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

Guide to Your Healthcare Benefits

FOR ACTIVE MEDICAL PLAN MEMBERS

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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-PRESPLAN (800-773-7752) (TTY:711) 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 Quantum Health. 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
- 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.

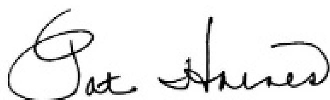
The Board of Pensions has three goals in its role overseeing this plan for you, your family, and other members: (1) encourage you to take care of your health; (2) support your efforts to be a wise consumer of healthcare services; and (3) steward plan resources for the benefit of all those who serve the 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.

With that being said, we recognize that today's healthcare system can be complex, and we believe no one should have to navigate it alone. To help guide you and your covered family members on your healthcare journey and make the most of your medical and prescription drug benefits, the Board has partnered with Quantum Health to bring you care navigation. I encourage you to take advantage of this personalized, value-added service that can assist with all your healthcare needs, from finding network providers and ordering replacement ID cards to answering questions about a medical procedure and explaining the copays, deductibles, and/or coinsurance that may apply. When you do, I think you'll find it's a better way to experience healthcare.

I also invite you to participate in Call to Health, which promotes all aspects of wholeness: spiritual, health, financial, and vocational. Participating in Call to Health for the 2025 program year also enables you to qualify for reduced individual and family deductibles for 2026. 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/medical for further information, call 800-PRESPLAN (800-773-7752) (TTY: 711) 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)
- a qualified high deductible health plan (HDHP)

The types of services covered under each option 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 benefits, which include treatment for mental health and substance use disorders
- prescription drug coverage
- special benefits and resources to improve your health and well-being, including:
    - Centers of Excellence
    - Livongo for Diabetes
    - Call to Health
    - an Employee Assistance Plan (EAP) that works seamlessly with your behavioral health benefits

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. Highmark Blue Cross Blue Shield (BCBS) is the service provider for healthcare provider network access and claims processing for medical benefits. Express Scripts, a leading pharmacy benefits manager, is the service provider for prescription drug benefits. Highmark BCBS handles precertification and case management for behavioral health services while Quantum Health handles the precertification process and case management for medical services. Quantum Health also provides customer service and support for both medical and 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 myqhealthpcusa.org, click **Care** under the left navigation bar, and then click the **Search Care Finder™** button to locate participating network physicians and other healthcare providers. You can also call Quantum Health at 855-497-1237 and a Care Coordinator can assist you with finding network 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 Blue Cross Blue Shield (BlueCard PPO) national 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 Quantum Health 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) provides access to the BCBS (BlueCard PPO) national network of doctors, hospitals, and other healthcare providers, and processes medical claims. Spring Health provides additional network options for behavioral health services.

> **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 Spring Health) and telemedicine (provided by Teladoc). Whenever you receive a new ID card, shred the old one.**

Spring Health is the service provider for 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 services

You may also see your provider through telemedicine, which lets your provider care for you without an in-person office visit. Many providers now offer telemedicine services as an alternative to in-person visits. Teladoc is a telemedicine benefit for acute needs that gives you 24/7 access to Teladoc doctors through the convenience of phone, video, or mobile app visits. (See Use the telemedicine option under Emergency and Urgent Care Services.)

Routine vision services

Your healthcare coverage includes access to the VSP network, a broad network of optometrists and ophthalmologists administered by VSP, for routine annual eye exams. The VSP 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 Benefit 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.

A separate prescription drug ID card from Express Scripts (in addition to your medical ID cards) is used to fill prescriptions. Show 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 COVID-19 and flu shots, at a participating pharmacy at no cost to you.

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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.*

If you newly elect medical coverage for 2025, you will receive a welcome email from Express Scripts with instructions to create an account on the Express Scripts website or Express Scripts mobile app and gain instant access to your digital prescription drug ID card. You can then download your card to your digital wallet or print one from the Express Scripts website.

Care navigation services

Quantum Health provides care navigation services which leverage available resources, including but not limited to the Medical Plan, the plan's service providers, your healthcare provider, and your community, to help you best navigate the healthcare system.

Care navigation is intended to help you and your covered family members obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and ensure early identification of and support for complex medical conditions. Quantum Health's Care Coordinators are available to you and your covered family members by phone, online, or by mobile app for information, assistance, and guidance.

In addition to the care navigation services provided by Quantum Health, Spring Health provides mental health care navigation as part of your EAP and behavioral health benefits.

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. If you aren't sure about who to call, start with Quantum Health.

EMERGENCY AND URGENT CARE SERVICES

If you need emergency care, call 911 or 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 the appropriate service provider within 48 hours of an inpatient emergency admission as follows:

- Quantum Health for physical illness or injury
- Highmark Blue Cross Blue Shield (BCBS) for behavioral health, including mental health or substance use disorders

This is generally an automatic part of the admitting process and is typically handled between the hospital and Quantum Health/Highmark BCBS on your behalf. The phone numbers to call are listed on the back of your medical ID card.

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 Quantum Health/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 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.
- **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.

DEDUCTIBLES, COPAYS, AND COINSURANCE
Your deductible, copay, 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:

- **Quantum Health's Care Coordinators** serve as your primary point of contact when you have questions about your medical or prescription drug benefits or need help understanding how to use them. If you aren't sure about who to call, start with Quantum Health.

  WAYS TO CONTACT YOUR QUANTUM HEALTH CARE COORDINATORS
  - **Call 855-497-1237 Monday-Friday, 8:30 a.m. to 10 p.m. ET.**
  - **Log on to myqhealthpcusa.org to access benefits and claims information, search for network providers, print and save a copy of your medical ID card, and live chat with a Care Coordinator.**
  - **Use the MyQHealth - Care Coordinators mobile app.**

- **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 change

- view dependent information
- simplify logins to the websites of many of the Board's service providers

- **Board of Pensions service representatives** can help you with your questions about plan benefits and are 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
  - 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-PRESPLAN (800-773-7752) (TTY: 711) Monday-Friday, 8:30 a.m. to 6 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 employees who are regularly scheduled to work at least 20 hours per week.

