Medical Plan (EPO)

The exclusive provider organization (EPO) provides quality coverage and includes features that promote wholeness and well-being.

HOW IT WORKS

When you need care, simply show your medical ID card at your healthcare provider or hospital admissions office. In some cases, you must get advance approval for the care. This is known as precertification. Visit pensions.org/members for a list of services that require precertification.

COVERAGE FEATURES

In addition to hospital and medical/surgical benefits, coverage automatically includes all these features at no additional cost to you. Visit pensions.org/members for details.

- preventive care benefits
- behavioral health benefits
- prescription drug coverage
- telemedicine benefits through Teladoc
- Centers of Excellence
- vision exam benefit
- Livongo for Diabetes Program
- international medical care benefits
- Employee Assistance Program (EAP)
- Call to Health

YOU MUST USE NETWORK PROVIDERS

Under the EPO option, you must use providers in the national Blue Cross Blue Shield network. 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 network provider, you are responsible for all costs.

To find network providers, visit highmarkbcbs.com and select **Find a Doctor or Rx**, then click **Find a Doctor, Hospital** or **other Medical Provider.** Under Pick a plan, select **BCBS PPO**).

The prescription drug program is administered separately; for details, visit pensions.org/members.

DEDUCTIBLES, COPAYS, COINSURANCE, AND OUT-OF-POCKET MAXIMUM

To better understand the coverage provided under the EPO, it's important to know these terms.

Deductible: A specified annual dollar amount you must pay for covered medical services before the plan begins to pay benefits.

- EPO deductibles are flat amounts ($2,000 for you and $2,000 for your covered family members).
- If you enroll any family members, you are responsible for two medical deductibles, one for yourself and one for all your family members combined.

The EPO covers care received from network providers; out-of-network care is not covered.

- You can reduce your deductibles by completing Call to Health, a well-being initiative that focuses on the four dimensions of wholeness: spiritual, health, financial, and vocational.

Copay: A flat dollar amount that you pay upfront for certain services when using network providers.

- Except for preventive care, you pay a copay for each network office visit: $40 for primary and behavioral health care visits, $60 for visits to a specialist or when seeking care at an urgent care center, and $10 when using the telemedicine benefit.
- There are different copay requirements for certain other covered services, such as X-rays and laboratory tests, as shown on the Key Provisions EPO chart.

Medical Plan (EPO)

- Copays do not count toward the plan deductible.
- There is a $25 copay for the vision exam benefit.
- There are separate copay amounts for prescription drugs. See the Key Provisions chart on pensions.org for details.

Coinsurance (previously referred to as *copayment*): The percentage of the cost for covered services that you pay *after* you pay the deductible:

- Your coinsurance for network services is 20 percent.
- The EPO does not cover out-of-network care or non-formulary prescription drugs.

Total maximum out-of-pocket: The most you will pay in a year in the form of deductibles, copays, and coinsurance. If your covered out-of-pocket expenses reach the total maximum out-of-pocket amount, the plan will pay 100 percent of allowable costs for the rest of the year.

- Expenses that count toward the EPO total maximum out-of-pocket include your deductibles, office visit copays, coinsurance, and prescription drug copays.
- The 2021 EPO total maximum out-of-pocket amounts are $5,000* for an individual and $10,000* for a family.

*decreased from $7,900 (individual) and $15,800 (family) in 2020

LEARN MORE

For more information about medical coverage, visit pensions.org/members or log in to highmarkbcbs.com. If you have questions, call Highmark Blue Cross Blue Shield at 888-835-2959 or the Board at 800-773-7752 (800-PRESPLAN).

Comprehensive

Coverage includes generous preventive care benefits, prescription drug benefits, medical, surgical, and behavioral healthcare, and more.

Network provider choice

Use any network healthcare provider for medically necessary care and treatment.

Easy to use

Receive services from any network provider without a referral from your primary doctor.

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