per week.

Your employer may ask you to contribute toward the cost of coverage (see Contributions). If you decide to enroll in medical coverage, you may also enroll your eligible family members, subject to any contributions required by your employer.

Note: If you are enrolled in Pastor's Participation, your employer pays 100 percent of the cost for coverage. See the section Pastor's Participation for more information.

Eligible family members are

- spouses;
- children younger than 26, regardless of their financial dependency, marital status, or residency; and
- financially dependent, totally disabled children who are disabled and covered under the plan before they reach age 26.

Unless you're enrolled in Pastor's Participation, you may waive medical coverage for yourself and any family members. See Waiving Medical Coverage.

Note: If you waive medical coverage for yourself and/or your eligible family members, you will not be able to elect Medical Plan coverage until the next annual enrollment (unless you have a qualifying life event).

Contributions

Employer-specific coverage-level rates apply to medical coverage (PPO, EPO, and/or HDHP) that is not provided through Pastor's Participation.

When only one medical option is offered, your employer must pay at least 50 percent of Member-only coverage for that option and you may be required to contribute the balance of the cost of coverage. If more than one option is offered, your employer must contribute at least 50 percent of Member-only coverage in the lowest-cost option offered, and you may be required to pay the balance of the cost of coverage.

You may also be required to pay up to the full cost of coverage for family members.

Waiving medical coverage

If you are considering waiving medical coverage, you should carefully consider the following:

- Before waiving Medical Plan coverage and enrolling in your spouse's employer health plan, you should confirm whether you are eligible to enroll in your spouse's plan and the cost. Some employer health plans allow spouses to enroll only if the spouse does not have access to other medical

coverage. If your spouse's employer has this rule, you would not be able to enroll in their plan. In addition, some employers may allow spouses to enroll but impose an additional charge for those who have access to coverage elsewhere.

- If you are offered coverage through the Medical Plan, you cannot qualify for a subsidy for coverage obtained through the federal Health Insurance Marketplace (healthcare.gov) or a state's health insurance exchange.

If you waive medical coverage for yourself and/or your family members, you will not be able to elect Medical Plan coverage until the next annual enrollment period (unless you have a qualifying life event).

PASTOR'S PARTICIPATION

Ministers in an installed pastoral relationship must be enrolled in Pastor's Participation, regardless of the number of hours the pastor is regularly scheduled to work. Pastor's Participation may be offered to ministers who are not in an installed pastoral relationship if regularly scheduled to work at least 20 hours a week.

Benefits in Pastor's Participation include full family medical coverage in the PPO option on a non-contributory basis (the employer pays 100 percent of the cost of coverage).

In addition to the pastor, the following family members are eligible for full family medical coverage:

- spouses
- children younger than 26, regardless of their financial dependency, marital status, or residency
- financially dependent, totally disabled children who are disabled and covered under the plan before they reach age 26

Waiving medical coverage offered through Pastor's Participation

If you are enrolled in Pastor's Participation, you may not waive medical coverage for yourself but may waive coverage for your spouse and/or other eligible family members. If you waive coverage for family members, your employer is still responsible for paying the full dues amount; family member participation does not affect dues.

IF YOU EXPERIENCE A QUALIFYING LIFE EVENT

You must report any change in marital or eligible dependent status to the Board of Pensions within 60 days of the event.

To report a life event, log on to Benefits Connect and choose My Benefits on the homepage; then select Life Events and follow the prompts to report your event, provide supporting documentation, and, if applicable, add eligible dependents.

MEDICAL CONTINUATION COVERAGE

If your coverage under the Medical Plan is ending, you may be eligible to extend your medical coverage on a self-pay basis by enrolling in medical continuation coverage; or, if Pastor's Participation coverage is ending, by enrolling in transitional participation coverage. For more information on these programs, including eligibility rules, see Continuing Coverage at Termination of Eligible Service later in this guide, or visit pensions.org.

Your Medical Benefits

Your medical coverage is designed to promote your health and well-being and give you significant financial protection. It includes coverage for preventive, routine, and catastrophic care through a network of providers with a proven record of delivering high-quality care. This section discusses what's covered and what's not, the rules and limitations of coverage under the Medical Plan, and your share of the costs for covered medical, surgical, and behavioral health treatment through the plan. It also outlines reimbursement procedures for out-of-network care, if applicable. (Prescription drug coverage is discussed in the next section.)

WHAT'S COVERED

The Medical Plan covers the services and supplies shown under Covered Medical Services. Coverage is for amounts up to the plan allowance and subject to the applicable deductibles, coinsurance, and/or copays. Although this list shows most of the services and supplies covered by the plan, it is not necessarily all-inclusive. (Prescription coverage under the plan is described in Your Prescription Drug Benefits.)

If you are unsure whether a service or supply is covered, contact Highmark Blue Cross Blue Shield at the number on the back of your medical ID card before incurring the expense. If still in doubt, call the Board of Pensions at 800-773-7752 (800-PRESPLAN) and speak with a service representative.

Limits to coverage

The Medical Plan has maximum reimbursement limits on certain services. (For a list of these limits, see the Appendix.)

Covered medical services[1]

- preventive care services[2]
- immunizations
- routine child, routine adult, and routine gynecological
- professional services
- primary care and specialist physician office visits (whether in-person or virtual), allergy shots, therapeutic injections, surgery, and second opinions before a non-urgent surgical or diagnostic procedure is performed;
- telemedicine (via phone, online video, or mobile app through Teladoc);
- diagnostic laboratory tests (whether outpatient, independent lab, or physician's office)
- outpatient imaging services, including MRI, CT scan, and PET scans and ultrasounds (with precertification), and X-rays (without precertification)
- nuclear stress tests (with precertification)
- hearing aids and fittings[3]
- advanced reproductive technology procedures (up to three attempts) [4]
- behavioral health (outpatient therapy, including counseling via EAP)
- outpatient rehabilitation, including physical, occupational, and speech therapy[5]
- routine eye exam[6]
- chiropractic care
- acupuncture
- consultations with a registered dietician

- hospital services
- inpatient stay (with precertification), including related services (imaging, testing, etc.) and surgery
- inpatient rehabilitation (with precertification)
- outpatient procedures (with precertification for designated procedures)
- skilled nursing facility
- mastectomy-related benefits, including reconstruction, surgery, prostheses, and treatment of physical complications
- emergency room care for medical emergency
- organ transplants[7]
- behavioral health (inpatient care) (with precertification)
- other services and supplies
- ambulance
- urgent facility care
- private duty nursing in a hospital (if intensive care unit not available)
- home health and hospice care (with precertification)
- durable medical equipment and supplies

[1]Subject to plan's managed care and exclusion and limitation provisions.
[2]For a detailed list, see the Preventive Schedule on pensions.org.
[3]The plan pays for hearing aids and fittings once every three years, up to a certain limit. See the Medical Plan Reimbursement Limits chart in the Appendix.
[4]See the Medical Plan Reimbursement Limits chart in the Appendix.
[5]See Specialized Therapies in this section.
[6]See the Key Provisions: Vision Exam Benefit chart in the Appendix.
[7]See Organ Transplants in this section.

YOUR SHARE OF THE COSTS FOR COVERED SERVICES

The Medical Plan promotes shared responsibility for healthcare costs by requiring plan members to pay copays, deductibles, and coinsurance for certain services. Your share of the costs for medical expenses depends on

- the medical option you elect — depending on whether you're covered under the PPO, the EPO, or the HDHP, you are responsible for different deductibles, copays for office visits (PPO and EPO only), costs for specific outpatient services, and coinsurance (up to specified maximum amounts).
- the type of service you need — when you visit the doctor, the amount you pay first depends on whether you are getting preventive care or seeking treatment for an illness, injury, or medical condition. In addition, your share of the cost for non-preventive services differs depending on whether you are in the PPO, EPO, or HDHP.
- your choice of provider — under the PPO, if you use a network provider you pay less than if you see an out-of-network provider. The EPO and HDHP do not cover care received from out-of-network providers, so you must see a network provider or you'll pay the full cost for the service.

For a complete list of covered preventive services, screenings, and procedures, see the Preventive Schedule on pensions.org.

For cost-sharing details for covered non-preventive care, see the Key Provisions chart in the Appendix.

PREVENTIVE CARE BENEFITS

The plan provides annual preventive care coverage for you and your covered family members, at no cost to you, to promote wellness and early detection of disease.

> **Plan allowance — this is the maximum amount payable by the plan (including the member's share) to the provider for a given procedure or service based on the Blue Cross Blue Shield PPO contracted rate in the area.**
>
> **The plan allowance for a given procedure or service differs depending on whether it is performed by a network, non-network, or out-of-network provider.**

Under all medical options, when you visit a network provider, the plan covers 100 percent of the plan allowance, with no deductible, copay, or coinsurance (you pay $0) for

- annual wellness exams with a primary care provider according to the Preventive Schedule; and
- eligible preventive screenings/procedures and immunizations.

Eligibility for covered preventive screenings/procedures and immunizations is based on age and gender. Refer to the Preventive Schedule on pensions.org for details. In addition to preventive screenings and immunizations for adults and children, covered preventive services include nutritional counseling and other services for prevention of obesity.

> **Special screenings, immunizations, and tests for internationally adopted children, through age 18, are covered at 100 percent of the plan allowance. For details, see Preventive Health Recommendations for Internationally Adopted Children under Other Well-Being Benefits later in this guide.**

Prescribed contraceptives on the formulary also are 100 percent covered under all medical options (you pay $0). Prescription drug coverage under the plan is described in the section Your Prescription Drug Benefits.

If you see an out-of-network provider

PPO only: You pay a percentage of the plan allowance for preventive care office visits (see below). Blood work, screenings, and tests listed on the Preventive Schedule (for your age and gender) are covered at 100 percent of the plan allowance.* You may be billed for the balance of charges over the plan allowance.

EPO and HDHP: You must visit a network provider to access preventive care benefits; otherwise, you pay the full cost for these services.

Preventive care office visits

If you use a network provider, you pay no copay for annual preventive care office visits with primary care physicians, pediatricians, and gynecologists. Blood work, screenings, and procedures listed on the Preventive Schedule (for your age and gender) are covered at no cost to you.*

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* *See the Preventive Schedule on pensions.org.*

If you live in a non-network area (see A Network-Driven Plan), you pay no copay for annual preventive care office visits with primary care physicians, pediatricians, and gynecologists. Allowed blood work and tests are covered at no cost to you.*

If a health condition is discovered or diagnosed during your exam, as long as no signs or symptoms of illness are apparent, your visit will still be 100 percent covered under the preventive care benefit, and your provider should code the visit as preventive. (Follow-up tests related to a detected health condition are subject to normal plan provisions.)

PPO only: If you use an out-of-network provider in a network area, the plan covers 50 percent of the plan allowance, with no deductible, and you pay the remaining 50 percent and any charges above the allowed amounts. You may be billed for the balance of charges over the plan allowance.

NON-PREVENTIVE MEDICAL BENEFITS

In addition to the plan's preventive benefits, if you are treated for an illness, injury, or medical or behavioral health condition, the plan pays a portion of the cost for medically necessary healthcare services and supplies.

Medical Necessity Standard

The Medical Plan pays its share of covered costs for non-preventive care when the services are medically necessary. Medically necessary healthcare services and supplies are

- provided or prescribed by an accredited hospital or a licensed healthcare practitioner;
- appropriate to the patient's symptom(s) and diagnosis or treatment plan;
- not custodial or for the convenience of the patient or provider;
- not educational, experimental, or investigative in nature;
- of demonstrated medical value to the patient (that is, the patient can benefit from the proposed care); and
- the most appropriate standard or level of services.

Your share of the cost for covered non-preventive services

Your out-of-pocket costs for covered non-preventive services include the following:

- **copays** - A copay is a flat dollar amount that you pay upfront for certain services when using network providers.
- **deductibles** - The deductible is a specified annual dollar amount you must pay for covered medical services before the plan begins to pay benefits.
- **coinsurance** (up to certain maximums) - Coinsurance (previously referred to as copayments) is the percentage of the plan allowance for covered services that you pay after meeting the deductible.

How much you pay out of pocket in the form of copays, deductibles, and coinsurance varies under each medical option (PPO, EPO, and HDHP), as outlined in the following sections.

You will also pay out of pocket for any ineligible medical expenses (see What's Not Covered).

See the Preventive Schedule on pensions.org.

Expenses that do not count toward the medical deductible
The following expenses do not count toward meeting your annual deductible (or the plan's medical out-of-pocket maximum, if enrolled in the PPO):

- **copays, including office and urgent care center visits and telemedicine consultations**
- **expenses that exceed the plan allowance, as determined by the service provider**
- **copays for prescription drugs covered by Express Scripts**
- **ineligible expenses, such as cosmetic surgery or experimental procedures**

PPO copays, deductibles, coinsurance, and out-of-pocket maximums

Copays

Except for preventive care, if you are enrolled in the PPO, you pay a fixed copay for each network office visit (whether in-person or virtual): $25 for primary care and behavioral healthcare visits or visits to a retail clinic, $45 for visits to a specialist or when seeking care at an urgent care center, and $10 when using the telemedicine benefit.

Copays do *not* count toward the PPO deductible or medical out-of-pocket maximum.

There are separate copay requirements for the vision exam benefit (see Key Provisions chart) and prescription drugs (see Prescription Drug Benefits).