Ministers serving in installed positions are not subject to the minimum 20-hour-per-week requirement.

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 the Congregational Pastors Package, your employer pays 100% of the cost for your medical coverage. You may be asked to contribute toward the cost of coverage for eligible family members. If you are enrolled in Transitional Pastor's Participation, your employer pays 100% of the cost of coverage for you and your eligible family members. See the sections Congregational Pastors Package and Transitional Pastor's Participation for more information.

Eligible family members are:

- 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

Contributions

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

When only one medical option is offered, your employer must pay at least 50% 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% 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

You may waive medical coverage for yourself — unless you're enrolled in the Congregational Pastors Package or Transitional Pastor's Participation — and for your eligible family members.

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.

Important: 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).

CONGREGATIONAL PASTORS PACKAGE

Ministers in an installed pastoral relationship must be enrolled in the Congregational Pastors Package or Transitional Pastor's Participation, regardless of the number of hours the pastor is regularly scheduled to work. The Congregational Pastors Package may be offered to any congregational pastoral leader regularly scheduled to work at least 20 hours per week.

Benefits in the Congregational Pastors Package include Member-Only coverage in the PPO option on a noncontributory basis (the employer pays 100% of the cost of coverage). Members may be required to contribute toward the cost of coverage for eligible family members, at the employer's discretion.

TRANSITIONAL PASTOR'S PARTICIPATION

This package was available to congregational pastoral leaders in Pastor's Participation as of Dec. 31, 2024, to transition to the dues structure introduced in the 2025 Benefits Plan. Installed pastors in this package will be enrolled in the Congregational Pastors Package beginning Jan. 1, 2028. Employers may offer the Congregational Pastors Package to those enrolled in Transitional Pastor's Participation at any time before 2028.

Benefits in Transitional Pastor's Participation include full family medical coverage in the PPO option on a noncontributory basis (the employer pays 100% 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 Congregational Pastors Package or Transitional Pastor's Participation

If you are enrolled in the Congregational Pastors Package or Transitional Pastor's Participation, you may not waive medical coverage for yourself. You may waive coverage for your spouse and/or eligible child(ren); however, if you are enrolled in Transitional Pastor's Participation and 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 family member status to the Board of Pensions within 60 days of the event.

To report a life event, log on to Benefits Connect and from the homepage click the **Quick Actions** button on the **MY BENEFITS** tile under **MY TOOLS** to report your event, make changes to your coverage, and provide any required supporting documentation.

COVERAGE AFTER ELIGIBILITY ENDS

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 Congregational Pastors Package or Transitional Pastor's Participation coverage is ending, by enrolling in Ministers Bridge Coverage. For more information on these programs, including eligibility rules, see Coverage for Special Circumstances 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. It also outlines reimbursement procedures for out-of-network care, if applicable. (Prescription drug benefits are 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 Quantum Health 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-PRESPLAN (800-773-7752) (TTY: 711).

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 exams
- professional services
- primary care and specialist physician office visits (whether in-person or virtual), allergy shots, therapeutic injections, surgery, and second opinions before a nonurgent 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 MRIs, CT scans, and PET scans (with precertification), and X-rays and ultrasounds (without precertification)
- nuclear stress tests (with precertification)
- hearing aids and fittings[3]
- advanced reproductive technology procedures (up to three attempts)[4]
- pregnancy and childbirth care
- behavioral health (outpatient therapy, including counseling)
- 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)
- anesthesia
- skilled nursing facility
- mastectomy-related benefits, including reconstruction, surgery, prostheses, and treatment of physical complications
- emergency room care for medical emergency
- organ transplants[7] (with precertification)
- behavioral health treatment in a hospital, treatment facility for substance use, or residential treatment center (with precertification) or outpatient treatment (without precertification)
- ambulance service or transportation to a local hospital or to the nearest hospital equipped to provide treatment not available in the local hospital
- 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 (precertification for all rentals and purchases over $1,500)
- other medically necessary services 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/or 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 nonpreventive 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 except for emergencies, 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 nonpreventive care, see the Key Provisions chart in the Appendix.

PREVENTIVE CARE BENEFITS

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

Under all medical options, when you visit a network provider, the plan covers 100% 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
- eligible preventive screenings/procedures and immunizations

> **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.**

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% 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% 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% 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.

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

Preventive care office visits

If you use a network provider, the plan covers 100% of the plan allowance (you pay $0) 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.[*]

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.[*] You may be billed for the balance of charges over the plan allowance.

If a health condition is discovered or diagnosed during your preventive exam, as long as no signs or symptoms of illness are apparent your visit will still be 100% 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% of the plan allowance, with no deductible, and you pay the remaining 50% and any charges above the allowed amounts. You may be billed for the balance of charges over the plan allowance.

NONPREVENTIVE 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 nonpreventive care when the services are medically necessary. Medically necessary healthcare services and supplies are:

- provided or prescribed by an accredited hospital, physician, or other 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)
- the most appropriate standard or level of services according to sound medical practice and which can be safely provided to the patient. When applied to hospitalization, this further means that acute care as an inpatient is required and appropriate to the nature of services or condition of the patient and that the care cannot be rendered safely or adequately in another treatment setting.

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

Your share of the cost for covered nonpreventive services

Your out-of-pocket costs for covered nonpreventive 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 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).

> **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 the prescription drug program**
> - **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 through Teladoc.

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).

> **Through the Employee Assistance Plan (EAP), you pay $0 for up to six clinical therapy visits per year with a Spring Health network provider. If treatment continues beyond the six visits, regular plan copays apply. Spring Health is the service provider for the EAP. See Employee Assistance Plan later in this guide for more information about EAP benefits.**

Deductibles

For other types of nonpreventive 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 2025 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).

2025 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 their eligible family is based on the lowest salary range.

