

# *Evangelical Presbyterian Church*



## *Employee Benefit Plans*

*Material in this booklet is located on the EPC  
website at the following address  
<http://www.epc.org/benefits>*

*Effective January 1, 2012*

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## INTRODUCTION

This document is a description of the Evangelical Presbyterian Church, (EPC), Employee Benefits Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and includes the following parts:

**Privacy Standards.** Explains handling of Protected Health Information.

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Plan Exclusions.** Shows what charges are not covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**Appendices.** Describes reimbursement formulas as well as payment limits on certain services.

## I. PRIVACY STANDARDS

The Evangelical Presbyterian Church ("Employer") sponsors a group health plan known as the Evangelical Presbyterian Church Employee Benefits Plan (the "Plan") for the benefit of its eligible employees and their dependents.

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the Plan is amended, effective January 1, 2003, as follows:

**A. GENERAL**

The Plan shall not disclose Protected Health Information to any member of Employer's workforce unless each of the conditions set out in this Amendment are met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

**B. PERMITTED USES AND DISCLOSURES**

Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms, "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage provisions of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment, evaluation, training or accreditation of health care providers, underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop loss insurance, medical review, legal services or auditing functions or business planning, management and general administrative activities.

**C. AUTHORIZED EMPLOYEES**

The Plan shall disclose Protected Health Information only to the Stated Clerk, the Director of Benefits and/or Benefits Administrator, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. For purposes of this Plan, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

1. Updates Required. The Employer shall amend this section promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
2. Use and Disclosure Restricted. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
3. Resolution of issues of noncompliance. In the event that any member of the Employer's workforce uses or disclosed Protected Health Information other than as permitted by this document and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:
  - a) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately, whether there is a pattern of breaches and the degree of harm caused by the breach;
  - b) Appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training or termination of employment;
  - c) Mitigation of any harm caused by the breach, to the extent practicable; and
  - d) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

**D. CERTIFICATION OF EMPLOYER**

The Employer must provide certification to the Plan that it agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law.
2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information.
3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.
4. Report to the Plan any use or disclosure of the Protected Health Information of which is becomes aware that is inconsistent with the uses or disclosures permitted by this Plan or required by law.
5. Make available Protected Health Information to individual Plan members in accordance with 164.524 of the Privacy Standards.
6. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with 164.526 of the Privacy Standards.
7. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with 164.528 of the Privacy Standards.
8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards.
9. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by 164.504(f)(2)(iii) of the Privacy Standards and set out in Section 1.3 hereof.

## **II. PARTICIPATORY REQUIREMENTS**

Non-ordained eligible employees of EPC churches shall be expected to participate in the denominational medical benefits Plan on a contributory basis, with the exception of employees whose spouses carry certifiable medical coverage which covers all eligible dependents, and employees offered group insurance coverage as a part of retirement benefits from a previous employer.

All ministers on the rolls of the presbytery are required to be enrolled in the EPC Medical Benefits Plan. However, this mandatory participation requirement will not apply to the following:

1. Missionaries laboring in cooperative agreements with mission agencies.
2. Ministers laboring in institutional agencies providing their own group insurance plan.
3. Ministers afforded group insurance coverage as part of retirement benefits from a previous employer.
4. Ministers without call and Ministers laboring less than 20 hours per week in a place of ministry.
5. Ministers with a spouse who has group health insurance through their employer and whose Presbytery Ministerial Relations Committee approves the coverage through the spouse is acceptable.

## **III. ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS**

### **A. ELIGIBILITY**

#### **Participating Employers**

Eligible Employers may elect to participate in the EPC Medical Plan. Eligible Employers include the Evangelical Presbyterian Church, its presbyteries and member churches with Eligible Classes of Employees. Employers become eligible on the date when they are constituted, particularized or otherwise become subject to the government of the Evangelical Presbyterian Church.

To become a Participating Employer, an employer must elect to participate in and be subject to the provisions of the EPC Medical Plan. Such election must be made within 31 days of when the employer first becomes an Eligible Employer.

A Participating Employer which withdraws its ministers and/or non-ordained employees as Plan Participants shall cease to be a Participating Employer.