Deductibles

For other types of non-preventive care, such as inpatient hospital stays, surgery, diagnostic lab tests, X-rays, and emergency room visits, you must first pay an annual deductible before the PPO pays a portion of covered expenses.

The PPO deductible amounts are based on a percentage of your effective salary (determined by salary range and subject to the medical participation minimum and maximum), as shown in the 2021 PPO Deductibles chart. If you cover your spouse and/or your children, you are responsible for two medical deductibles, one for yourself and one for all other family members combined.

You can reduce your deductibles for the next plan year by participating in Call to Health (see Health and Wholeness: Call to Health in the Other Well-Being Benefits section).

2021 PPO deductibles			
Salary range	Network deductible[1,2,3]		Out-of-network deductible[1,2,3]
	Without Call to Health	Call to Health[4]	
Up to $48,759	$660	$440	$1,100
$48,760 -$53,514	$735	$490	$1,220
$53,515-$58,269	$805	$540	$1,340
$58,270-$63,024	$875	$585	$1,460
$63,025-$67,779	$950	$635	$1,580
$67,780-$72,534	$1,020	$680	$1,695
$72,535-$77,289	$1,090	$730	$1,815
$77,290-$82,044	$1,160	$775	$1,935
$82,045-$86,799	$1,235	$825	$2,055
$86,800 or more	$1,305	$870	$2,170

[1] Members with covered spouses and/or children are responsible for two medical deductibles, one for themselves and one for all other family members combined.

[2] The annual deductible for a disabled member and his/her eligible family is based on the lesser of the disabled member's last effective salary or the congregational ministers' median at the time the disability began.

[3] The annual deductible for individuals enrolled for medical continuation coverage shall be established on the basis of the congregational ministers' median.

[4] Completion of Call to Health in the current year reduces the member's deductibles in the following year.

Effective salary — any compensation received by a plan member from an employer during a plan year (January 1 through December 31), including sums paid for housing or the value of a manse. Effective salary is used to determine medical dues paid by employers for those in Pastor's Participation. Effective salary also determines your medical deductibles and medical out-of-pocket maximums if you're enrolled in the PPO.

For more information, see Course 1: Effective Salary of the Board's e-learning series Terms of Call or the publication Understanding Effective Salary, both available from pensions.org.

Coinsurance and out-of-pocket maximums

After reaching the deductible amount, you are still responsible for paying a defined percentage of the cost for certain services — your coinsurance — up to a maximum annual amount. For network services, your coinsurance is 20 percent of the allowable charges; for out-of-network care, it is 40 percent (50 percent with no deductible for doctors' office visits).

The annual medical out-of-pocket maximum (the most you will pay in the form of coinsurance) is based on your effective salary. Unlike deductibles, only one medical out-of-pocket maximum applies per family (see 2021 PPO Medical Out-of-Pocket Maximums chart).

After your out-of-pocket costs (*not including office visit and prescription copays and deductibles*) reach the medical out-of-pocket maximum, the plan pays 100 percent of all additional eligible expenses incurred for the remainder of the year. A separate out-of-pocket maximum applies for prescription drugs (see the Prescription Drug section of the Key Provisions chart in the Appendix).

2021 PPO medical out-of-pocket maximums[1] (does not include office visit copays, deductibles, or prescription drug costs)		
Salary range	**Network**	**Out-of-network**
Up to $48,759	$2,200	$6,600
$48,760 -$53,514	$2,440	$7,320
$53,515-$58,269	$2,680	$8,040
$58,270-$63,024	$2,915	$8,745
$63,025-$67,779	$3,155	$9,465
$67,780-$72,534	$3,390	$10,170
$72,535-$77,289	$3,630	$10,890
$77,290-$82,044	$3,865	$11,595
$82,045-$86,799	$4,105	$12,315
$86,800 or more	$4,340	$13,020

[1] After a member reaches the annual medical out-of-pocket maximum; the Medical Plan pays 100 percent of eligible expenses up to the plan allowance, except for office visit copays. The medical out-of-pocket maximum applies to the member and family combined.

If your salary changes during the year and you enter a new salary range, your deductibles and medical out-of-pocket maximums will be adjusted to reflect the new salary range as of the date the Board of Pensions is notified of the change in salary.

Your total maximum out-of-pocket expenses in a given year, including the member's or family's deductible, office visit copays, coinsurance, and prescription drug costs combined, are capped at $5,000 per member and $10,000 per family, which is less than the Affordable Care Act (ACA) limit on annual out-of-pockets costs. However, it is very unlikely that your annual costs would reach these amounts.

EPO copays, deductibles, coinsurance, and out-of-pocket maximums

Copays

Except for preventive care, if you are enrolled in the EPO, you pay a fixed copay for most outpatient services: $40 for primary care and behavioral healthcare office visits (whether in-person or virtual) or visits to a retail clinic, $60 for specialists or when seeking care at an urgent care center, and $10 when using the telemedicine benefit. You also pay flat dollar copays, rather than percentage coinsurance, for diagnostic services (basic and advanced); physical, speech, and occupational therapy; and spinal manipulations, as shown in the Key Provisions chart.

Copays do *not* count toward the EPO deductible.

There are separate copay requirements for the vision exam benefit (see Key Provisions chart) and prescription drugs (see Prescription Drug Benefits).

Deductibles

Under the EPO medical option, deductibles are flat dollar amounts, listed in the Key Provisions chart in the Appendix. If you cover your spouse and/or your children, you are responsible for two medical deductibles, one for yourself and one for all other family members combined.

You must pay the annual deductible before the EPO begins to pay benefits for in- and outpatient hospital services, emergency room visits, and certain other services (see Key Provisions chart).

You can reduce your deductibles for the next plan year by participating in Call to Health (see Health and Wholeness: Call to Health in the Other Well-Being Benefits section).

Coinsurance and out-of-pocket maximums

After reaching the deductible amount, you are still responsible for paying coinsurance — 20 percent of the allowable charges for covered services — up to the total maximum out-of-pocket amount. The EPO total maximum out-of-pocket amounts are shown on the Key Provisions chart in the Appendix.

All your healthcare-related out-of-pocket expenses for covered services, including copays, deductibles, coinsurance, and prescription drug costs, count toward the total maximum out-of-pocket amount.

HDHP copays, deductibles, coinsurance, and out-of-pocket maximums

Copays

There are no copays for medical care and treatment. All covered non-preventive care is subject to the annual deductible.

There are separate copay requirements for the vision exam benefit* (see Key Provisions chart) and preventive prescription drugs (see Prescription Drug Benefits).

Deductibles

Like the EPO, HDHP deductibles are flat dollar amounts, listed in the Key Provisions chart in the Appendix. However, the HDHP deductibles are significantly higher than the PPO or EPO. If you cover your spouse and/or your children, *you are responsible for the entire family deductible amount*.

Except for preventive care, if you are enrolled in the HDHP, you pay out of pocket for *all* covered healthcare services — including network office visits, telemedicine consultations through Teladoc, and visits to an urgent care center — until your expenses reach the deductible amount. The HDHP deductible also applies for prescription drugs unless the drug is designated as preventive (see Prescription Drug Benefits).

You can reduce your deductible for the next plan year by participating in Call to Health (see Health and Wholeness: Call to Health in the Other Well-Being Benefits section).

If you enroll in the HDHP, you may be eligible to set up and contribute to a health savings account (HSA) and use your HSA funds to help pay your deductible, coinsurance, and other eligible medical expenses. Visit pensions.org/members for more details.

Coinsurance and out-of-pocket maximums

After reaching the deductible amount, you are still responsible for paying coinsurance — 20 percent of the allowable charges for covered services — up to the total maximum out-of-pocket amount. The HDHP total maximum out-of-pocket amounts are shown on the Key Provisions chart in the Appendix. All your healthcare-related out-of-pocket expenses for covered services, including deductibles, coinsurance, and prescription drug costs, count toward the total maximum out-of-pocket amount.

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

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* *Individuals enrolled in the HDHP will be automatically enrolled in the VSP vision exam benefit. The vision exam benefit is not considered part of the HDHP.*

Under all three medical options (PPO, EPO, and HDHP), expenses not covered by the plan do not count toward your deductible, medical out-of-pocket maximum (PPO only), or total maximum out of pocket. Expenses may be excluded from consideration for reimbursement because they exceed the plan allowance, are not covered services, or were incurred for services, products, or medications that were not medically necessary.

Plan allowance differences

The Medical Plan's reimbursement of charges by physicians and other providers is based on the plan-allowed charge in the area for each particular procedure or service. This plan allowance represents the total amount payable under the plan (including your deductibles and coinsurance) to the provider for a given procedure or service.

The plan allowance for a given procedure or service also differs depending on whether you visit a network, out-of-network, or non-network provider, as follows:

- **Network:** When you use a network provider, the allowance is the national Blue Cross Blue Shield (BlueCard PPO) network contracted rate for the procedure or service.
- **Out of network (PPO):** If you are enrolled in the PPO option and you use an out-of-network provider, the plan allowance is the BlueCard PPO participating provider rate in that area for the procedure or service. Out-of-network providers may bill you for the difference between what they charge for a service and the plan allowance. This is referred to as *balance billing*.
- **Non-network (medical/surgical only):** For non-network area providers, the plan covers up to 120 percent of the BlueCard PPO participating provider rate in that area.

Behavioral health services

The Board urges you to contact Highmark Blue Cross Blue Shield (BCBS) at the number on the back of your ID card before beginning treatment with a therapist, although this is not a requirement. As your service provider, Highmark BCBS can help match you with a network provider who has the appropriate background and experience to address your concerns. Network providers all are properly credentialed and licensed.

PPO: Your out-of-pocket costs will be lower if you choose network providers. If you choose a provider who is not part of the network and Highmark BCBS certifies that the treatment is medically necessary, you receive benefits on the out-of-network basis. (For deductible, copay, and coinsurance information, see the Key Provisions chart in the Appendix.)

EPO and HDHP: To access your benefits, you must use a network provider. If you choose a provider who is not part of the network, you will be responsible for 100 percent of the costs.

You are also entitled to free counseling through the Employee Assistance Plan (EAP). To learn more about the services provided through the EAP, see Employee Assistance Plan under Other Well-Being Benefits.

If you require inpatient, partial hospitalization, intensive outpatient, or residential treatment center care, Highmark BCBS will review your treatment with your therapist and authorize continued stays in the program based on medical necessity guidelines.

Depending on the type of service you receive, a case manager from Highmark BCBS may contact you by phone (and sometimes by letter if the case manager can't reach you). The Board strongly encourages you to accept the call and speak directly to the case manager. This individual is a licensed behavioral health professional who can help you in a variety of ways, including

- helping you obtain the right services at the right time for your situation;
- coordinating your care and advocating for you with your providers or program;
- helping you to develop realistic and attainable short- and long-term goals;
- helping you learn about community resources; and
- providing a listening ear.

Case management provides an important service to support overall success in treatment. Remember that inpatient behavioral health or substance use disorder treatment must be medically necessary. If you are admitted for inpatient treatment, have your provider contact Highmark BCBS to certify your admission. Either you or someone acting on your behalf must notify Highmark BCBS within 48 hours of your admission so the treatment plan can be reviewed with your doctor and a determination made regarding the medical necessity of the admission and any continued inpatient care.

Centers of Excellence specialty care

Centers of Excellence are select, designated facilities proven to deliver superior results for complicated, costly surgical procedures. The designation is based on evidence-based, objective criteria and thorough review by expert physicians and medical organizations. The Center of Excellence designation helps you identify facilities that offer the highest quality specialty care for bariatric surgery, cancer, cardiac care, knee and hip replacements, maternity, spinal surgery, and transplants.

Overall, patients treated at Centers of Excellence have

- better outcomes;
- fewer complications;
- fewer readmissions; and
- lower total cost of care.

Patients who must travel more than 100 miles to any Center of Excellence are eligible for a travel benefit of up to $10,000 to cover expenses for themselves and a companion.

Centers of Excellence specialty care benefits

Under all medical options (PPO, EPO, and HDHP), if you or your enrolled family members have the following select procedures performed at a Center of Excellence, the plan will pay *100 percen*t of allowable charges *after* the annual plan deductible is met.

- bariatric surgery
  - Roux-en-Y gastric bypass
  - vertical banded gastroplasty
  - biliopancreatic bypass
  - biliopancreatic bypass with duodenal switch
  - adjustable gastric banding
  - gastric sleeve resection
  - revision of gastric restrictive procedures

- transplants
  - heart
  - lung (deceased or living donor)
  - combination heart/lung
  - liver (deceased or living donor)
  - simultaneous pancreas kidney (SPK)
  - pancreas (PAK/PTA)
  - bone marrow/stem cell (autologous and allogenic)
- knee and hip replacements
  - total knee replacements
  - total hip replacements
- spinal surgery
  - discectomy
  - fusion
  - decompression procedures

To find a Center of Excellence

Blue Distinction is the Centers of Excellence designation used by the Blue Cross and Blue Shield Association. To find providers with these designations, log on to highmark.com/pcusa, click on **View Centers of Excellence**, then scroll down to search by desired specialty and state. Designated hospitals are clearly identified as a Blue Distinction Center (BDC) or Blue Distinction Center+ (BDC+).