[3] The Board may, in its sole discretion, establish the deductible and medical out-of-pocket maximum for members enrolled in medical continuation coverage. For 2025, the deductible and out-of-pocket maximum are based on salary range $58,270-$63,024.

[4] Completion of Call to Health in the current program 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 (Jan. 1 through Dec. 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 the Congregational Pastors Package and Transitional 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 path Terms of Call Series 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% of the allowable charges; for out-of-network care, it is 40% (50% 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 2025 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% 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).

2025 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% of eligible expenses up to the plan allowance for the rest of the year, except for office visit and prescription 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 network deductible and coinsurance, office visit copays, and prescription drug costs (except for non-formulary brand drugs and certain non-essential specialty pharmacy drugs) 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 network primary care and behavioral healthcare office visits (whether in-person or virtual) or visits to a retail clinic, $60 for network specialists or when seeking care at an urgent care center, and $10 when using the telemedicine benefit with Teladoc. 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).

Through the Employee Assistance Plan (EAP), you pay $0 for up to six clinical therapy visits per year with a Spring Health network provider. If treatment continues beyond the six visits, regular plan copays apply. Spring Health is the service provider for the EAP. See Employee Assistance Plan later in this guide for more information about EAP 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% 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 (except for certain nonessential specialty pharmacy drugs), count toward the total maximum out-of-pocket amount.

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

Copays
If you are enrolled in the HDHP, there are no copays for medical care and treatment. All covered nonpreventive 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 Your Prescription Drug Benefits).

> **Through the Employee Assistance Plan (EAP), you pay $0 for up to six clinical therapy visits per year with a Spring Health network provider. If treatment continues beyond the six visits, regular plan deductibles and coinsurance apply. Spring Health is the service provider for the EAP. See Employee Assistance Plan later in this guide for more information about EAP 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. Although you are responsible for the entire cost of your care until you pay the deductible, the amount you pay is the discounted Blue Cross Blue Shield network rate.

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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.*

The HDHP deductible also applies for covered prescription drugs unless the drug is designated as preventive (see Your 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/medical for more details.**

Coinsurance and out-of-pocket maximums

After reaching the deductible amount, you are still responsible for paying coinsurance — 20% 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% of allowable charges for that family member for the rest of the year.

> **Under all three medical options (PPO, EPO, and HDHP), expenses not covered by the plan do not count toward your deductible(s), 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 Blue Cross Blue Shield (BlueCard PPO) national 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. For behavioral health counseling visits, the plan allowance equals the provider's billed charges. Out-of-network providers may bill you for any 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% of the BlueCard PPO participating provider rate in that area.

Behavioral health services

The Board urges you to contact Spring Health at the number on the back of your medical ID card before beginning treatment with a therapist, although this is not a requirement. When you call Spring Health, a mental health care navigator will help you access care without the guesswork of finding the right provider and services. All Spring Health providers are in-network for the Medical Plan.

You are entitled to up to six no-cost visits with a Spring Health network counselor/therapist as part of your Employee Assistance Plan (EAP) benefits. If treatment continues beyond the six no-cost visits, regular plan copays or deductibles and coinsurance apply.

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, any benefits are payable 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% of the costs. (See the Key Provisions chart in the Appendix for deductible, copay, and coinsurance information.)

If you require inpatient, partial hospitalization, intensive outpatient, or residential treatment center care, Highmark Blue Cross Blue Shield (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 behavioral health case manager from Highmark BCBS may contact you by phone (and sometimes by letter if they can't reach you). The Board strongly encourages you to accept the call and speak directly to the behavioral health case manager. This individual 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
- providing a listening ear

The behavioral health case manager 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 24 hours of the next business day after 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
- lower total cost of care

Travel benefits

Covered individuals 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 travel and lodging expenses for themselves and a companion. (See the Appendix for more information.)

You must submit a claim to Highmark Blue Cross Blue Shield for reimbursement. Your request must include dated receipts showing the service provided, the cost of the service, and the service provider's name, address, and telephone number.

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%* of allowable facility 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

Network Centers of Excellence are designated as Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+) by the Blue Cross and Blue Shield Association. To find facilities with these designations, log on to myqhealthpcusa.org and click **Care** under the left navigation bar and then click the BlueCardPPO link on the Care Finder tab, or call Quantum Health at 855-497-1237 and a Care Coordinator will help you find a Center of Excellence.

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. If you need help finding a Center of Excellence for a specific procedure, call Quantum Health at 855-497-1237.

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 disorders
- cerebral palsy
- Down syndrome
- intellectual disability
- 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 their 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 — contact Highmark Blue Cross to work with a case manager. The case manager has 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. After an initial number of visits in a given therapy, the family should contact Highmark Blue Cross about continued 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% — and you pay 20% — 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%.

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.

Contact Quantum Health when you know you will need a transplant.

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 is provided for the covered patient and a companion. (See the Appendix for more information.)

You must submit a claim to Highmark Blue Cross Blue Shield for reimbursement. Your request must include dated receipts showing the service provided, the cost of the service, and the service provider's name, address, and telephone number.

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.)

Women's health protection

Reproductive health coverage

The plan covers medical, surgical, and diagnostic services to diagnose and treat fertility as well as medically necessary assisted reproductive technology (ART) services, including but not limited to in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)/zygote intrafallopian transfer (ZIFT), and cryopreserved embryo transfers. Covered ART procedures are subject to plan limits, which include a

lifetime maximum. (See the Appendix.) For more information about covered ART services, call Quantum Health at the number on the back of your medical ID card.

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.

Pregnancy and childbirth care

You or the attending physician should notify Quantum Health in advance of an inpatient admission for childbirth, preferably 30 days before the expected delivery date. 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
- 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. If the mother's or newborn's attending physician, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the plan will only consider benefits for the actual length of the stay. The plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48- or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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, click the Quick Actions button on the MY BENEFITS tile under MY TOOLS 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.