### **Eligible Classes of Employees**

1. Full-time employees of Participating Employers in the United States who regularly work 30 or more hours per week.
2. An ordained or non-ordained employee who is a missionary in cross-cultural placement and under the oversight of the Committee on World Outreach.
3. An ordained or non-ordained employee who is a Home Missionary in the United States and under the oversight of the Committee on National Outreach.
4. A minister who is an active member of an Evangelical Presbyterian Presbytery in the United States, or in process.
5. Candidates in the United States who are under care of an Evangelical Presbyterian Church Presbytery for ministry as defined in the Book of Order of the Evangelical Presbyterian Church.

### **Eligibility Requirements for Employee Coverage**

A person is eligible for Employee coverage from the first day of the month on or after the date that he or she:

1. Begins active work, and
2. Completes the employment Waiting Period of the date of employment to the first day of the following month. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-existing conditions exclusion time. And
3. Is in a class eligible for coverage.

### **Eligible Classes of Dependents**

Dependent is any one of the following persons:

1. A covered Employee's Spouse and dependent children.
2. A covered Employee's Spouse and dependent children, who were eligible to join the Plan but are not Plan Participants because they could not give evidence of good health to the Plan when such evidence was required, but are otherwise still eligible through dependency status as defined by this Plan. Effective 1/1/2011, there is a prohibition on pre-existing condition exclusions for children under the age of 19.

The term "Spouse" shall mean the spouse under a legally valid marriage between persons of the opposite sex in their state of residence. "Spouse" does not include any person who is a domestic partner. The Plan Administrator may require documentation.

The term "dependent" shall include natural children, adopted children, children placed with a covered Employee in anticipation of adoption, and stepchildren. If a covered Employee is the Legal Guardian of child or children, these children may be enrolled in this Plan as covered Dependents. Eligibility no longer depends upon financial dependency, residency, student or marital status. Coverage for the dependent may continue until 12:01 a.m. of the dependent's 26<sup>th</sup> birthday. Coverage will not be extended to a child of an adult child receiving coverage. Neither will coverage be extended to the spouse of an adult child.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for

total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan with no Pre-Existing Conditions provisions applied.

3. A covered Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical handicap. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both.

### **Eligibility Requirements for Dependent Coverage**

A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

### **Eligibility to transfer among the Basic Coverage Plan, the Premium Coverage Plan, and the High Deductible Health Plan**

An Employee already enrolled in the Basic or Premium Coverage Plans, or the High Deductible Health Plan may not move or be moved between coverage plans except on January 1, provided the Plan Administrator is notified consistent with timing parameters specified in the "Change Plan" window announcement document.

### **Retiree Medical Benefits**

Employees will be eligible to continue their Medical Benefit Plan coverage if they retire from the EPC and they:

1. Are at least age 59 ½,
2. Have served at least five years in an EPC presbytery approved ministry (including service in another denomination immediately prior to being accepted by an EPC Presbytery), and
3. Make the required monthly premium contributions.

### **Coverage for Disabled Employees**

If an Employee is determined to be totally disabled, they may continue the medical coverage for themselves and their eligible dependents by making the required monthly premium contributions.

To be considered totally disabled, the disability must prevent the Employee from performing all of the normal duties of their regular occupation for any employer, and must at no time engage in any occupation or employment for pay or profit.

### **Extended Medical Benefits**

If an Employee or any of their enrolled dependents are hospitalized at the time their coverage ends, benefits will be paid for eligible expenses incurred in connection with that one confinement. However, no benefits will be paid after the earliest of:

1. The date maximum benefits are paid under this Plan,
2. The date which is twelve months from the date coverage ends, or
3. The date the Employee or dependent is released from the hospital.

### **Coverage for Dependents of Deceased, Disabled or Retired Employees**

In the event of an Employee's retirement, death or disability as defined in the EPC Medical Benefits Plan, their enrolled dependents may continue medical coverage by paying the required contributions. Coverage can be continued while this Plan remains in force but not beyond:

1. The death of the surviving widow or widower, or
2. The date the last surviving eligible child ceases to be an eligible dependent.

### **Medicare Coverage**

Benefits payable under this Plan are based on the assumption that benefits for Medicare-covered services will be provided to Plan Participants who are eligible for benefits under Part A of Medicare, Part B of Medicare or both as applicable. Employees or their spouses may become eligible for Medicare benefits upon reaching age 65 or in the event of disability or end-stage renal disease.