Important: Not every facility is designated as a Center of Excellence for all listed procedures. For example, a facility may be a Center of Excellence for knee and hip replacements but not for spinal surgery. To qualify for Centers of Excellence specialty care benefits, your procedure must be done at a facility that is a designated Center of Excellence for that particular procedure. You can check this when on the Highmark website.

Or, call the number on the back of your medical ID card.

Habilitative services for developmental disabilities

The plan covers the habilitative services described here for eligible children who have any of the following developmental disabilities:

- autism spectrum disorder
- cerebral palsy
- Down syndrome
- intellectual disability (mental retardation)
- spina bifida

The services covered are intended to improve the level of the child's physical, mental, and social development, and assist the child in acquiring and maintaining life skills to cope more effectively with the demands of his or her condition and environment. Covered habilitative services are subject to the plan allowance, deductible, and coinsurance provisions of the plan.

Applied behavior therapy

To be eligible for applied behavior therapy — i.e., the design, implementation, and evaluation of environmental modifications — the child must participate in Highmark Blue Cross Blue Shield's Case Management Program. Through this program, the child is assigned a case manager with expertise in pediatric developmental issues to coordinate all available resources for the child, including medical and school services and any other community agency services.

Different provisions and limitations apply to specialized therapies when provided outside of the habilitative services benefit, as described in Specialized Therapies.

Specialized therapies

Specialized therapies, including speech, occupational, and vocational therapies, are covered, subject to a standard of medical necessity defined below, up to an annual maximum number of visits per therapy type. After an initial number of visits in a given therapy, the child must participate in the Case Management Program to continue coverage.

Habilitative services and medical necessity

For purposes of the habilitative services benefit described in this section, medically necessary means that the covered therapy, subject to plan limits, is reasonably expected to accomplish (or will accomplish) one or more of the following:

- arrive at a correct medical diagnosis
- prevent the onset of an illness, condition, injury, or disability
- reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury, or disability
- assist in the achievement or maintenance of sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities

Hospital and emergency room visits

After you meet your annual deductible, the plan pays 80 percent — and you pay 20 percent — of the plan allowance for network hospital and emergency room services up to the specific medical out-of-pocket maximum (PPO) or total maximum out-of-pocket (EPO and HDHP), after which it pays 100 percent.

Organ transplants

For organ transplants, you and your eligible family members have access to Centers of Excellence facilities throughout the country (see Centers of Excellence Specialty Care). These facilities, deemed among the best in the nation, are rigorously evaluated for quality of care.

As a transplant patient, you are enrolled in Highmark Blue Cross Blue Shield's Case Management Program.

Special transplant benefit: For a covered transplant at any network facility (not necessarily a Center of Excellence facility), if the surgery occurs 100 or more miles from home, a travel and lodging benefit for the covered patient and a companion is provided. (See the Appendix.)

Specialized therapies

The Medical Plan covers medically necessary visits for physical, occupational, and speech therapy. Speech therapy, however, is covered only when prescribed by a physician for correction of a speech impairment resulting from disease or trauma. Therapy services that are primarily developmental are not covered under the plan, except through the rehabilitative services benefit for children with certain congenital developmental disabilities. (See Habilitative Services for Developmental Disabilities.)

If you and your therapist expect you will need more than 25 sessions, ask your provider to initiate such a review by your 20th session. By allowing adequate time for the review process, you can avoid interrupting your therapy.

Women's health protection

Reproductive health coverage

Medically necessary in vitro fertilization procedures are covered services, subject to plan limits, which include a lifetime maximum. (See the Appendix.)

Consistent with the Presbyterian Church (U.S.A.)'s affirmation of the ability and responsibility of a woman to make good moral choices regarding problem pregnancies, the Medical Plan reimburses medical costs for abortion procedures, subject to plan limits. The Presbyterian Church (U.S.A.) further affirms that abortion should not be used as a method of birth control, for gender selection only, or solely to obtain fetal parts for transplantation.

For details of the PC(USA) affirmation, see Minutes, 204th General Assembly (1992), available upon request from the Board of Pensions.

Churches and affiliated employers that object, as a matter of conscience, to the use of their dues for abortion procedure costs may apply for relief of conscience. Monies offset from Medical Plan dues of employers that have applied for and received relief of conscience are deposited in the Board's Assistance Program and used to help provide Adoption Assistance grants to plan members. For more information regarding this administrative policy and Adoption Assistance grants, contact the Board of Pensions and speak with a service representative.

Maternity care

In conformity with federal law, the plan covers maternity expenses, including a hospital stay of not less than

- 48 hours following a normal vaginal delivery; or
- 96 hours following a delivery by cesarean section.

The mother may be discharged sooner, but only if the decision is made by the attending physician in consultation with the mother.

The plan covers medical expenses for services provided in a hospital or in a birthing facility by a midwife, if the midwife is state-licensed.

ADD YOUR NEW CHILD TO YOUR COVERAGE WITHIN 60 DAYS OF BIRTH OR ADOPTION
To do so, log on to Benefits Connect and choose My Benefits on the homepage; then select Life Events and follow the prompts to report the birth or adoption, provide supporting documentation (either a birth certificate or adoption papers), and add your new child for coverage. If you do not enroll your new child within this time frame, you will need to wait until annual enrollment.

Baby BluePrints

The Baby BluePrints maternity program is included in your healthcare benefits. Baby BluePrints offers tools, educational resources, and ongoing support throughout your pregnancy. Upon enrolling in Baby BluePrints, you will receive an enrollment confirmation mailing with helpful pregnancy tips. In addition, online resources are available and include topics such as the proper use of medications, avoiding alcohol and tobacco, working, travel considerations, nutrition and weight gain, exercise, and body changes.

Once enrolled, you will also have access to a personal nurse health coach throughout your pregnancy.

There's no cost to you to enroll in Baby BluePrints. Simply call 866-918-5267 or call Highmark at 888-835-2959 and ask to be directed to Baby BluePrints.

Breast reconstruction

Also in conformity with federal law, the plan provides breast reconstruction benefits to members and dependents who are receiving care in connection with a mastectomy. These benefits will be provided in a manner determined in consultation with the attending physician and the patient. The plan provides coverage for the following:

- all stages of reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prostheses and treatment for physical complications, including lymphedemas, at all stages of the mastectomy

These services are subject to the plan's deductible and coinsurance requirements.

PRECERTIFICATION REQUIREMENTS

You must get approval before having certain tests and procedures performed; this is known as precertification. If you do not precertify the specified tests and procedures, you may be responsible for their cost. Most tests and procedures that require advance approval are listed on the back of your medical ID card, along with the phone numbers to call.

If your physician recommends a non-urgent hospital admission or a procedure or test that requires precertification, your doctor's office should immediately call Highmark BCBS, using the phone number on the back of your medical ID card. The approval process takes up to 10 days, so it's important your doctor's office request precertification as soon as you're aware that the test or procedure needs to be performed; otherwise, the medical service may be delayed.

Certain specialized procedures — bariatric surgery, for example — may require additional time.

CALL THE NUMBER ON THE BACK OF YOUR ID CARD TO PRECERTIFY:

- **hospital admission for non-emergency medical or surgical treatment**
- **bariatric or other weight-loss surgery**
- **scheduled outpatient imaging, excluding X-rays**
- **cardiac imaging, including scheduled nuclear stress tests**
- **all facility-based treatment for behavioral health or substance use disorders**
- **prescriptions for medical injectable drugs**

Precertification requirements are the same regardless of whether you live in a network area. In many instances, your provider's office will coordinate the precertification process for you. However, it's your responsibility to verify that precertification has been obtained. If you are unsure whether a test or procedure needs advance approval, call the number on the back of your ID card or the Board of Pensions at 800-773-7752 (800-PRESPLAN) before having it performed.

If a procedure requires precertification, you may receive a letter approving or denying the procedure from eviCore, a medical benefits management company that works with Highmark to provide support for precertification of outpatient imaging.

Emergency admission

In an emergency, seek the care you need from the nearest provider. *You must call Highmark Blue Cross Blue Shield within 48 hours of an inpatient emergency admission* to have the admission certified and maximize your benefits.

If you don't obtain advance approval

The precertification process helps to manage costs for you and the plan by ensuring members receive medically necessary and appropriate care. *If you fail to precertify services when necessary, benefits may be denied*. Highmark will retroactively review the appropriateness and medical necessity for the services.

If the services …

- would have been precertified had they been submitted as required, the claim is processed as usual.
- do not qualify for certification as appropriate and medically necessary, no benefits are payable, including all related charges.

WHAT'S NOT COVERED

The Medical Plan does not cover certain expenses. The following list includes most of the services and supplies excluded from coverage under the plan; however, it does not include every item that is not covered. (For information on excluded drugs, see Your Prescription Drug Benefits.)

- any experimental or investigational medical treatment, as determined by your service provider
- dental care:[1]
  - dentures
  - dental X-rays
  - dental services (including orthodontic services that are related to a covered medical cost), except for services related to the removal of bony impacted wisdom teeth, injury to sound natural teeth, and treatment for TMD[2]
- vision surgery to alter the refractive character of the eye (Discounts are available through VSP providers.)
- foot orthotics[3] if prescribed for:
  - weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions, corns, calluses, or toenails
  - replacement of existing orthotics designed to treat a covered condition, unless they are irreparably damaged due to normal wear and tear or a change in the patient's condition or size
- other professional services and supplies:
  - cosmetic surgery, treatment, or supplies
  - services provided by a person who ordinarily resides in a member's home or is related to the patient
  - custodial care
  - group homes, educational programs (except the educational benefit for diabetics), wilderness/boot camps, and educational testing
  - medical reports or charges
  - services payable under any workers' compensation law or similar legislation
  - medical services provided by a U.S. government facility or received elsewhere for which the member is not legally obligated to pay
  - reversal of a previous sterilization procedure

[1] The Medical Plan does provide limited coverage for dental reconstruction resulting from trauma or injury. An optional dental plan is available on a self-pay basis.

[2] Benefits for TMD-related services have a lifetime limit. See Plan Maximum Reimbursement Limits in the Appendix.

[3] Foot orthotics are covered if prescribed by a physician for treatment of metabolic, peripheral vascular disease, or other medical conditions if not specifically excluded above.

If you are unsure whether a service or supply is covered, contact Highmark Blue Cross Blue Shield or the Board of Pensions at 800-773-7752 (800-PRESPLAN) before incurring the expense.

HOW TO GET REIMBURSED

To get reimbursed from the plan, you may or may not need to file claims yourself depending on your choice of provider. To be eligible for reimbursement, all claims must be submitted within 12 months of the date of service.

Network providers

When you use a network provider, you do not need to file a claim for reimbursement. The provider's office does this for you, using identifying information from your medical ID card. The plan then pays its portion automatically, and you pay only your out-of-pocket costs.

Out-of-network providers (PPO only)

Many out-of-network providers will bill your service provider (Highmark Blue Cross Blue Shield) first and then bill you for the balance. Some out-of-network providers, however, require you to pay out of pocket and then file a claim for reimbursement.

Contact Highmark or go to their website, to obtain claim forms and the address for claims submission (see Contact Information). Complete a separate form for each family member for whom you are seeking reimbursement. All claims filed should include your member ID number (on the front of your medical ID card).

After completing the claim form, attach your itemized bill, which must include the procedure code(s), diagnosis code, and provider's tax ID number to avoid processing delays. Send your completed claim form and itemized bill to the address on the form.

Retail health clinics, such as those found in large pharmacy chains, typically charge for services based on the service provider's negotiated network rate but may not file claims for you. You may have to pay out of pocket for their services and then submit the claims yourself directly to Highmark Blue Cross Blue Shield at the address listed on the claim form. (Retail health clinics typically do, however, handle claims processing for flu shots, so it's unlikely you'll need to pay out of pocket for these.)

CLAIMS SUMMARIES AND EXPLANATION OF BENEFITS STATEMENTS

Review your medical claims summaries or explanation of benefits (EOB) statements to confirm that you received all the services being billed. These summaries and statements are available online, or you can receive printed EOBs.

Online claims summaries

Highmark Blue Cross Blue Shield (BCBS) offers you online resources to view and track your claims.

To access your claims information online, go to their website (see Contact Information) or access their site through Benefits Connect.

Reviewing your claims

When you review your claims, check for two things: First, make sure you received the services for which you — and the plan — are being billed.

Second, be aware that, under the plan, while you are an inpatient under the care of a network physician at a network hospital, all ancillary services provided — anesthesia, diagnostic pathology, and diagnostic radiology, where you had no choice of provider — are covered at the more favorable, network level (80

percent), regardless of the provider's network status. Check your online claim summary or EOB to make sure any ancillary services you receive at a network hospital are processed at the network benefit level. If you receive out-of-network benefits for these claims, contact Highmark BCBS to request an adjustment.

QUESTIONS?

If you have questions about your claims, contact Highmark Blue Cross Blue Shield at the number on the back of your medical ID card. After speaking with them, if you need further assistance or still have concerns, contact the Board of Pensions.

Make the most of your medical benefits

Healthcare costs are high and continue to rise. It's important to minimize your own costs and the plan's expenses. Follow these tips to be a better healthcare consumer:

Use your preventive care benefits.

- Preventive care helps detect health conditions early, when they are less costly to treat, so have an annual checkup with your network primary care physician or gynecologist and get scheduled screenings, tests, and immunizations at no cost to you.
- Complete Call to Health to improve your health and well-being.

Save money on prescription drugs.