Breast reconstruction

Also, in conformity with federal law, the plan provides breast reconstruction benefits to individuals 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 care, services, and procedures; this is known as precertification. If you do not precertify the specified care, services, and procedures, you may be responsible for their cost. The care, services, and procedures that require precertification are listed on the back of your medical ID card, along with the phone number to call.

If your physician recommends a nonurgent hospital admission or a procedure or test that requires precertification, your doctor's office should immediately call Quantum Health (for medical admissions) or Highmark Blue Cross Blue Shield (BCBS) (for behavioral health admissions), using the phone number on the back of your medical ID card. To avoid delays, the precertification request should be made within the following time frame:

- at least three business days, before a scheduled (elective) inpatient admission
- by the next business day after an emergency hospital admission
- upon being identified as a potential organ or tissue transplant recipient
- at least three business days before receiving any other services requiring preauthorization

Depending on the request, a Quantum Health Care Coordinator or Highmark BCBS representative may contact your doctor to obtain additional clinical information to support the request for the precertification and to ensure that the care, service, and/or procedure meet plan and nationally accepted medical criteria. If a precertification request does not meet those criteria, you and your doctor will be notified, and Quantum Health/Highmark BCBS will assist in redirecting care if appropriate.

The precertification process is typically completed within two business days after all the information needed from your provider is received. You can check the status of a precertification request by logging on to myqhealthpcusa.org or contacting Quantum Health directly.

FOR MEDICAL CARE AND TREATMENT, CALL QUANTUM HEALTH AT THE NUMBER ON THE BACK OF YOUR ID CARD TO PRECERTIFY:

- **inpatient and skilled nursing facility admissions**
- **outpatient surgeries**
- **MRI/MRA/PET scans**
- **oncology care and services**
- **genetic testing**
- **dialysis**

- **transplants**
- **home health care**
- **hospice care**
- **durable medical equipment (all rentals and purchases over $1,500)**

FOR BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE USE DISORDERS) CARE AND TREATMENT, CALL HIGHMARK BCBS AT THE NUMBER ON THE BACK OF YOUR ID CARD TO PRECERTIFY:

- **inpatient admissions**
- **ABA therapy**
- **partial hospitalization and intensive outpatient care**

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 healthcare service needs advance approval, call Quantum Health at the number on the back of your ID card before having it performed.

Emergency admission

In an emergency, seek the care you need from the nearest provider. *You must call Quantum Health/Highmark Blue Cross Blue Shield by the next business day after 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*. Quantum Health/Highmark Blue Cross Blue Shield 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.

Note: The precertification process does not provide a guarantee of payment of benefits. Approvals of precertification requests for care, services, and procedures indicate that the medical condition, services, and care settings meet the utilization criteria established by the plan. Such approvals do not indicate that the care, service, or procedure is a covered benefit, that the patient is eligible for such benefits, or that other benefit provisions such as copays, deductibles, coinsurance, or out-of-pocket maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the plan.

CONCURRENT UTILIZATION REVIEW

Quantum Health/Highmark Blue Cross Blue Shield (BCBS) regularly monitors inpatient hospital stays, other facility admissions, or ongoing courses of care, and evaluates the appropriateness of the level of care and whether the stay is medically necessary. If needed, they will examine the possible use of alternate levels of care or facilities. As part of this process, Quantum Health/Highmark BCBS will communicate regularly with the attending providers, the facility's utilization management staff and/or discharge planners, and you and/or your family to monitor the patient's progress and anticipate and initiate planning for discharge needs. This concurrent review, and authorization for covered inpatient days, is conducted in accordance with the utilization criteria adopted by the plan, Quantum Health/Highmark BCBS, and nationally accepted medical criteria.

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, or procedures for purposes of research
- 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 temporomandibular joint dysfunction (TMD)[2]
- vision surgery to alter the refractive character of the eye (Discounts are available through VSP providers.)
- eye refractions, eyeglasses, or exams for eyeglasses (except for corrective lenses needed following cataract surgery, or for orthoptic treatment)[3]
- treatment or supplies, including foot orthotics,[4] 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 covered person'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 for failing to keep an appointment or for completion of claim forms

- 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
- services or supplies provided primarily for personal hygiene, comfort, or convenience

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

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

[3] The Medical Plan does provide coverage for an annual routine vision exam. An optional vision plan that includes benefits for covered eyewear is available. 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.

[4] 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 Quantum Health at 855-497-1237 or 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 Highmark Blue Cross Blue Shield (BCBS) 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 Quantum Health 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 Highmark BCBS at the address on the form.

Retail health clinics, such as those found in large pharmacy chains, typically charge for services based on Highmark BCBS'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 BCBS 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

While Highmark Blue Cross Blue Shield is responsible for processing and, when applicable, paying medical claims, Quantum Health offers you online resources to view and track your claims.

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%), 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 Quantum Health to request an adjustment.

QUESTIONS?

If you have questions about your claims, contact Quantum Health 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 and complicated to treat and the opportunities for improved health outcomes are better, 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 and save on your medical deductible(s) for the next plan year.

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 for nonurgent healthcare facility admissions or certain tests — at the time you schedule them. See Precertification Requirements in this guide for a list of services that must be precertified and who to call. 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 through Teladoc.

Connect with Quantum Health's Care Coordinators

- Care Coordinators are highly trained nurses, clinicians, and benefits specialists who will help you navigate today's complex healthcare system and get the most from your medical coverage.
- If you have a medical test or procedure coming up, contact your Care Coordinator to find out if it requires precertification and if your doctor has submitted the request.
- Your Care Coordinator can answer questions about covered healthcare services, explain the copays, deductibles, and/or coinsurance that may apply, and help you avoid unnecessary out-of-pocket costs.