Prior to your 65<sup>th</sup> birthday, you will receive a letter and plan information regarding Medicare eligibility specific to your circumstances. A Plan Participant who is eligible for Medicare must complete any document and take any action necessary to enroll in Part A. Your personalized letter will describe options relative to enrollment in Part B. Consistent with federal law, an employee who is yet employed and his or her Family Unit who are entitled to Medicare Part A and or Part B Benefits may elect to have the EPC Plan as their primary health coverage if they are employed at a church with 20 or more employees.

Individuals eligible for Medicare as their primary coverage are not eligible to participate in the High Deductible Health Plan.

Regarding Medicare Part D, prescription drug coverage, The Board of Benefits of The Evangelical Presbyterian Church has deemed that the prescription drug coverage offered by the Benefits Plan is better for the majority of Plan participants and, on average for all Plan participants, is expected to pay out more than the standard Medicare Part D prescription drug plan. Plan Participants eligible for Medicare should obtain and consider "Important Notice from the Evangelical Presbyterian Church about Your Prescription Drug Coverage and Medicare Part D" before making a decision about which prescription drug plan is best in their personal circumstances.

### **Medical Coverage Available After Termination or Loss of Eligibility as a Dependent**

An Employee or Dependent may elect to extend their medical coverage for up to one (1) year following the month they terminate their employment or lose eligibility as a dependent. The cost is their normal premium plus an additional 2% to cover the cost of administration. Prepayment of premiums may be required.

### **B. FUNDING: COST OF THE PLAN**

Funding for benefits, up to the amount specified in excess insurance coverage, is derived solely from the funds of the Employer. Premium for each month of coverage is due on or before the 15<sup>th</sup> of that month.

The level of Employee contributions, if any, is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

### **C. ENROLLMENT**

An employee will be covered on the date they become eligible provided they have completed a full day of active work on that date, or a full day of active work on their last scheduled work day and are able to work on the date they became eligible. If they do not meet this Active at Work requirement, coverage for the Employee and their dependents begins on the day they return to active work. However, if an enrolled dependent (other than a newborn child) is hospitalized when coverage would otherwise begin, his or her coverage does not take effect until the day following the date of discharge.

#### **Enrollment Requirements**

An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage also. If the covered Employee already has Dependent coverage, a newborn child will be automatically enrolled from birth; otherwise, separate enrollment for a newborn child is required.

#### **Enrollment Requirements for Newborn Children**

A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for 31 days. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, if the newborn child is required to be enrolled, he or she must be enrolled as a Dependent under this Plan within 31 days of the child's birth in order for non-routine coverage to take effect from the birth.

### **D. TIMELY ENROLLMENT**

#### **Timely Enrollment**

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

Employees and their Dependents who are not on this Plan because they could not present evidence of good health to the Plan before the Health Insurance Portability and Accountability Act (HIPAA) was effective, but are otherwise eligible for coverage under the terms of this Plan, will be treated by this Plan as Timely Enrollees during the first 31 days after this Plan is subject to HIPAA.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

### **E. SPECIAL ENROLLMENT PERIODS**

Group health plans are required to permit certain employees and dependents special enrollment rights. These rights are provided both to employees who were eligible but declined enrollment in the plan when first offered because they were covered under another plan and to individuals upon the marriage, birth, adoption or placement for adoption of a new dependent. The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special

enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

**1. Individuals losing other coverage: An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if all of the following conditions are met:**

- a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
- c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.
- d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

**NOTE:** If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual shall not have a Special Enrollment right.

**2. Dependent beneficiaries**

If:

- a) The Employee is a participant under this Plan, and
- b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period must be a period of not less than 31 days and must begin on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- a) In the case of marriage, not later than the first day of the first month beginning after the date of the completed request for enrollment is received;
- b) In the case of a Dependent's birth, as of the date of birth; or
- c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