- When appropriate, use drugs included on the plan's preventive drug list. These drugs are your lowest-cost option.
- Use generic drugs whenever possible: They cost significantly less than their brand-name equivalents.
- Make sure the brand-name drug you were prescribed is listed on the plan's formulary (list of covered drugs) before you fill your prescription. If it's not, ask your doctor for an appropriate alternative.
- Use mail-order for maintenance medications.

Get advance approval when required.

- Request precertification from your claims administrator for non-urgent healthcare facility admissions or certain tests — at the time you schedule them. If you do not precertify as required, you are responsible for all costs.

Consider emergency alternatives.

- Seek emergency room care only for an emergency. The emergency room should not be used on an ongoing basis as a substitute for primary care or when visiting an urgent care center is a safe and reasonable option.
- Also consider the telemedicine benefit.

Your Prescription Drug Benefits

Administered by Express Scripts, the prescription drug program provides you with coverage for medications prescribed by your doctor to keep you healthy, treat an ongoing condition, or restore your health following an illness.

For this program, your share of the cost of medically necessary drugs — your copayment — will vary with the

- medication you take, and whether it's a generic or brand name;
- medical option you are covered under (PPO, EPO, or HDHP); and
- pharmacy you use to fill your prescription.

This section explains your benefit and, to help slow the rapid rise in prescription drug costs for you and the plan, suggests ways you can limit your costs while ensuring you receive safe and effective treatment. Your copayments for prescription drugs are summarized in the Key Provisions chart in the Appendix.

You do not pay a deductible for prescription drugs under the PPO or EPO; however, if you enroll in the HDHP, you pay the full cost for prescriptions you fill until you have paid the HDHP deductible, the same as you do for other medical expenses. Once you've satisfied the deductible, you start paying a copayment for covered drugs. The only exception is if you fill a prescription for a medication that is on the plan's preventive drug list. You pay a flat dollar copay — with no deductible — when filling prescriptions for these designated preventive drugs.

> **Under the HDHP, you pay the full cost of covered non-preventive prescription drugs until you've paid the HDHP deductible. Your cost when using participating retail pharmacies and the mail service reflects the plan's discounted rate.**

PPO, EPO, or HDHP?

Prescription drug coverage under the three medical options differs in the following ways:

- The PPO covers non-formulary drugs at 50 percent subject to minimum and maximum amounts; the EPO and HDHP do not cover non-formulary drugs.
- Under the HDHP, the annual deductible applies when filling prescriptions for covered drugs, except for medications that are included on the plan's preventive drug list.
- For 2021, the PPO has an annual prescription out-of-pocket maximum of $3,000 for prescription drugs (excluding non-formulary brand names); the EPO and HDHP do not have a prescription out-of-pocket maximum for prescription drugs apart from the total maximum out-of-pocket amount that applies for all covered healthcare expenses.
- The copayments differ. See the Prescription Drug section of the Key Provisions chart in the Appendix for details.

Unless otherwise specified, the benefits described in this section are available under all three medical options, PPO, EPO, and HDHP.

DECIDING ON THE RIGHT PRESCRIPTION FOR YOU

Often, you can choose among alternatives before your medication is prescribed, and your choice determines your out-of-pocket costs. Two similar drugs with very different prices may be equally effective. Talk with your doctor about your options.

Preventive drugs

Your prescription drug benefit includes special coverage for preventive medications. These drugs help protect against or manage medical conditions including but not limited to

- preventing blood clots and reducing the risk of a stroke;
- preventing heart disease and reducing high blood pressure; and
- preventing osteoporosis (a disease that leads to an increased risk of bone fracture).

Taking preventive medications as directed by your healthcare provider can help you avoid serious illness and high healthcare costs. You can save money and get the medications you need to help you live a healthier life.

The amount you pay for designated preventive drugs varies depending on the medical option you elect:

- **PPO** and **EPO** – You pay reduced copays
- **HDHP** – You pay a flat dollar copay with no deductible

For copay amounts, see the Key Provisions chart in the Appendix.

The preventive drug list, available on pensions.org, includes generic and select formulary brand drugs. As with non-preventive drugs, you will pay less when choosing generic drugs. Preventive medications are a subset of products included within the plan's formulary, or list of covered prescription drugs. To check the cost of any medication, log on to express-scripts.com and click on **Price a Medication** in the menu under Prescriptions, or contact Express Scripts at the number on your prescription drug ID card.

Brand vs. generic drugs

The brand name of a drug, protected by a limited-time patent, is the product name under which it is advertised and sold. Once the patent has expired, a generic equivalent may be manufactured and sold under its chemical name. Chemically equivalent generics are required to have the same active ingredients as their brand-name counterparts and are subject to the same U.S. Food and Drug Administration (FDA) standards for quality, safety, purity, and effectiveness.

Before your doctor writes a prescription for a brand-name drug, ask if a generic is available and right for you. By using a generic, you'll pay less — sometimes a lot less — for essentially the same drug, and by using home delivery you save even more.

See the Prescription Drug section of the Key Provisions chart in the Appendix for the copayment amounts that apply for generic and brand-name drugs.

Listing of covered drugs

Each time you visit the doctor's office, share the plan's formulary with your physician. The formulary is a list of preferred medications reviewed and approved by a group of doctors and pharmacists based on clinical effectiveness and cost and covered by the prescription drug program. Both generic and brand-name drugs are included on the formulary. Medications, mostly brand name, that are not on the

formulary generally are considered non-formulary drugs (unless they are specifically excluded from coverage; see Excluded Drugs).

The formulary is updated for additions and deletions twice a year and is subject to change without notice. The best way to find out if a drug you need to take is on the formulary and to see your cost is to log on to express-scripts.com. You may also review an abridged formulary listing on pensions.org or call the Board of Pensions at 800-773-7752 (800-PRESPLAN) to request a copy.

AVOID ANCILLARY CHARGES
If you choose to fill a prescription for a brand-name medication when a chemically equivalent generic exists, you will be responsible for an ancillary charge, plus the applicable copayment. The ancillary charge is the cost difference between the price of the brand-name drug and the chemically equivalent generic drug.

Costs for formulary and non-formulary drugs

Generics are not always available or may not be the best choice for you. If you need to take a brand-name drug, ask your physician if he or she can prescribe one that's listed on the formulary.

- **PPO:** If you fill a prescription for a brand-name drug that is …
  - on the formulary, you pay a percentage of the cost (up to a maximum), except for formulary contraceptives, which are 100 percent covered with no copayment required;
  - not on the formulary, you pay a larger percentage of the cost (up to a maximum) and that amount does not count toward your annual prescription out-of-pocket maximum or total maximum out-of-pocket.

Both formulary and non-formulary brand-name drugs also have a minimum amount you must pay. If the actual cost of your prescription is less than the minimum, you pay the actual cost.

- **EPO:** If you fill a prescription for a brand-name drug that is …
  - on the formulary, you pay a percentage of the cost (up to a maximum), except for formulary contraceptives, which are 100 percent covered with no copayment required. Formulary brand-name drugs also have a minimum amount you must pay. If the actual cost of your prescription is less than the minimum, you pay the actual cost.
  - not on the formulary, you pay 100 percent of the cost and that amount does not count toward your total maximum out-of-pocket.
- **HDHP:** If you fill a prescription for a brand-name drug that is …
  - on the formulary, you pay the full cost of the drug up to the annual HDHP deductible. Once you've paid the deductible, you pay a percentage of the cost (up to a maximum). Formulary brand-name drugs also have a minimum amount you must pay. If the actual cost of your prescription is less than the minimum, you pay the actual cost.
  - not on the formulary, you pay 100 percent of the cost and that amount does not count toward your total maximum out-of-pocket.

Refer to the Prescription Drug section of the Key Provisions chart in the Appendix; it lists the copayment percentages as well as the minimums and maximums for formulary brand-name and non-formulary brand-name (PPO only) drugs.

Annual family prescription out-of-pocket maximum

PPO: For the PPO option, there is an annual family prescription out-of-pocket maximum to limit your out-of-pocket costs for the prescription drug program. This means you will not pay more than the prescription out-of-pocket maximum amount each year for all covered generic and formulary drug prescriptions for you and your covered family members (non-formulary brand-name drugs do not count toward the prescription out-of-pocket maximum). Once you and/or your spouse and children reach the family prescription out-of-pocket maximum, the plan pays 100 percent of your remaining eligible generic and formulary drug prescription costs for the rest of the calendar year. Refer to the Key Provisions chart in the Appendix.

EPO and **HDHP:** There is no out-of-pocket maximum for prescription drugs specifically (i.e., the plan sets no limit on your out-of-pocket prescription drug costs). The plan's total maximum out-of-pocket limit governs, and it counts all your healthcare-related out-of-pocket expenses, including copays, deductibles, and coinsurance for both medical care and prescription drugs.

HOW TO GET PRESCRIPTIONS FILLED

You can access your prescription drug benefits in one of two ways:

- at your local participating pharmacy (using your Express Scripts ID card).
- through mail order (using Express Scripts Pharmacy home delivery service) for the greatest possible savings

At your local participating pharmacy

Use your local participating pharmacy to fill short-term prescriptions — and, if you choose, to fill your long-term prescriptions as well. Use your Express Scripts ID card with a pharmacy that participates in the broad Express Scripts network to take advantage of reduced network rates.

If you fill a prescription at an out-of-network pharmacy, you must pay the entire cost for the medication and then submit a claim form to Express Scripts for reimbursement. Your reimbursement will be based on the contracted rate for out-of-network prescriptions minus the applicable copayment (see Key Provisions). Claim forms are available at express-scripts.com, or by calling Express Scripts at 800-344-3896.

Note: Prescription drugs you buy at a hospital pharmacy for use at home are considered prescription drug expenses. Prescription drugs administered during a hospital stay are considered medical expenses.

Through mail order

The Board has negotiated discounts with Express Scripts on maintenance medications filled through mail order. To save money, use Express Scripts Pharmacy home delivery service to fill prescriptions for your maintenance medications (including medications on the preventive drug list) — those you take on a regular basis (for example, medications to treat high blood pressure, high cholesterol, or thyroid conditions). If you choose to fill prescriptions for maintenance medications at your local pharmacy, typically you — and the plan — will pay more.

To order a 90-day supply of your medication through Express Scripts Pharmacy home delivery service, do any of the following:

- Have your doctor e-prescribe the prescription to Express Scripts.
- Ask your doctor to fax the prescription to Express Scripts.
- Mail the written prescription from your doctor along with the required copayment in the envelope provided with your welcome package. Forms are also available at express-scripts.com.

Medications are shipped via standard service at no cost to you. Express shipping is also available for an additional fee. You can also set up auto refill and auto renewal of your prescriptions at express-scripts.com.

To view your prescription costs, order refills, find pharmacies that participate in the Express Scripts network, and more, log on to express-scripts.com. You'll need to register if it is your first visit; you will be asked to provide your member ID number (shown on your Express Scripts prescription ID card) and email address when registering. Or, you may call Express Scripts at 800-344-3896.

THINGS TO CONSIDER ABOUT GENERIC DRUGS

- **Generic drugs are regulated by the FDA, just like their brand-name counterparts. They are proven to be safe and effective.**
- **Nearly eight in 10 prescriptions dispensed in the United States are for generic drugs.**
- **Generics cost about 80 percent less than brand-name drugs, mostly because manufacturers of generic drugs do not have the expense of research, development, and advertising related to a new drug.**
- **Trademark laws do not allow generic drugs to look exactly like their brand-name counterparts, but these differences don't affect their effectiveness.**

SPECIAL PROGRAMS TO LIMIT COSTS

Some drugs your doctor may prescribe are subject to step therapy, prior authorization, quantity limits, or specialty medication programs — additional ways the prescription drug program seeks to slow rising costs while providing you with safe and effective medications.

Step therapy

In some cases, it will be required that you first try certain drugs to treat your medical condition before the plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

To find out if step therapy applies for your medication, log on at express-scripts.com and select **Price a Medication** from the Prescriptions menu. Enter your drug's name and view coverage information on the results page. Or, call Express Scripts at 800-344-3896. The step therapy list is subject to change.

Prior authorization

A prior authorization requires you or your physician to get approval from Express Scripts before you fill prescriptions for certain drugs. If you do not get approval, the drug may not be covered.

Drugs that require prior authorization typically are drugs that are very costly or have significant potential for negative side effects. When you present a prescription for one of these drugs — growth hormones,

for instance — the pharmacy receives notice that certain clinical information must be obtained from your physician before it can fill the prescription. You can find out if a drug requires prior authorization by logging on to express-scripts.com and selecting **Price a Medication** from the Prescriptions menu; then enter your drug's name and view coverage information on the results page. Or, call Express Scripts at 800-344-3896.

You must obtain prior authorization from Highmark Blue Cross Blue Shield to fill a prescription for medical injectable drugs.

Quantity limits

For certain drugs, there is a limit on the amount of the drug that will be covered. To find out if quantity limits apply for your medication, log on to express-scripts.com and select **Price a Medication** from the Prescriptions menu. Enter your drug's name and view coverage information on the results page. Or, call Express Scripts at 800-344-3896.

Specialty medications

Specialty medications, typically used to treat complex conditions such as cancer, hepatitis, and multiple sclerosis, are limited to a 30-day supply due to high costs, special storage needs, limited shelf life, and frequent dosage changes.