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 varies depending on:

- which medical option you are enrolled in (PPO, EPO, or HDHP)
- whether the drug is on the preventive drug list
- the drug type (generic, formulary, or non-formulary)
- whether you fill your prescription at a retail pharmacy or through the plan's mail service

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 out-of-pocket costs 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 nonpreventive 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 coinsurance (subject to maximum amounts) for covered drugs, as shown in the Key Provisions chart in the Appendix. 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 nonpreventive 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% 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 2025, the PPO has an annual family prescription out-of-pocket maximum of $3,000 for prescription drugs (excluding non-formulary brand names and certain nonessential specialty pharmacy drugs); 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 copays and coinsurance differ. See the Prescription Drug section of the Key Provisions chart in the Appendix for details.
- The PPO and EPO include a copay assistance benefit for certain specialty pharmacy drugs.

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
- 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 nonpreventive 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 select **Price a Medication** from the menu under Prescriptions, or contact Express Scripts at the number on your prescription drug ID card. You can also contact Quantum Health (their number is also on your prescription drug ID card) and a Care Coordinator can help you find and compare drug costs.

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 copay and coinsurance 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, which 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. You can also contact Quantum Health at the number on your prescription drug ID card and a Care Coordinator can answer your questions about formulary drugs.

> **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 copay, deductible (HDHP only), and/or coinsurance. 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 they 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 amount*), except for formulary contraceptives, which are 100% covered with no copay or coinsurance required.
    - not on the formulary, you pay a larger percentage of the cost (up to a maximum amount*), 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 amount*), except for formulary contraceptives, which are 100% covered with no copay or coinsurance 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% of the cost, and that amount does not count toward your total maximum out-of-pocket.

**Except for certain nonessential specialty pharmacy drugs.*

- **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. Your cost when using participating retail pharmacies and the mail service reflects the plan's discounted rate. Once you've paid the deductible, you pay a percentage of the cost (up to a maximum amount). 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% 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 coinsurance 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 and certain nonessential specialty pharmacy drugs do not count toward the prescription out-of-pocket maximum). Once you and/or your covered family members reach the family prescription out-of-pocket maximum, the plan pays 100% 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 covered healthcare-related out-of-pocket expenses, including copays, deductibles, and coinsurance for both medical care and prescription drugs [except for certain nonessential specialty pharmacy drugs (EPO only)].

NICOTINE-FREE LIVING

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

- be age 18 or older
- have a prescription from your doctor, even if the medication is available over the counter (OTC)
- 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 and your prescription from your doctor when you pick up your prescription; no copay, deductible, or coinsurance 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*

HOW TO GET PRESCRIPTIONS FILLED

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

- at your local participating pharmacy (using your prescription drug 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. Simply show your prescription drug ID card at a pharmacy that participates in the 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 your share of the cost (see the Key Provisions chart in the Appendix for the applicable copays, deductible, and/or coinsurance). Claim forms are available at express-scripts.com, or by calling Express Scripts at 800-344-3896. You may also call Quantum Health at 855-497-1237 for assistance.

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 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 payment in the envelope provided with your welcome package. Forms are also available at express-scripts.com. You may also call Quantum Health at 855-497-1237 for assistance.

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

Medications are shipped via standard service at no cost to you. Express shipping is 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 prescription ID card) and email address when registering. Or you may call Express Scripts at 800-344-3896. You may also call Quantum Health at 855-497-1237 for assistance.

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.**
- **Nine in 10 prescriptions dispensed in the United States are for generic drugs.**
- **Generics typically cost 80-85% 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. You may also call Quantum Health at 855-497-1237 for assistance.

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 may also call Quantum Health at 855-497-1237 for assistance.

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. You may also call Quantum Health at 855-497-1237 for assistance.

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 coinsurance minimums and maximums as other prescriptions. Contact Accredo at 800-803-2523 for more information.

SaveOnSP – Specialty Medication Assistance

If you are enrolled in the PPO or EPO, you may be eligible to participate in a copay assistance program designed to save you money on certain specialty drugs. The copay assistance program, administered by SaveOnSP, supports you with enrollment in the drug manufacturer's copay assistance program so you can pay as little as $0 out of pocket. If you do not enroll in the program when eligible, you will be responsible for the usual coinsurance for your drug with no maximum amount, and your coinsurance will not count toward your total maximum out-of-pocket amount. If you're enrolled in the PPO, it also will not count toward your prescription out-of-pocket maximum.

For more information about SaveOnSP, contact Quantum Health at 855-497-1237.

The SaveOnSP program is not available if you are enrolled in the HDHP.

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
- 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 (nondiscounted) 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 view the Drug Formulary and Excluded Drug List for Active and Disabled Members available from the Documents page under Prescription Drug.

If you fill a prescription for a drug that is excluded from coverage, you'll pay the full (nondiscounted) cost of the drug, and that payment will not count toward your total out-of-pocket maximum. If you're enrolled in the PPO, it also will not count toward your prescription 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 Quantum Health at 855-497-1237 and speak with a Care Coordinator.

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 BENEFIT

Routine eye exams can lead to the early detection of serious eye conditions and early signs of other chronic health conditions. Getting a documented vision exam also 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 exams and services to treat pink eye and sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more (coordination with your medical benefits may apply; ask your VSP provider for details), and for retinal screening for those with diabetes.

> **The vision exam benefit is separate from the Vision 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, you can receive discounts on these items when you purchase them through a VSP network provider within 12 months of your last covered VSP WellVision Exam:

- glasses
  - 20% savings on complete pair of prescription glasses and nonprescription glasses, including sunglasses[**]
- contact lens exams
  - 15% savings on contact lens exams (fitting and evaluation; no discount on contact lenses)[**]

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. You can maximize your benefits when using VSP Premier Edge locations, which include private practice doctors and Visionworks retail stores.

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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.*

[**] *Not available at retail chains.*

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

The Employee Assistance Plan (EAP), provided by Spring Health in partnership with Highmark Blue Cross Blue Shield, is included with medical coverage through the Board of Pensions.

The EAP provides easy access to high-quality mental health care and support for all of life's challenges, from personal crises to health issues to work-related problems.

All care with Spring Health is private and confidential.