**F. EFFECTIVE DATE**

**Effective Date of Employee Coverage**

An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

1. The Eligibility Requirement.
2. The Active Employee Requirement.
3. The Enrollment Requirements of the Plan.

**Active Employee Requirement**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

## **Effective Date of Dependent Coverage**

A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

## **G. TERMINATION OF COVERAGE**

### **When Employee Coverage Terminates**

Employee coverage will terminate on the earliest of these dates:

1. The date the Plan is terminated.
2. The date the covered Employee's Eligible Class is eliminated.
3. The day the covered Employee ceases to be in one of the Eligible Classes.
4. The end of the month during which the Employee or their enrolled dependents cease to meet the eligibility requirements for this coverage.
5. The end of the period for which the Employee made their last contribution, if required.
6. The end of the month during which the Employee ceases active employment with the EPC except as provided under **Coverage for Disabled Employees and Extended Medical Benefits**.
7. With respect to dependents, the date the Employee's coverage ceases, except as provided under **Coverage for Dependents of Deceased Employees**.
8. The effective date of termination as contained in the notification of cancellation of coverage for lack of premium payment.

### **Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff**

A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

1. **For disability leave only**
  - The date the Employer ends the continuance.
2. **For leave of absence or layoff only**
  - The date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

### **Continuation During Family and Medical Leave**

Regardless of the established leave policies mentioned above, this Plan complies with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

If you take a leave of absence for your own serious health condition or to care for a family member with a serious health condition or to care for newborn or adopted child, you may be able to continue your health coverage under the Plan. At the end of the medical or family leave, you may also be eligible to have your previous health coverage reinstated on the date you return to work, assuming you pay any required contributions.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

## **Employees on Military Leave**

This Plan complies with the Uniformed Services Employment and Reemployment Rights Act. Employees going into or returning from military service will have plan rights mandated by that act. These rights include up to 18 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no Pre-Existing Conditions exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Plan exclusions and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

## **When Dependent Coverage Terminates**

A Dependent's coverage will terminate on the earliest of these dates:

1. The date the Plan or Dependent coverage under the Plan is terminated.
2. The date that the Employee's coverage under the Plan terminates for any reason except death, retirement or disability.
3. The death of the surviving widow or widower.
4. On the first date that he or she ceases to be a Dependent as defined by the Plan.
5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

## **IV. SCHEDULE OF BENEFITS**

### **Verification of Eligibility**

Call the **Claims Supervisor** to verify eligibility for Plan benefits before the charge is incurred. Hospital admissions require pre-certification. See the section **GENERAL PLAN INFORMATION** for the number to call.

### **Precertification**

Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the appropriate precertification service provider, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

Precertification is set in motion by a telephone call from the Covered Person **at least one week before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The diagnosis and/or type of surgery
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the appropriate precertification service provider listed under **GENERAL PLAN INFORMATION within 48 hours** of the first business day after the admission.

This service provider will determine the number of days of Medical Care Facility confinement authorized for payment. If the attending Physician feels that it is medically necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time that has been pre-certified, the attending Physician must request the additional services or days.

**If these pre-certification requirements are not satisfied, the Plan benefits otherwise available to the Covered Person will be reduced by the amount specified in the Plan Benefit Schedule, in Appendices 1, 2 or 3**

### **Medical Benefits**

All benefits described in this schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Reasonable and Customary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

### **Network Provider Plan**

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers or Preferred Provider Organizations (PPO). Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-network Provider is used. It is the Covered Person's choice as to which Provider to use.

All eligible claims filed by Foreign Based Missionaries who are enrolled in the Premium or Basic Coverage Plans while outside the United States of America are deemed to be in Network. This exception does not apply to the High Deductible Health Plan.

Additional information about this option, as well as a list of Network Providers will be given to covered Employees and updated as needed.

### **Deductibles/Co-payments payable by Plan Participants**

Deductibles/Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required.

A co-payment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments.

## **V. MEDICAL BENEFITS**

Medical Benefits apply when covered charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

### **A. DEDUCTIBLE**

#### **Deductible Amount**

This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Appendices.

#### **Deductible Three-Month Carryover**

For the Premium Coverage and Basic Coverage Plans, covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year. This does not apply to the High Deductible Health Plan.

### **Family Unit Limit**

When the dollar amount shown in the Appendices has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

### **Benefit Payment**

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible and any co-payments. Payment will be made at the rate shown under Percentage Payable in the Appendices. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan. All monies will automatically be paid to the provider of eligible medical services and NOT to the employee.