Specialty drugs must be obtained through Accredo, an Express Scripts specialty pharmacy, to be covered under the prescription drug program; specialty medications are not available through Express Scripts Pharmacy home delivery service or your local retail pharmacy.

Specialty medications are subject to the same deductible requirements (HDHP only) and copayment minimums and maximums as other prescriptions. Contact Accredo at 800-803-2523 for more information.

DRUGS NOT COVERED

The prescription drug program does not cover medications that

- are not approved by the FDA;
- have over-the-counter equivalents;
- are on the plan's exclusion list because less expensive, clinically proven alternatives are available (see Excluded Drugs);
- are appetite suppressants;
- are approved or prescribed for cosmetic purposes only; or
- are lost, stolen, spilled, or otherwise damaged.

In addition, the *EPO and HDHP do not cover non-formulary drugs*.

If you want to take a prescription that is not covered under the prescription drug program, you may, but you'll pay the full (unreduced) cost of the drug and that payment will not count toward your prescription out-of-pocket maximum (PPO only) or total out-of-pocket maximum.

Excluded drugs

Large pharmacy benefits managers such as Express Scripts negotiate with pharmaceutical companies to buy certain medications in volume, at a discount, in exchange for excluding similar medications made by other drug companies. The Board of Pensions and Express Scripts are attempting to slow the spiraling rise in drug costs by excluding from coverage certain medications when less expensive, clinically proven alternatives are available on the formulary. To see which drugs are excluded, go to pensions.org and search for drug exclusion list.

If you fill a prescription for a drug that is excluded from coverage, you'll pay the full (unreduced) cost of the drug and that payment will not count toward your prescription out-of-pocket maximum (PPO only) or total out-of-pocket maximum.

QUESTIONS?

For more information, go to pensions.org or express-scripts.com. To find out whether a specific drug is covered, call

- Express Scripts, 800-344-3896; or
- Accredo for specialty medications, 800-803-2523.

You also can call the Board of Pensions at 800-773-7752 (800-PRESPLAN) and speak with a service representative.

Other Well-Being Benefits

Having a sense of wholeness, or well-being, helps you bring your best gifts to all dimensions of your life — spiritual, health, vocational, and financial — which is why medical coverage through the Board of Pensions includes special features and programs to help you maintain and improve your overall health and well-being.

ROUTINE VISION EXAM

Routine eye exams can lead to the early detection of serious eye conditions and early signs of other chronic health conditions. And, getting a documented vision exam counts toward your Call to Health point total.

If you enroll in the Medical Plan, you will be automatically enrolled in the VSP vision exam benefit. The vision exam benefit includes an annual well vision exam with a VSP-participating optometrist or ophthalmologist, subject to a $25 copay with no deductible.* There is a $20 copay for follow-up exams related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD), and for retinal screening for those with diabetes.

The vision exam benefit is separate from the Vision Eyewear Plan, which may be offered at the employer's option.

If you have a routine annual eye exam with an out-of-network provider — an eye doctor who does not accept payment from VSP — you pay for the service up front and submit a claim for reimbursement, along with an itemized bill, to VSP. You will be reimbursed up to a certain dollar amount after your copay is deducted. (See the Key Provisions: Vision Exam Benefit chart in the Appendix.) The cost of prescription eyeglasses and contact lenses is *not* covered under this benefit; however, discounts for these items are available at participating providers.

You don't need an ID card to use your vision exam benefit. When you visit a participating provider, simply give your name and the last four digits of your Social Security number to confirm your coverage. To find VSP-participating providers, go to vsp.com/choice.

VSP OUT-OF-NETWORK CLAIMS
You can limit your costs if you see a VSP-participating provider for your routine eye exam. If your optometrist or ophthalmologist is out of network, however, you can submit your claim to VSP and you'll be reimbursed up to a certain dollar amount after your copay is deducted.

EMPLOYEE ASSISTANCE PLAN

Your healthcare benefits include an Employee Assistance Plan (EAP), provided by Cigna 24 hours a day, seven days a week — and there's no cost to you.

Your EAP is a professional, *confidential* resource that can help you and members of your household find answers to a variety of personal concerns. (Household members do not need to be enrolled in the

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* *If enrolled in the HDHP, you will be automatically enrolled in the VSP vision exam benefit. The vision exam benefit is not considered part of the HDHP.*

Medical Plan to use the EAP.) Through it, you can receive consultations, support, and personalized assistance as well as referrals to licensed counselors and professional resources in your community.

The EAP can help with just about any concern:

Emotional health and family support

Get help to manage stress, address depression and anxiety, cope with illness, and adjust to life challenges. You can also get help with marriage and relationship issues.

- Phone consultations: You have unlimited access to licensed clinicians by phone for routine or urgent concerns. To access phone consultations, call the EAP and ask to speak with a clinician, or log in to the Cigna website and schedule a call.
- Counseling sessions: In addition to phone consultations, you can receive up to six free private counseling sessions per issue with a provider in the Cigna Behavioral Health network. Sessions may be in-person or virtual on your phone, tablet, or home computer.[*]

Note: If you need more support after your free sessions, the EAP can help you transition to using your behavioral health benefits under your medical benefits for ongoing support. Applicable copays, deductibles, and/or coinsurance will apply once you transition to using your medical coverage. Additionally, if you continue with the Cigna Behavioral Health counselor and he or she does not also participate in the Medical Plan's network, you may incur out-of-network costs. Any ongoing therapy must be with a network counselor to be covered at the network rate. If you continue sessions with a counselor who is not in the Medical Plan's network and you are enrolled in the EPO or HDHP, you will have no coverage beyond the six free sessions.

Financial and legal assistance

Speak with financial consultants about budgeting, debt, identity theft, retirement, and more. Consult with a network attorney at no cost.

- **Financial consultation:** Have 30-minute telephone consultations with a qualified specialist on issues such as budgeting, debt counseling, tax planning, clergy tax issues, retirement planning, and college funding.
- **Legal consultation:** Get a 30-minute telephone or face-to-face consultation with a participating attorney plus a 25 percent discount on select fees for services such as adoption, family law, and will preparation (consultations related to employment matters are not available).
- **Identity theft assistance:** Have a 60-minute expert consultation by phone to learn what to do to protect yourself, or for help if you are victimized.
- **Tax assistance:** Receive a 25 percent discount on regular tax preparation services through the EAP. The discount covers one federal tax return, Schedule A (itemized deductions), Schedule B (dividends/interest), and one state income tax return. If additional forms are required, such as for a rental property or a small business, the charge is $65 per form. You must call Cigna at 866-640-2772, to access this discount.

[*] *Telephone sessions with an EAP provider are not a substitute for in-person or virtual visits. Members should contact Cigna to request counseling sessions by phone. Authorization is required for telephone sessions.*

Home life referrals

Get support and request referrals to help you find a healthy work/life balance.

- **Parenting and childcare:** Get referrals for adoption services, prenatal classes, day care, before- and after-school programs, summer camps, and more.
- **Education:** Get help with college searches or locating kindergarten programs and public schools, if you're new to an area.
- **Elder care:** Get an assessment of an older loved one's needs and referrals for housing options, such as assisted living or nursing home care.
- **Pet care:** Get referrals for veterinary services, emergency care, boarding, pet sitters, obedience training, and groomers.

Job and career support

Discuss career growth and get tips for managing workplace stress and change and other issues.

- **Higher education:** Get help with college searches if you are thinking of continuing your education.
- **Online tools and resources:** Access seminars, e-learning, and articles on topics such as effective communications, goal setting, collaboration, and more. To locate these and other resources, including videos, podcasts, checklists, and more, log on to the Cigna website and click on the Work/Life Resources link on the EAP coverage page under Job and Career Support.

To use your EAP benefits

- call 866-640-2772. Your EAP advocates are available any time, any day, for routine or urgent concerns; or
- log in to mycigna.com > Coverage > Employee Assistance Program (EAP) to live chat with an EAP advocate, schedule a phone consultation with a clinician, access online resources, and more.

A one-time registration is required to use mycigna.com:

- Click **Register** to create an account and set up a username and password.
- Follow the step-by-step instructions to enter your name, date of birth, and ZIP code, clicking **Next** after completing each step.
- For What best describes you, select ***I want to register for the Employee Assistance Program ONLY***.
- When you reach the Confirm Your Identity screen, follow these instructions:
  - For Employer Name or ID, enter **pcusa**
  - For Your Relationship to the Employee, select **Employee** or **Other person living in the home** (household member).
- Select your security questions.
- Create a username and password that you will use to access your EAP coverage on mycigna.com, enter your email address, review, and click **Create Account.**

If you or a member of your household has any problems with the EAP registration process explained above, call the customer support line at 800-853-2713. When asked for an ID number or Social Security number, simply state, "I don't have it," to connect to a customer service representative.

HEALTH AND WHOLENESS: CALL TO HEALTH

Call to Health is a well-being initiative that runs December 1, 2020, through November 12, 2021, for employees and their spouses with medical coverage through the Board of Pensions. Employees earn reduced deductibles for the next plan year by completing certain challenges presented on calltohealth.org.

- **Level 1**: To answer the call, you complete two required challenges — taking the Well-Being Assessment and having a preventive exam — plus other challenges you select to earn points. Employees who complete the required challenges along with other optional challenges for a combined total of at least 1,000 points qualify for reduced Call to Health individual and family deductibles for the next plan year.
- **Level 2**: Employees who accumulate at least $1,500 points receive a $50 Tango card. You may redeem your Tango card for gift cards from retailers selected from the Board of Pensions for their focus on healthy living and well-being, for example, Adidas, Amazon, CVS, Fitbit, Hello Fresh, and REI. Or, you may donate the value of your Tango card to well-known charities, such as the American Cancer Society, Habitat for Humanity, and World of Children Award, among others.
- **Level 3**: Employees who accumulate at least 2,000 points receive a second $50 Tango card.

Covered spouses who complete Level 1 (1,000 points including required challenges) receive a $100 Tango card.

Call to Health points may be earned through participation in Ignite Your Life, a coaching program to help you and your spouse change your health habits, to lose weight, reduce stress, or quit smoking or using other tobacco products (see Tobacco-Free Living), among other topics.

Visit calltohealth.org often to learn about required challenges, participate in new optional challenges, and complete Call to Health.

NEW TO CALL TO HEALTH?
Employees who register for the first time at calltoehalth.org *and* complete the Well-Being Assessment receive a $50 Tango card.

Your Well-Being Assessment

Taking the confidential and secure Well-Being Assessment on calltohealth.org is a required challenge for Call to Health each year. When you complete your assessment, you'll get personalized health results, including recommendations for your top three things to improve and your top three strengths from a holistic health perspective. After you've completed your Well-Being Assessment, you can select activities that will help you improve or explore other activities to make your strengths even stronger.

To take the Well-Being Assessment, go to calltohealth.org and click on **Take Your Assessment**.

NICOTINE-FREE LIVING

If you or your covered spouse uses tobacco, Ignite Your Life coaching offers a program, Breathe Easy, to help you change your habits and become nicotine-free. Designed by tobacco treatment specialists, this webinar-based coaching program is available online. Go to calltohealth.org and click on **Ignite Your Life,** then **Breathe Easy**. Participating in the Breathe Easy program counts toward Call to Health.

For you and your eligible family members, certain prescription generic or formulary smoking cessation medications are 100 percent covered with a prescription from your physician. Simply show your prescription ID card when you pick up your prescription; no copay is required.

Prescribed smoking cessation medications

You and your covered family members may be eligible to receive certain smoking cessation medications at no cost. To qualify, you must

- be age 18 or older;
- have a prescription from your doctor, even if the medication is available over the counter (OTC); and
- fill the prescription at a network pharmacy.

You can receive up to a 180-day supply each year of the following medications (maximum daily dose quantity limits apply). Show your prescription ID card when you pick up your prescription; no copay or copayment is required.

- OTC medications
  - nicotine replacement gum
  - nicotine replacement lozenge
  - nicotine replacement patch
- prescription medications
  - bupropion sustained-release tablet (generic Zyban)
  - Chantix tablet*
  - Nicotrol inhaler*
  - Nicotrol nasal spray*

* *100 percent covered only after you have first tried one OTC nicotine replacement product and bupropion sustained release tablets.*

24-HOUR NURSE LINE

You can get valuable health information and guidance from a registered nurse practitioner through the 24-Hour Nurse Line. Provided at no cost to you, the 24-Hour Nurse Line is available through Highmark Blue Cross Blue Shield to you and your eligible family members whenever you need it, including weekends and holidays.

Call the 24-Hour Nurse Line at the number on the back of your medical ID card if you

- wonder whether you need to get medical care;
- need information about a medication, test, or medical procedure;
- want reliable information about a health condition; or
- are not sure what questions you should ask your doctor.

CASE MANAGEMENT

Your medical benefits include a confidential Case Management Program, provided by Highmark Blue Cross Blue Shield. This program helps you when you

- have frequent or prolonged hospital admissions;
- require ongoing healthcare services in your home; or
- need ongoing care in outpatient settings.

Case Management helps you get the best available treatment when underlying health conditions are complex or challenging to address. The program can assist you by

- helping you understand the care resources available to you;
- coordinating and helping arrange medical services for you; and
- providing education and support for you and your family.

A nurse case manager will work with you and your physician to facilitate approval for medically necessary services under the provisions of the Medical Plan. Your nurse case manager will also help evaluate treatment needs and options under the direction of your attending physician.