Personalized care

Spring Health's digital self-assessment screens for different mental health conditions and helps guide you to appropriate care. Complete the self-assessment to get a personalized care plan matched to your needs.

Treatment recommendations provided with your personalized care plan may include on-demand wellness exercises, coaching, and/or clinical therapy and medication management. Along with personalized recommendations for treatment, you'll receive the names of Spring Health providers that match your criteria.

No-cost clinical therapy sessions

As part of your EAP benefits, you and your covered family members ages 6 and older can receive up to six clinical therapy sessions per year from a Spring Health provider at no cost to you. This includes both in-person and virtual visits.

When looking for a therapist, Spring Health's search tool allows you to filter by specialty (including faith-based), ethnicity, language, gender, and session type (virtual or in person).

- Appointments are typically available within three days or less.
- All Spring Health providers are in-network for the Medical Plan, providing you with seamless care on your mental well-being journey when you need it.
- Regular plan copays, deductibles, and/or coinsurance apply after the sixth visit.

Mental health care navigation

Spring Health's licensed care navigators are available to assist during a crisis, help you find a provider, and provide additional support when you need it. Mental health care navigators are available to:

- assist during a crisis
- advocate for your immediate needs
- discuss your long-term goals
- provide emotional support
- book appointments for you

Unlimited coaching

You can access unlimited virtual coaching sessions with certified coaches who can help you build better habits, navigate life transitions, improve communication skills, and set and achieve your goals.

Coaching programs can help with a wide range of topics:

- personal development, including life transitions, identity support, career growth, self-development, and work-life balance
- health and wellness, including nutrition, physical activity, stress management and resiliency, sleep habits, and self-care
- parenting, including behavioral concerns, neurodiverse advocacy and education, academic readiness and stress, and supporting children in therapy

Mental health exercises

Spring Health offers a digital library of on-demand mental wellness exercises called Moments, so you can develop long-term skills or get immediate relief anytime, anywhere.

The Moments library offers quick tips and exercises on a variety of subjects related to your mental well-being, like anxiety, depression, burnout, sleep, relationships, substance use, and mindfulness.

Guidance for work/life needs

Spring Health works with you to understand your personal needs and provides guidance and support in the following areas, to name a few:

- legal or financial matters
- adoption
- child care and elder care,
- pet sitters/kennels, pet obedience training
- home repair, chore services/house cleaning
- transportation and travel services
- education programs, schools for exceptional children
- moving/relocation services

Connect with Spring Health

- You can go to **care.springhealth.com/sign_in** to create and activate your Spring Health account by clicking the **CREATE MY ACCOUNT** button or download the Spring Health Mobile app and tap **Sign up**.
- You can call Spring Health at 844-931-4465.
    - General support/live chat: Monday-Friday, 8 a.m.-11 p.m. ET
    - Crisis support: 24/7 (press 2)

CRISIS SUPPORT

If you feel like you need to speak with a licensed professional right away and cannot wait to book an appointment, Spring Health offers crisis support. You don't need to register or log in to your Spring Health account to call for crisis support. Just call 844-931-4465 (option 2) for 24/7 support.

HEALTH AND WHOLENESS: CALL TO HEALTH

Call to Health is a well-being initiative that runs from December to November of the following year 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 activities presented on calltohealth.org.

- **Level 1**: To answer the call, you complete two required activities — taking the Well-Being Assessment and having a preventive exam — plus other activities you select to earn points. Employees who complete the required activities along with other optional activities 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 Select, Fitbit, Whole Foods, 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 activities) receive a $100 Tango card.

For more details, visit pensions.org/calltohealth. Then, log on to calltohealth.org to complete activities and answer the call. New activities are introduced throughout the year, so log on often to keep your momentum going.

> **NEW TO CALL TO HEALTH?**
> **Employees who register for the first time at calltohealth.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 activity 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.

To take the Well-Being Assessment, log on to calltohealth.org and click **Take Your Assessment** on the Discover page. After you've completed your assessment, you'll see a section **Based on your Well-Being Assessment** on the Discover page with recommended activities for you. For example, you may see recommended activities to help with managing stress and anxiety, financial well-being, or self-care, depending on your results.

WORKING WITH A PERSONAL CARE GUIDE NURSE

Your medical benefits include access to Personal Care Guide nurses through Quantum Health. Working with a Personal Care Guide nurse helps you when you:

- have questions about a diagnosis or a care plan your provider gave you
- have frequent or prolonged hospital admissions

- are managing a chronic condition and require ongoing healthcare services in your home
- need ongoing care in outpatient settings

Your Personal Care Guide nurse helps you get the best available treatment when underlying health conditions are complex or challenging.

They can assist you by:

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

Quantum Health uses a primary nurse model to provide support and address clinical needs for chronic conditions as well as acute conditions. If you choose to participate, you (or your covered family member) will be assigned a Personal Care Guide nurse who will consult with you, your family (if requested), your attending physician, and other members of your treatment team to assist in facilitating and implementing proactive care plans to provide the most appropriate healthcare in a timely, efficient, and cost-effective manner. The Personal Care Guide nurse will assist with benefits, incidental healthcare issues, becoming healthier, finding resources, or an unexpected healthcare journey.

During outreach, the Personal Care Guide nurse will focus on the patient's physical and emotional needs and perform certain assessments which may lead to subsequent referrals to additional resources such as the Employee Assistance Plan (EAP). They will also look at psychosocial needs and social determinants of health as well as evaluate any financial issues or cultural barriers that may exist. Conversations with the Personal Care Guide nurse occur at least monthly, if not more frequently, and continue until the patient's health goals and needs are met.

LIVONGO FOR DIABETES PROGRAM

Your medical benefits include the Livongo for Diabetes Program. This program combines the latest technology with coaching to help individuals living 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. You may also call Quantum Health at 855-497-1237 for assistance.