Livongo for Diabetes Program

Your medical benefits include the Livongo for Diabetes Program. This program combines the latest technology with coaching to help individuals with diabetes manage their condition.

You may participate in the program at no cost to you. Your covered spouse and children also may participate.

You receive all this when you sign up:

- An **advanced glucose meter** ($200 value) – Your Livongo meter automatically uploads blood glucose readings to your private account. With each reading, you receive a personalized message to help you make informed choices for your health. You can also view trends of past readings at any time. And, you can earn Call to Health points for checking your blood glucose with your Livongo meter.
- **Unlimited test strips** – You can get as many strips and lancets as you need with no deductibles, copays, or coinsurance. When you need more strips, you simply tap the meter to reorder, and a new supply will be shipped to you.
- **Access to a Livongo health coach** – Livongo's experienced coaches, all Certified Diabetes Educators, are available to support you 24/7 and answer your questions about blood glucose readings, nutrition, or lifestyle changes. You also can schedule phone appointments or get expert advice by email or text message.

To learn more and to enroll, visit join.livongo.com/BOP/register, or call Livongo Member Support at 800-945-4355 and mention code BOP.

PREVENTIVE HEALTH RECOMMENDATIONS FOR INTERNATIONALLY ADOPTED CHILDREN

If you have medical coverage through the Board of Pensions and adopt a child from overseas, you can take advantage of a provision designed to meet the unique health needs of children from other countries. This benefit is available for children through age 18. (GeoBlue and Triple-S enrollees should consult their plan’s provisions for information about covered preventive health services.)

Overseas medical exam

Infants and children being adopted from other countries must have a medical exam overseas by a designated physician to detect contagious diseases that may affect their eligibility to obtain a visa. If they are ill or infected, they may be issued a visa after effective treatment. Requirements include:

- for children 15 and younger, a chest X-ray for tuberculosis (TB) and blood tests for syphilis and HIV
- for children older than 15, tests are given if disease is suspected

Children older than 11 may be exempted from this regulation. Instead, their adoptive parents sign a waiver indicating intention to comply with required medical examinations within 30 days after a child's arrival in the United States.

Exams and screenings in the United States

Children adopted from other countries should undergo a thorough health exam by a pediatrician within one to two weeks of their arrival in the United States, but children with chronic conditions should be seen immediately. Although children may actually show no symptoms of TB, parasites, hepatitis B, lead poisoning, or growth failure from a dysfunctional thyroid, they may have any or all of these conditions.

Physicians can accept records of prior immunizations only if the vaccine type, date of administration, number of doses, intervals between doses, and age of the patient at the time of administration are comparable to the U.S. schedules. After initial screening is completed, it is necessary to retest children for some diseases. The health exam should include the following screenings and tests:

- hepatitis A screen for previous immunity in children who will live in high-risk areas of the United States (if needed, initiate vaccination series)
- hepatitis B screen, including hepatitis B surface antigen, hepatitis B surface antibody, and hepatitis B core antibody (children should be retested six months after the initial screenings)
- hepatitis C screen for children from Asia, Eastern Europe, and Africa
- hepatitis D (available at the Centers for Disease Control and Prevention) for children from the Mediterranean area, Africa, Eastern Europe, and Latin America who have chronic infection with hepatitis B virus
- HIV ELISA and PCR screen Mantoux tuberculin skin test
- stool examination for ova and parasites, giardia antigen, and bacterial culture (three specimens, obtained 48 hours apart, are strongly recommended, especially if the child is from an orphanage)
- complete blood count (CBC) (a hemoglobin electrophoresis is recommended for children who are anemic and at risk for abnormal hemoglobins, such as children of African, Asian, or Mediterranean descent)
- lead level
- blood screen for syphilis
- TSH to rule out low thyroid levels
- G6PD deficiency screening to detect this enzyme deficiency in children from Asia, the Mediterranean, and Africa
- PPD to evaluate for tuberculosis
- urinalysis dipstick
- diphtheria and tetanus antibody profile may be done if vaccines were given to verify immunity
- calcium, phosphatase, alkaline phosphatase, and rickets survey if there is a suspicion of rickets
- repeat testing for hepatitis B, hepatitis C, HIV, and tuberculosis (with a repeat PPD test)

Other recommended screening tests

- Hearing screen by audiometry or BSER (Many previously institutionalized children have been diagnosed with ear infections after their arrival in the United States. Early intervention ensures proper language development and hearing augmentation.)
- Vision screen and evaluation by an ophthalmologist (In many countries it is not known whether the mother had infections during childbirth that could have affected the child's vision.)
- Developmental screen
- Dental evaluation for children 18 months and older

Your Responsibilities

The Board of Pensions has certain obligations to you as a Medical Plan member, and you have certain responsibilities in return. By all parties fulfilling their responsibilities, the entire community of members covered by the plan receives a benefit. Together, we can ensure smart, safe, and efficient use of a critically important resource — our Medical Plan.

CARRY YOUR ID CARDS

As a member of the Medical Plan, you will have two ID cards. Your medical ID card shows that you access your medical benefits through the national Blue Cross Blue Shield network; your Express Scripts ID card shows that your coverage includes prescription drug benefits. Carry both cards so that you have them available for emergency and routine use. You do not need special ID cards to access your EAP benefits with Cigna or vision exam benefits with VSP.

You may request additional or replacement cards at any time by contacting your service providers (Highmark Blue Cross Blue Shield and Express Scripts). Be sure to shred the old cards whenever you receive new ID cards.

GET ADVANCE APPROVAL WHEN REQUIRED

For certain tests and procedures, you must receive approval before having them performed — that is, you must get them precertified or you may be responsible for their cost. Most of the tests and procedures that require advance approval are listed on the back of your medical ID card, along with the phone number to call.

You also must precertify non-urgent hospital admissions. In many cases, your provider's office will coordinate the precertification process for you to ensure precertification has been obtained.

In an emergency, seek the care you need from the nearest provider. Notify Highmark Blue Cross Blue Shield (BCBS) within 48 hours of an inpatient emergency admission.

To precertify a non-urgent hospital admission, procedure, test, or facility-based behavioral health treatment, you or your doctor's office should immediately call Highmark BCBS, using the phone number listed on the back of your medical ID card.

For detailed precertification requirements, how-to information, and more, see Precertification Requirements in Your Medical Benefits.

REPORT QUALIFYING LIFE EVENTS

Certain events or changes in your life can affect your benefits status or coverage. For this reason, you must inform the Board of Pensions within 60 days of any *qualifying life event*, such as welcoming a child, getting married, losing a covered family member, or losing other medical coverage.

Reporting these changes accurately and on a timely basis ensures your benefits are in place when and where you need them and allows the Board of Pensions to better communicate with and serve you.

You can notify the Board of Pensions of a qualifying life event through Benefits Connect. Log on and choose **My Benefits** on the homepage; then select **Life Event**s and follow the prompts to report your event, provide supporting documentation, and, if applicable, add eligible dependents.

UNDERSTAND YOUR SHARE OF THE COSTS

The following Summary of Coverage chart helps you determine the types of charges for which you are responsible. Your costs largely depend on whether your providers are in the network or not. Additional cost details are provided in the Your Medical Benefits section and in the Key Provisions chart in the Appendix.

Summary of coverage	
If the provider is …	**Benefit level**[1]
a network provider	**Office visits:** Preventive care visits[2] and screenings listed in the plan's Preventive Schedule are provided at no charge to you. For office visits when you are sick, your cost depends on which medical option you are enrolled in: • PPO or EPO: You pay a fixed copay amount; the amount depends on whether you visit a primary physician, specialist, urgent care center, or retail clinic or consult with a Teladoc doctor. Copays do not count toward the plan's annual deductible and PPO medical out-of-pocket maximum. Other services during sick visits (such as blood tests) may be subject to other copays, network deductibles, or coinsurance requirements.[3] • HDHP: You pay out of pocket for sick visits and related services up to the annual deductible amount. Network coinsurance requirements apply after you pay the deductible.
	Hospital inpatient and outpatient services: You pay annual network deductible(s) and network coinsurance of 20% (after deductible) up to a maximum. The plan pays a percentage of the contracted rate (100% after the applicable annual medical out-of-pocket maximum or total maximum out-of-pocket amount is reached). Providers may not bill you for the balance of charges.
	Routine eye exam: You pay a fixed copay, without a deductible, for a routine annual eye exam with a VSP provider.[4]
an out-of-network provider	**Office visits (PPO only):** You pay a percentage of the plan allowance for all office visits, including preventive care visits, to out-of-network providers.[1]
	Inpatient and outpatient services (PPO only): You pay annual out-of-network deductible(s) and coinsurance of 40% (after deductible) up to a maximum. The plan pays a percentage of the plan allowance (100% after annual out-of-network medical out-of-pocket maximum is reached). Providers may bill you for the balance of charges over the allowance established by the plan.
	Routine eye exam: At time of visit, you pay the full amount owed for the routine annual eye exam. Upon making a claim, you will be reimbursed up to a limit after your fixed copay is deducted.[4]

[1] See the Key Provisions chart and the 2021 PPO Deductibles and Medical Out-of-Pocket Maximums chart for deductibles, applicable copays, and out-of-pocket maximums.

[2] For details and limitations of preventive care coverage, see Preventive Care Benefit in Your Medical Benefits.

[3] If you reside in an area not served by the plan's network — a non-network area — and therefore cannot access a provider that participates in the network, your medical costs under the plan will be the same as if you were using a network provider.

[4] If enrolled in the HDHP, you will be automatically enrolled in the VSP vision exam benefit. The vision exam benefit is not considered part of the HDHP.

Mix of Network and Out-of-Network Providers

In some cases, inpatient and outpatient services may be received from both network and out-of-network providers; for example, you have surgery at a network hospital but the anesthesiologist is out of network. In these situations, claims are processed as follows:

- The hospital, outpatient facility, and attending physician* are network providers: All claims are paid at the network rate, subject to deductibles and PPO medical out-of-pocket maximum or total out-of-pocket maximum.
- The hospital, outpatient facility, or attending physician* is out of network: Network providers are paid at the network rate; all others are paid at the out-of-network rate (PPO only; charges from out-of-network providers are excluded under the EPO and HDHP).
- The hospital and attending physician* are network providers: Ancillary services that may be provided by out-of-network providers (anesthesiologists, radiologists, and others) are reimbursed at the network rate, subject to the plan allowance.

PROTECT PLAN RESOURCES

The Medical Plan has finite resources. Its financial viability depends largely on current dues and claims experience. The health of its members, in part, determines the claims experience.

As steward of the Medical Plan, the Board of Pensions encourages you to pursue every opportunity to improve your health and well-being — for your sake as well as the plan's. Eat healthy foods, get plenty of exercise, and take advantage of the preventive care and well-being resources provided by the plan. Participate in and complete Call to Health each year. Also, seek care from the right providers in the appropriate settings. (See Emergency and Urgent Care Services in the Overview section of this guide.)

Protect your medical and prescription ID cards so that no one other than you and your eligible family members uses your Medical Plan benefits. It is in everyone's interest not to permit expenses to be incurred by individuals who are not eligible for coverage.

And finally, please review the online claims summaries or explanation of benefits statements provided by Highmark Blue Cross Blue Shield on its website or in print. Check that any claims paid are for services received by you or your eligible family members.

This helps to minimize inappropriate and mistaken charges to the plan. If, for any reason, you believe your Medical Plan benefits have been accessed inappropriately, please call the Board of Pensions immediately.

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* *Attending physician means the physician who is the primary treating physician for an inpatient stay — e.g., the surgeon when a patient is admitted for surgery.*

Coverage for Special Circumstances

CHILDREN LIVING AWAY FROM HOME

Your covered child who lives in a different location than you may be in a network or non-network area, depending on that location. When your child seeks services, all plan provisions and requirements continue to apply. An example would be a child attending college in another city.

You can obtain a local provider list for your child from your service provider (see Contact Information).

TRAVEL WITHIN THE UNITED STATES

For expenses related to non-emergency care while traveling outside your area, reimbursement depends on whether the services were provided in a network or non-network area and, if in a network area, whether network services were used. (For information on emergency care, see Emergency and Urgent Care Services in the Overview section.)

For information about network providers while you are traveling within the United States, use the number(s) on your medical ID card to contact Highmark Blue Cross Blue Shield for medical/surgical providers.

All plan provisions and requirements continue to apply.

INTERNATIONAL TRAVEL

The Medical Plan provides coverage for medically necessary services for you and your eligible family members traveling outside the United States.

BCBS Global

You and your covered family members may use BCBS Global for medical attention during an international trip including

- inpatient hospital care (precertification required);
- outpatient hospital care and physician services; and
- locating recommended hospitals and physicians.

Remember to carry your medical ID card wherever you go.

If you need medical assistance, call BCBS Global, collect, at 804-673-1177 from outside the United States.

> **For inpatient hospital admissions when traveling abroad, Blue Cross Blue Shield members should contact BCBS Global, toll-free, at 800-810-BLUE (2583) or, collect, at 804-673-1177.**

You may have to pay for any medical expenses when you receive treatment (cash, travelers' checks, and credit cards usually are accepted). If you are treated as an inpatient at a hospital that belongs to the BCBS Global network, however, you may not have to pay in advance. If you pay for treatment, when you return, send your bills with a claim form for reimbursement under the Medical Plan:

Highmark Blue Cross Blue Shield
120 Fifth Ave.
Fifth Avenue Place, Suite 2035
Pittsburgh, PA 15222

International SOS

The Board of Pensions also contracts with International SOS to assist plan members when traveling outside the United States. The services of International SOS are available to active members and their families who participate in the Medical Plan.