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 show no symptoms of TB, parasites, hepatitis B, lead poisoning, or growth failure from a dysfunctional thyroid, they may have any or all 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 Blue Cross Blue Shield national network; your prescription drug ID card, available digitally from the Express Scripts website or Express Scripts mobile app, shows that your coverage includes prescription drug benefits administered by Express Scripts. Have both cards available for emergency and routine use. You do not need special ID cards to access your EAP benefits or vision exam benefits with VSP.

You may request additional or replacement cards at any time by contacting Quantum Health. Be sure to shred the old cards whenever you receive new ID cards.

You can also print medical ID cards from the Quantum Health website or display a virtual ID card on your smartphone using their mobile app.

Print a medical ID card

- Log on to myqhealthpcusa.org.
- On the homepage, click **View ID Card**.
- Click **Print**.

View a virtual medical ID card

- Log in to the Quantum Health mobile app (available free from both the Apple and Google Play app stores).
- From the homepage, tap ID Card.
- An image of your medical ID card will appear.

Print a prescription ID card

- Log on to express-scripts.com (or use the single-sign-on link from myqhealthpcusa.org).
- From the homepage, select **Prescription ID Card** from the menu under Account.
- Click the **Get ID Card** button.

View a virtual prescription ID card

- Log in to the Express Scripts mobile app (available free from both the Apple and Google Play app stores).
- Tap the **More** icon.
- Tap **Prescription ID Card**.
- An image of your prescription drug ID card will appear.

NEED HELP?
If you need help obtaining a medical ID card, call your Quantum Health Care Coordinators at 855-497-1237. Once you're registered, your Care Coordinators will also be available by chat or secure message.

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 nonurgent 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. You or your doctor's office must call for precertification by the next business day after an inpatient emergency admission. See Precertification Requirements for more information.

To precertify a nonurgent hospital admission, procedure, test, or facility-based behavioral health treatment, you or your doctor's office should immediately call to precertify the admission, procedure, test, or facility-based treatment, 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 from the homepage click the **Quick Actions** button on the **MY BENEFITS** tile under **MY TOOLS** to report your event, make changes to your coverage, and provide any required supporting documentation.

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. After you pay the deductible network coinsurance requirements apply (i.e., you pay 20% of the plan allowance) until you reach the total maximum out-of-pocket amount. Providers may not bill you for the balance of charges.
	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. Providers may bill you for the balance of charges over the allowance established by the plan.
	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. [1]
	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 2025 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.

NEED HELP?
Quantum Health's Care Coordinators can explain the copays, deductibles, and/or coinsurance that may apply for a particular medical test or procedure. Call Quantum Health at 855-497-1237 to speak with a Care Coordinator.

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.

For scheduled surgeries, it is important to confirm that the facility where the procedure will be performed is a network facility, even when the surgeon is a network provider, so charges will be paid on a network basis.

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, review the online claims summaries or explanation of benefits (EOB) statements available on myqhealthpcusa.org 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.

**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 find local network providers for your child by logging on to myqhealthpcusa.org or by calling Quantum Health at the number on the back of your medical ID card. To find local network pharmacies, log on to express-scripts.com or call Express Scripts at the number on the back of your prescription ID card. You may also call Quantum Health and a Care Coordinator will assist you with locating participating Express Scripts pharmacies.

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 on your medical ID card to contact Quantum Health 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.

Global Care (Telemedicine)

Global Care, accessed through the Teladoc mobile app, allows you to talk to a U.S. licensed physician for non-emergency conditions, such as sore throats, rashes, and sinus infections, 24/7 from anywhere in the world. You can receive a diagnosis and recommended treatment advice as well as medication recommendations you can take to local pharmacies for further assistance.

To download the free app, open the Apple App Store or Google Play Store and search for Teladoc. To request a consult, log on, request a general medical visit, and indicate your current location.

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
- 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, you can submit a claim for reimbursement. Claims may be submitted online through the BCBS Global website or through the Blue Cross Blue Shield Global Core mobile app available from both the Apple App Store and Google Play Store. If you prefer to submit your claim by mail, you can download a claim form from the BCBS Global website and mail the completed form along with copies of your bill(s) to the address on the form.

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/medical 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 for on-the-go access to expert advice and support through the ISOS assistance center. You can also use the app to receive alerts and risk updates specific to your location. To download the app, open the Apple App Store or Google Play Store and search for International SOS Assistance App.

CONTINUING COVERAGE AFTER ELIGIBILITY ENDS

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. It is also suggested that you review options through the federal Health Insurance Marketplace or a state's health insurance exchange, which may better fit your needs or be more affordable.

To enroll in medical continuation coverage, you must return to the Board the completed personal information, enrollment, and authorization sections of the Medical Continuation Enrollment 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.

> **For more information about medical continuation coverage, visit pensions.org/medical or call the Board at 800-PRESPLAN (800-773-7752) (TTY: 711).**

SITUATIONS THAT MAY RESULT IN LOSS OF ELIGIBILITY

Employment termination

Any medical coverage (except coverage provided under the Congregational Pastors Package or Transitional Pastor's Participation) will end *on the last day of the month* of your last day worked. For example, if your last day worked were October 12, your benefits would end October 31. 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 the Congregational Pastors Package or Transitional Pastor's Participation
When your employment ends, you are eligible for one month of medical coverage at no cost to you. The no-cost coverage period begins on the first day of the month after your last day worked.

> **Ministers in the Congregational Pastors Package or Transitional 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 Ministers Bridge Coverage.)**

Death of member

If, as an active member, you are enrolled in the Death and Disability Plan, your surviving eligible family members who were enrolled for medical coverage on the date of your death 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, they 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.

MINISTERS BRIDGE COVERAGE

If you are a member in the Congregational Pastors Package or Transitional 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 Ministers Bridge Coverage are eligible to continue healthcare benefits under medical continuation for an additional 18 months. For more information, visit pensions.org/medical or call the Board of Pensions at 800-PRESPLAN (800-773-7752) (TTY: 711).

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.

> **Effective Jan. 1, 2025, an eligible employee who is also the spouse or child of a covered member may not enroll in concurrent coverage in the Medical Plan.**

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.

If a plan does not have a coordination of benefits provision, that plan will pay first.

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

> **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.**

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 above).
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

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, they are eligible for Medicare coverage, including Part A hospitalization coverage. You are not eligible to enroll in the Humana Group Medicare Advantage PPO plan because it is a retiree-only plan.

If you continue to work, you may waive coverage* but it is important to compare Medical Plan coverage with that of a Medicare Advantage or Medigap plan. The aggregate premium costs may be less, but depending on the plan selected, the coverage may not be as comprehensive as the Medical Plan's.

*Note:

- If you waive coverage under the Medical Plan, your family members lose Medical Plan eligibility.
- If you are enrolled in the Congregational Pastors Package or Transitional Pastor's Participation, you may not waive medical coverage for yourself.

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 after you are eligible for Medicare, you may be eligible for the Humana Group Medicare Advantage PPO plan. Please contact the Board to discuss this option. Regardless of whether you want to enroll, you must promptly enroll in Medicare 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 myqhealthpcusa.org 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.

- Appeals related to a medical benefit that is reduced or denied should be submitted to Quantum Health.
- Appeals related to a behavioral health benefit that is reduced or denied may be submitted directly to Highmark Blue Cross Blue Shield.
- Appeals related to a prescription drug benefit that is reduced or denied may be submitted directly to Express Scripts.

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 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 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.

**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.*

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-PRESPLAN (800-773-7752) (TTY: 711).

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-PRESPLAN (800-773-7752) (TTY: 711).

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-PRESPLAN (800-773-7752) (TTY: 711) Outside the U.S.: 215-587-7200 8:30 a.m.-6 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	Quantum Health	855-497-1237 (TTY: 711) 8:30 a.m.-10 p.m. ET, Monday through Friday	myqhealthpcusa.org
Employee Assistance Plan (EAP)	Spring Health	844-931-4465 8 a.m.-11 p.m. ET Monday through Friday, 24/7 crisis support (press 2)	care.springhealth.com/sign_in
Prescription drugs (retail and mail order)	Express Scripts	800-344-3896 Available 24/7	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**
Behavioral health (mental health and/or substance use disorders)	Spring Health	844-931-4465 24/7 crisis support (press 2)	care.springhealth.com/sign_in
Inpatient emergency hospital admission* for medical/surgical	Quantum Health	855-497-1237 (TTY: 711) 8:30 a.m.-10 p.m. ET, Monday through Friday	myqhealthpcusa.org
Inpatient emergency hospital admission* for behavioral health	Highmark Blue Cross Blue Shield	800-258-9808 8 a.m.-10 p.m. ET, Monday through Friday	

**Call within 48 hours.*

Precertification

TYPE	PROVIDER	PHONE	WEBSITE
Medical/surgical inpatient hospital admission health/substance use disorder facility-based admission	Quantum Health	855-497-1237 (TTY: 711) 8:30 a.m.-10 p.m. ET, Monday through Friday	myqhealthpcusa.org
Behavioral health facility-based admission	Highmark Blue Cross Blue Shield	800-258-9808 8 a.m.-10 p.m. ET, Monday through Friday	

Claims information

TYPE	PROVIDER	PHONE	WEBSITE
Medical, surgical, and behavioral	Quantum Health	See above.	See above.

Other

TYPE	PROVIDER	PHONE	WEBSITE
Telemedicine	Teladoc	800-835-2362 Available 24/7	teladoc.com/enter
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, fitting, and repair) 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 attempts/life maximum)	Member pays 20% after deductible		Member pays 20% after deductible	
ABA therapy	Member pays 20% after deductible		Member pays 20% after deductible	
Facility charges for select surgeries	Member pays 0% after deductible for allowable facility charges when these select surgeries are performed in a BCBS Blue Distinction Center: bariatric surgery, knee replacement surgery, hip replacement surgery, spinal surgery, and transplants. 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		

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
Nonpreventive 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
Specialty drugs	Same as above for formulary and non-formulary brands; no max applies for certain nonessential specialty pharmacy drugs		Same as above for formulary brands; no max applies for certain nonessential specialty pharmacy drugs	Same as above for formulary brands
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 and certain nonessential specialty pharmacy 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 [certain nonessential specialty pharmacy drugs (PPO and EPO) and non-formulary brand drugs excluded].

KEY PROVISIONS: VISION EXAM BENEFIT

Your costs		
Type of visit	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	Up to $50 per day[1] for the covered patient, or up to $100 per day[1] for the covered patient and one companion, to a máximum benefit of $10,000 as follows: • Travel and lodging for covered transplants if the surgery occurs 100 or more miles from the patient's home. • Travel and lodging for covered services at a Center of Excellence if the treatment occurs 100 or more miles from the patient's home. If the covered patient is a minor child, expenses for two companions may be covered up to $100 per day.
$500	Lifetime maximum for temporomandibular joint dysfunction (TMD) treatment
$2,500 every 3 years	Hearing aid (device, fitting, and repair)
3 attempts	Lifetime maximum for medically necessary use of advanced reproductive technology[2]
100 visits	Annual maximum visits, of up to 8 hours each, for home healthcare
180 days	Annual maximum for extended-care facilities

[1] Per IRS guidelines.

[2] 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.

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
  - written information in other formats (large print, audio, accessible electronic formats, other formats)
- free language services to people whose primary language is not English, such as:
  - qualified interpreters
  - 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-PRESPLAN (800-773-7752) (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-PRESPLAN (800-773-7752) (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-PRESPLAN (800-773-7752) (TTY: 711)

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 or Quantum Health 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 Plans – Request for Access to PHI, HPA-003	Allows a covered individual or personal representative access to their protected health information maintained by the Medical Plan
Benefits Plan of the Presbyterian Church (U.S.A.) Medical Plans – 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 Plans – 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.)

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