International SOS has many clinics and 24-hour assistance centers throughout the world. Although International SOS refers travelers to local community services when possible, in worst-case scenarios, depending on the availability of local medical options and the severity of the medical condition, International SOS can assist with a medical evacuation to the nearest appropriate provider. International SOS is prepared 24 hours a day to help with referrals or evacuations using its own air ambulance fleet or a scheduled assisted flight on a commercial airline, depending on the situation.

If you are planning to travel outside the United States, you should visit pensions.org/members or call the Board of Pensions before leaving the country to obtain a membership information card and emergency contact numbers for International SOS services. There's also a convenient mobile app, which provides medical and security information by country. To download the app, open the iOS App Store or Google Play and search for International SOS Assistance App.

CONTINUING COVERAGE AFTER ELIGIBILITY IS LOST

Medical continuation coverage

If your coverage under the Medical Plan is ending, you and/or your eligible family members may enroll in medical continuation coverage. Medical continuation coverage enables you to continue essentially the same healthcare coverage that you had as an employee of a PC(USA) congregation or affiliated employer, but on a self-paid basis and for a limited time.

To enroll in medical continuation coverage, you must return to the Board the completed personal information, subscription, and authorization sections of the Medical Continuation, Subscription, or Waiver form, with the initial payment, *within 60 days* of the event that caused your coverage to end. The Medical Continuation Enrollment or Waiver form is provided by the Board of Pensions when your employment terminates. Surviving and former covered spouses, children losing their eligibility status, and members who retire before they are Medicare-eligible also may be eligible to enroll in medical continuation coverage.

Typically, medical continuation coverage for terminated members lasts up to 18 months. Former spouses and children who lose their eligibility at age 26 (or later, if disabled) may elect medical continuation coverage for up to 36 months.

You are not required to elect this medical continuation coverage; another healthcare plan's benefits — such as a plan available through the federal Health Insurance Marketplace or a state's health insurance exchange — may better fit your needs and be more affordable. As long as you continue to receive coverage under a qualified plan, you will satisfy the continuous coverage requirement for enrolling in the Medicare Supplement Plan at age 65 (although maintaining such coverage satisfies just one of several eligibility criteria for the Medicare Supplement Plan). For more details, see Guide to the Medicare Supplement Plan for Retired Members on pensions.org.

For more information about medical continuation coverage, visit pensions.org/members or call the Board at 800-773-7752 (800-PRESPLAN).

SITUATIONS THAT MAY RESULT IN LOSS OF ELIGIBILITY

Employment termination

Any medical coverage (except coverage provided under Pastor's Participation) will end *on the last day of the month* in which your employment ends. Employers will be required to remit dues through the end of the month and therefore may collect applicable contributions from you for your coverage.

If enrolled in Pastor's Participation

When your employment ends, you are eligible for 30 days of medical coverage at no cost to you. The 30 days begins on the first day of the month after your employment ends.

> **Ministers in Pastor's Participation who are temporarily unemployed and actively seeking church service, on an approved leave of absence, or under discipline may first participate in transitional participation coverage before enrolling in medical continuation coverage. (See Transitional Participation Coverage.)**

Death of member

If, as an active member, you are enrolled for pension, death and disability, and medical coverage, your surviving eligible family will receive 12 months of coverage at no charge to them or the employer, provided they notify the Board within 60 days of the date of your death.

To continue coverage after this 12-month period, your eligible family members must enroll in medical continuation coverage on a self-pay basis; they may enroll in this coverage for up to 36 additional months.

Divorce or dissolution

If, as an active member, you are divorced or your marriage is dissolved, your former covered spouse may continue coverage in the same medical option (PPO, EPO, or HDHP) by electing medical continuation coverage and making the monthly payments. If your former spouse wants to continue medical coverage through the Board of Pensions, he or she must elect this coverage before active coverage ends (the date of divorce). The Board must receive a copy of the divorce decree or proof of dissolution.

Employer withdrawal

If your coverage ends because your employer wholly withdraws or withdraws an entire employment class from the Benefits Plan, there are no extended coverage periods and you are not eligible for medical continuation coverage.

If you are on medical continuation and your former employer ceases to offer medical benefits, your medical continuation coverage will end.

TRANSITIONAL PARTICIPATION COVERAGE

If you are a member in Pastor's Participation who is seeking other church employment or are engaged in full-time church-related studies, you can continue full or partial coverage, on a self-pay basis, through transitional participation coverage. Coverage on this basis is available for 24 months for ministers and graduated seminary student members whose presbyteries verify their status.

Members who reach their maximum eligibility for continuing benefits through transitional participation coverage are eligible to continue healthcare benefits under medical continuation for an additional 18 months. For more information, visit pensions.org/members or call the Board of Pensions at 800-773-7752 (800-PRESPLAN).

Claims and Appeals

The plan's rules for claims payment and procedures for appeals are covered in this section.

CLAIMS FILING DEADLINE

All claims must be submitted within 12 months of the date of service to be eligible for reimbursement.

CLAIMS PAYMENT WITH DUAL COVERAGE

When you or a covered family member also has coverage from another source, the Medical Plan (with the exception of the prescription drug program) and the other coverage are coordinated as follows.

Maintenance of benefits

The plan provides for this order of payment:

- The employer plan of the patient generally pays first.
- The plan of the parent whose birthday falls earlier in the calendar year pays children's claims first (the *birthday rule*).
- When paying second, this plan coordinates benefits on a maintenance of benefits basis. In other words, the plan pays the benefit level it would normally pay less any amount paid by the plan that pays first.

Maintenance of benefits does not apply to the prescription drug benefit.

Member couple coverage

When a member couple is enrolled, each has full healthcare coverage under the PPO medical option, both as an employed member and as a covered spouse. This dual coverage benefits the member couple by lowering the coinsurance obligation.

For a member couple, claims are processed just once for each member, under his or her account, with no secondary calculation under the spouse. Children's claims are processed under the coverage of the parent whose birthday falls earlier in the calendar year (the *birthday rule).*

WHAT IS A MEMBER COUPLE?
When both individuals in a marriage are employed by PC(USA) employers and each is enrolled in the PPO medical option of the Benefits Plan of the Presbyterian Church (U.S.A.), they are termed a member couple.

If both you and your spouse work for a PC(USA) or affiliated employer, at least one of you must enroll for Member + Spouse coverage or Member + Family coverage (if you have eligible children) to qualify as a member couple. For example, if you and your spouse have no children and you enroll for Member-only coverage while your spouse enrolls for Member + Spouse coverage, you would qualify as a member couple. If you both elect Member-only coverage or if one of you waives medical coverage, you are not considered a member couple and will not qualify for member couple enhanced benefits.

Children of divorced or separated parents

For a covered child whose parents are not living together, are separated, or are divorced, or where a marriage has been dissolved, benefits are paid in this order:

1. The plan of the parent responsible under a court decree that established financial responsibility for the healthcare expenses of the child pays first.
2. The plan of the parent meeting the birthday rule pays the child's claims first if both parents are responsible under a court decree (see The Birthday Rule below).
3. If there is no court decree, this order applies:
   a. the plan of the parent with custody
   b. the plan of the stepparent married to the parent with custody
   c. the plan of the parent not having custody
   d. the plan of the stepparent married to the parent who does not have custody

THE BIRTHDAY RULE
When both parents have coverage by different plans, the birthday rule determines which plan pays your children's claims first. The parent having the earlier birthday in the calendar year is responsible, regardless of which parent is older; if the birthdays are the same day, the employer-provided health insurance plan that has covered a parent longer pays first.

When these rules do not establish an order of benefit determination, the benefits of the plan that has covered the person for the longer time are primary.

Medicare

When an active member reaches age 65, he or she is eligible for Medicare coverage, including Part A hospitalization coverage. You are not eligible to enroll in the Medicare Supplement Plan because it is a retiree-only plan.

If you continue to work and you are not enrolled in Pastor's Participation, you may waive Medical Plan coverage for medical insurance under Medicare. If you are enrolled in Pastor's Participation, you may not waive medical coverage (but still should enroll in Medicare Part A).

If you are not enrolled in Pastor's Participation and you are considering waiving coverage, carefully compare your Medical Plan coverage with that of a Medicare Advantage or Medigap plan. The aggregate premium costs may be less, but the coverage may not be as comprehensive as the Medical Plan's.

Coordination of benefits with Medicare and the Medical Plan

Active employees over age 65

Unless you are working for a small employer with fewer than 20 employees, the Medical Plan will be primary to your Medicare coverage. If you are employed by a small employer, when enrolling for Medicare at age 65, you should advise Medicare and the Board that you are still working and that your employer has fewer than 20 employees. Your employer may apply for a small employer exception to the Medicare Secondary Payer rule by completing the Small Employer Exception Submittal Certification form, available on pensions.org or by calling the Board of Pensions. This form should be filed with Medicare before you reach age 65 to establish Medicare as the primary payer of your claims and the

Medical Plan as secondary. This will not impact your coverage but may save the Medical Plan significant costs if you are hospitalized.

If your employer grows and has more than 20 employees, it must be reported to Medicare.

If your Medical Plan coverage as an active member ends, you must promptly enroll in Parts B, C, or D to avoid delayed enrollment penalties.

Disabled employees

For disabled members covered by Medicare, Medicare is the primary payer provided the employment relationship with the member has terminated.

The plan coordinates with Medicare coverage as described under Maintenance of Benefits.

APPEALS PROCESS

The Medical Plan's service providers are responsible for processing claims according to the terms of the plan. When presented with your claim, a service provider determines whether it is payable under the Medical Plan. If it is, the claim will be paid according to plan provisions. If it is not, you'll be advised of the reason(s) for the claim's denial in your explanation of benefits (EOB) statement, available online from the service provider's website or in print.

If your claim for a benefit under the Medical Plan is reduced or denied, you have the right to appeal that decision to the service provider (Highmark Blue Cross Blue Shield or Express Scripts) who made it.

The procedures for filing an appeal and for its review are explained here.

1. You appeal a denied claim

You should direct your appeal for a medical, prescription drug, or behavioral health/substance use disorder claim to the service provider indicated on the denial. There are two requirements:

- You must make your appeal request, in writing, within 180 days of the date of the written claim denial.
- The request for an appeal must explain your reasons for appealing the decision and include any additional information that supports the appeal.

2. Service provider reconsiders your claim

When presented with your appeal, the service provider reviews your reasons, documents, and related information and reconsiders whether the claim is payable under the Medical Plan.

Time frames

The time frame within which the plan's service providers must decide your appeal depends on the type of claim:

- **Urgent care** – Your appeal of an adverse decision for an urgent care claim* will be decided no later than 72 hours after its receipt. If the service provider needs additional information to decide if benefits are payable, you'll be notified within 24 hours and be given at least 48 hours to provide that

* *An urgent care claim is one that must be expedited because, in the professional judgment of your physician, the normal process may seriously jeopardize your life, health, or ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.*

information. You'll be notified of the service provider's decision within 48 hours of its receipt of the additional information.

- **For any other medical service denial or reduction** – Your appeal will be reviewed no later than 30 days after it is received, although the service provider may have a 15-day extension, if necessary.

3. You request an external review

If you are not satisfied with the results of your initial appeal decision, you may request a final review by an independent review organization (IRO). *You must do so within four months of the date the initial appeal was decided* and file your appeal with the service provider that advised you of the initial review decision.

IROs are state-approved and state-accredited organizations that are independent of the Board of Pensions and the plan's service providers. The service provider will select an IRO from at least three IROs, randomly or by rotation, to review your appeal.

4. The IRO reviews your claim

The IRO will make its decision and notify you in writing within 45 days after the service provider receives your request for external review.

Once you have exhausted the plan's appeals process, you have the right to challenge the decision in a court of law.

Administrative and Miscellaneous Provisions

CONFIDENTIALITY AND PRIVACY PRACTICES

Ensuring the privacy of member information is a responsibility the Board of Pensions takes very seriously. It is important that employers and their employees cooperate with the Board's policies concerning confidentiality. The privacy of health plan records for you, your spouse, and your children, if any, is also protected by special security and privacy regulations as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Board of Pensions Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice describes the Medical Plan's privacy practices and your rights to access your records. The notice is available on pensions.org or by calling the Board at 800-773-7752 (800-PRESPLAN).

Under HIPAA, Board employees and the Medical Plan's service providers may not release your Medical Plan protected health information (other than enrollment information) to your employer or anyone else, including your spouse, unless you authorize this by completing a power of attorney or an authorization form and file it with the plan. The Board will require your written authorization before sharing your protected health information for any reason other than payment, treatment, or healthcare operations with anyone other than you or your personal representative (that is, your guardian or named representative in a power of attorney). You may be asked to fill out and return authorization forms and to provide verification of information (see the Appendix). These and other actions are taken to safeguard your privacy and that of your family.

For an authorization form or more information, visit pensions.org or call the Board at 800-773-7752 (800-PRESPLAN).

PLAN'S RIGHT TO RECOUPMENT, SUBROGATION, AND REIMBURSEMENT FOR MEDICAL COSTS RECOVERED FROM THIRD PARTIES

The plan does not cover medical costs that are recoverable from a third party, including a personal injury, medical malpractice, or motor vehicle claim. However, because those recoveries often take time to resolve, the plan, in its sole discretion, may advance payment for the member's medical claims subject to the plan's requirement that the member repay the plan, in full, for those claims from the proceeds of the third-party recovery. The plan's rights are a lien and first priority claim against the member until the plan is reimbursed.

If you incur medical costs as a result of an accident or a negligent act for which you will recover your medical costs from insurance, a damage award or settlement, other medical coverage, or otherwise, you have the obligation to notify the Board. The Board will work with your legal counsel to assist in the recovery of your medical expenses. You should contact the Board to coordinate reimbursement to the plan when the case is settled.

FRAUD AND/OR MISREPRESENTATION

If you present false or misleading information about yourself or your family members with respect to any aspect of the plan, including but not limited to eligibility or claims, the Board will take appropriate action, including the forfeiture of your benefits or loss of coverage for you or your family members. If

coverage is terminated retroactively, you are responsible for repaying all benefit payments made under the plan for amounts incurred after your coverage termination date.

LIMITATION OF LIABILITY

The Board of Pensions will not be legally responsible for any failure of your church or employer to enroll you or your family members for coverage or to pay the dues for coverage.

> **The Board reserves the right to terminate or suspend the benefits coverage of any member for whom dues payments are delinquent, that is, not paid by the final day of the next month.**

AMENDMENTS TO THE PLAN AND RESERVATION OF RIGHT TO TERMINATE BENEFITS

The Board of Pensions, in its sole discretion, has the right to amend the Medical Plan and report any such amendment to the next succeeding General Assembly of the Presbyterian Church (U.S.A.).

Although the Board of Pensions expects and intends to continue the Medical Plan indefinitely, it reserves the right to modify, terminate, or suspend this plan and its provisions, including, but not limited to, benefits and contributions for coverage, at any time by action of the Board of Directors of The Board of Pensions of the Presbyterian Church (U.S.A.). The Board is required to report amendments to the Medical Plan to the General Assembly.

Contact Information

Member services			
TYPE	**PROVIDER**	**PHONE**	**WEBSITE**
Any question	The Board of Pensions of the Presbyterian Church (U.S.A.)	800-773-7752 (800-PRESPLAN) TTY: 877-522-7948 no answer when dialing on regular phone Outside the U.S.: 215-587-7200 8:30 a.m. – 7 p.m. ET, Monday through Friday Fax: 215-587-6215	pensions.org

Key service providers			
TYPE	**PROVIDER**	**PHONE**	**WEBSITE**
PPO, EPO, and HDHP network and provider information	Highmark Blue Cross Blue Shield	888-835-2959 8 a.m.–5 p.m. ET, Monday through Friday	highmark.com/pcusa
Employee Assistance Plan (EAP)	Cigna	866-640-2772 Available 24 hours	mycigna.com (Employee's Employer ID: pcusa)
Prescription drugs (retail and mail order)	Express Scripts	800-344-3896 Available 24 hours	express-scripts.com
Vision exam	VSP	800-877-7195 8 a.m. –11 p.m. ET, Monday through Friday 10 a.m. –11 p.m. ET, Saturday 10 a.m.–10 p.m. ET, Sunday	vsp.com or vsp.com/choice (to find a VSP participating provider)

Emergency			
TYPE	**PROVIDER**	**PHONE**	**WEBSITE**
24-hour nurse line	Highmark Blue Cross Blue Shield	See above.	See above.
Behavioral health/substance use disorder	Highmark Blue Cross Blue Shield	See above.	See above.
Inpatient emergency hospital admission* for medical/surgical	Highmark Blue Cross Blue Shield	See above.	See above.
Inpatient emergency hospital admission* for behavioral health/substance use disorder	Highmark Blue Cross Blue Shield	See above.	See above.

* Call within 48 hours.

Precertification			
TYPE	**PROVIDER**	**PHONE**	**WEBSITE**
Medical/surgical inpatient hospital admission and behavioral health/substance use disorder facility-based admission	Highmark Blue Cross Blue Shield	See above.	Highmark.com/pcusa

Claims information			
TYPE	**PROVIDER**	**PHONE**	**WEBSITE**
Medical, surgical, and behavioral	Highmark Blue Cross Blue Shield	See above.	See above.

Other			
TYPE	**PROVIDER**	**PHONE**	**WEBSITE**
24-hour nurse line	Highmark Blue Cross Blue Shield	See above.	See above.
Telemedicine	Teladoc	800-835-2362 Available 24 hours	teladoc.com/enter
Tobacco-free living	Ignite Your Life	855-451-6754 7 a.m. –10 p.m. ET, Monday through Friday	calltohealth.org
Livongo for Diabetes	Livongo	800-945-4355 Mention code BOP	join.livongo.com/BOP/register

Appendix

KEY PROVISIONS

Network benefit	PPO		EPO	HDHP
	Lowest salary band	Highest salary band	N/A	N/A
Deductible (without Call to Health)	$660/member[1] $660/all other family members[1,2]	$1,305/member[1] $1,305/all other family members[1,2]	$2,000/member $2,000/all other family members[2]	$3,000/member only $6,000 member + family[3]
Deductible (Call to Health)[3]	$440/member[1] $440/all other family members[1,2]	$870/member[1] $870/all other family members[1,2]	$1,500/member $1,500/all other family members[2]	$2,250/member only $4,500 member + family[3]
Spending account compatibility	Healthcare flexible spending account (FSA)		Healthcare FSA	Health savings account (HSA)
Medical coverage after deductible (coinsurance)	Member pays 20%		Member pays 20%	Member pays 20%
Preventive care[4]	Covered 100%		Covered 100%	Covered 100%
Telemedicine (Teladoc)	$10 copay		$10 copay	Member pays 100% up to deductible amount; after deductible, member pays 20%
Primary and behavioral office visit	$25 copay		$40 copay	
Retail clinic visit	$25 copay		$40 copay	
Specialist office visit	$45 copay		$60 copay	
Urgent care visit	$45 copay		$60 copay	
Basic diagnostic services (imaging, lab, X-rays, etc.)	Member pays 20% after deductible		$65 copay	
Advanced imaging (MRI, CT, PET, etc.)	Member pays 20% after deductible		$200 copay	
Physical, speech, and occupational therapy	Member pays 20% after deductible		$40 copay	
Spinal manipulations	Member pays 20% after deductible		$40 copay	
Hearing aid (device and fitting) plan maximum of $2,500 every 3 years	Member pays 20% after deductible		Member pays 20% after deductible	
Hospital inpatient and outpatient	Member pays 20% after deductible		Member pays 20% after deductible	
Emergency room	Member pays 20% after deductible		Member pays 20% after deductible	
Infertility treatment (3 procedures/life maximum)	Member pays 20% after deductible		Member pays 20% after deductible	
ABA therapy	Member pays 20% after deductible		Member pays 20% after deductible	
Select surgeries	Member pays 0% after deductible when these select surgeries are performed in a BCBS Blue Distinction Center: bariatric surgery, knee replacement surgery, hip replacement surgery, spinal surgery, and transplants. Family travel benefit also available depending upon distance.			

Out-of-network benefit	PPO		EPO	HDHP
Deductible	$1,100/member[1] $1,100/all other family members[1,2]	$2,170/member[1] $2,170/all other family members[1,2]	N/A	N/A
Coverage after deductible	Member pays 40%; 50% (no deductible) for doctors' office visits			
Out-of-pocket maximum (member and family combined)	$6,600	$13,020		

See next page for references.

KEY PROVISIONS (continued)

Prescription drugs	PPO		EPO	HDHP
	Lowest salary band	Highest salary band	N/A	N/A
Preventive drugs				
Preventive generic retail (30/90) mail (90)	$5 / $15 $12.50		$6 / $18 $15	not subject to HDHP deductible $6 / $18 $15
Preventive formulary brand retail (30/90) mail (90)	$20 / $60 $50		$30 / $90 $75	not subject to HDHP deductible $30 / $90 $75
Non-preventive drugs				
Generic retail (30/90) mail (90)	$10 / $30 $25		$12 / $36 $30	Member pays 100% up to deductible amount; after deductible, member pays 30% subject to $150 (30 day), $450 (90 day), or $375 (90 day mail) max
Formulary brand retail (30/90)	30% of cost; 30 days: $20 min to $100 max 90 days: $60 min to $300 max		35% of cost; 30 days: $35 min to $150 max 90 days: $105 min to $450 max	
Formulary brand mail (90)	30% of cost; $50 min to $250 max		35% of cost; $85 min to $375 max	
Non-formulary brand retail (30/90)	50% of cost; 30 days: $50 min to $150 max 90 days: $150 min to $450 max		Not covered	Not covered
Non-formulary brand mail (90)	50% of cost; $125 min to $375 max		Not covered	Not covered
Annual out-of-pocket maximums				
Medical out-of-pocket maximum	$2,200/family[1]	$4,340/family[1]	Part of total maximum out-of-pocket	Part of total maximum out-of-pocket
Prescription out-of-pocket maximum	$3,000[5] (member & family combined		Part of total maximum out-of-pocket	Part of total maximum out-of-pocket
Total maximum out-of-pocket	$5,000/member[6] $10,000/family[6]		$5,000/member[6] $10,000/family[6]	$5,000/member[6] $10,000/family[6]

[1] See PPO Deductibles and Medical Out-of-Pocket Maximums for specific amounts at all effective salary levels. The medical out-of-pocket maximum is the most a member will pay in a year in the form of coinsurance. It does not include copays, deductibles, or prescription drug costs.

[2] Members with covered spouses and/or children are responsible for two medical deductibles, one for themselves and one for all other family members combined.

[3] Members with covered spouses and/or children are responsible for the entire family deductible amount.

[4] Coverage for preventive services exceeds ACA definition.

[5] Any costs for non-formulary brand-name drugs do not count toward the prescription out-of-pocket maximum.

[6] The total maximum out-of-pocket includes network deductibles and coinsurance; medical out-of-pocket maximum (PPO only); prescription drug out-of-pocket maximum (PPO only); copays (PPO and EPO); and prescription drug copays (non-formulary brand-name drugs excluded).

KEY PROVISIONS: VISION EXAM BENEFIT

Type of visit	Your costs	
	VSP provider	Out-of-network provider
Routine eye exam	$25 copay	Submit claim for reimbursement up to $45 after $25 copay
Contact lens exam	15% discount on exam (fitting and evaluation)	No coverage

PLAN MAXIMUM REIMBURSEMENT LIMITS

Medical Plan reimbursement limits	
Maximum benefit reimbursement	**Category**
$10,000	Travel and lodging benefit for the covered patient and a companion for covered transplants if the surgery occurs 100 or more miles from the patient's home Travel and lodging benefit for the covered patient and a companion for covered services at a Center of Excellence if the treatment occurs 100 or more miles from the patient's home
$500	Lifetime maximum for temporomandibular joint dysfunction (TMD) treatment
$2,500 every 3 years	Hearing aid (device and fitting)
3 procedures	Lifetime maximum for medically necessary use of advanced reproductive technology[1]
100 visits	Annual maximum visits, of up to 8 hours each, for home healthcare
180 days	Annual maximum for extended-care facilities

[1] Includes in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), ovum microsurgery, and the supplies and prescription drugs related to such therapies.

DISCRIMINATION IS AGAINST THE LAW

The plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity, or recorded gender. Furthermore, the plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The plan provides

- free aids and services to people with disabilities to communicate effectively with us, such as
  - qualified sign language interpreters; and
  - written information in other formats (large print, audio, accessible electronic formats, other formats); and
- free language services to people whose primary language is not English, such as
  - qualified interpreters; and
  - information written in other languages.

If you need these services, contact the Civil Rights Coordinator. If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 800-773-7752 (800-PRESPLAN).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-773-7752 (800-PRESPLAN).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-773-7752 (800-PRESPLAN)

PRIVACY FORMS

The following privacy forms are available on pensions.org or by request from the Board of Pensions.

HIPAA forms	
Form	**Actions**
Authorization to Release Medical Plan Information, HPA-001	Allows the Board to release the protected health information to other specified persons, including a covered spouse; an organization, including a presbytery representative; or an internal Board department
Authorization for Use or Disclosure of Protected Health Information, HPA-002	Allows another health plan, a physician, practice, hospital, or healthcare provider or organization to release protected health information to the Board for purposes other than treatment, payment, or healthcare operations (for which no authorization is required)
Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plan – Request for Access to PHI, HPA-003	Allows a covered individual or personal representative access to his or her protected health information maintained by the Medical Plan
Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plan – Request to Amend PHI, HPA-004	Allows a covered individual or personal representative to request an amendment to his or her protected health information maintained by or for the Medical Plan
Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plan – Request for Accounting of Disclosures, HPA-005	Allows a covered individual or personal representative to request an accounting of disclosures of protected health information
Member or Dependent Authorization to Use and Disclose Personal Employment and Financial Information, HPA-006	Authorizes the Board to disclose personal/employment/financial information
Designation of Personal Representative, ENR-904	Provides limited powers of attorney to the personal representative of a covered person; authorizes the Board to provide information to that individual

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

2000 Market Street
Philadelphia, PA 19103-3298
800-773-7752 (800-PRESPLAN)

pensions.org

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