If medical benefits are paid on behalf of a person and it is later determined that the person was not eligible for these benefits, that person shall immediately reimburse the Plan for such payments.

### **Out-of-Pocket Limit**

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Appendices is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year. Excluded charges include:

1. Charges paid by the Plan.
2. Charges that exceed the Reasonable and Customary fee.
3. Charges for services and supplies not covered under the Plan.
4. Charges denied by the Claims Administrator in accordance with Plan provisions.
5. Charges assessed by the Claims Administrator for failure to comply with rules for specified outpatient surgical procedures (see **Surgical Expense Benefit**).
6. Charges for services and supplies that exceed calendar year or lifetime maximums under the Plan.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

### **Maximum Benefit Amount**

The Maximum Benefit Amount is shown in the Appendices. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person.

## **B. COVERED CHARGES**

Covered charges are the Reasonable and Customary charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

### **1. Hospital Expense Benefit**

The Claims Supervisor will pay the benefits described in (1) and (2) below for the charges described therein which are made to an employee or dependent in connection with a hospital confinement:

- a) Which result directly from a non-occupational illness or non-occupational injury of the employee or dependent, as the case may be.
- b) Which commence while such employee and dependent is covered under this Plan.

Upon receipt of satisfactory proof by the Claims Supervisor that a covered person has incurred necessary, reasonable and customary expenses, which are recommended and approved by a physician, for hospital care for diagnosis or treatment of an illness or injury, the Plan will pay such hospital charges not exceeding the maximum amount specified in the Appendices and such other exclusions or limitations as appear herein for services listed below.

Charges made by a hospital to cover the cost of a ward or semi-private room for care of general conditions in a hospital, including meals, special diets, and nursing services. Coverage is also provided when special units are required such as intensive care, burn or cardiac care units. Private rooms are limited to the usual and customary charge for a semi-private room rate. The maximum room and board benefit is 365 days.

### **Emergency Accident and Medical Treatment**

If a covered person is injured in an accident or experiences a medical emergency, the Plan pays the applicable percentage of eligible expenses with no deductible required.

### **Benefits for Special Services**

A benefit, equal to the reasonable and customary charges incurred, in connection with a hospital confinement in which room and board benefits are paid, will be provided for the following:

- a) Charge for services and supplies furnished by the hospital for medical care. This includes the charges for operating room, x-rays, medicines, etc., but does not include charges for professional services except for professional fees for the readings and interpretation of diagnostic testings which are under the direction of a pathologist retained by the hospital.
- b) Charges for the administration of anesthetics by a physician retained by the hospital.
- c) Charges for hemodialysis, supplies and equipment used for either acute or chronic conditions.
- d) Charges for the services of a physical therapist or physician who provides such services.
- e) In-hospital newborn care for a newborn child qualifying as a covered dependent (newborn "well baby" care is limited to the duration of the mother's hospital confinement).
- f) Charges for blood derivatives, blood plasma, and administration of blood, but excluding whole blood and packed red blood cells.
- g) Charges made by a hospice for a terminally ill patient. Hospice care concentrates on pain management and professional counseling for both patients and their families. Approved eligible charges will be payable on an inpatient, outpatient, or in home basis. See Appendices for maximums.
- h) Eligible charges for use of a birthing center, not to exceed the rate for the hospital's semi-private accommodations.
- i) Electroshock therapy.
- j) Private duty nursing services ordered by the attending physician.
- k) All laboratory examinations including typing of blood donors, and pathological laboratory services which are under the direction of a pathologist retained by the hospital, including fees for interpretation.
- l) Oxygen and other gas therapy.
- m) Drugs, biologicals and solutions used while the covered person is in the hospital if listed in the latest edition of the United States Pharmacopeia, the National Formulary, or the New or Non-Official Drugs.
- n) Use of radium owned or rented by the hospital.
- o) Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings and plaster casts.
- p) Use of iron lungs, incubators, oxygen tents, or kidney machines.
- q) Intermittent positive pressure breathing therapy.
- r) Skin bank, bone bank, and other tissue storage closets.
- s) Internal prosthetic appliances which are considered part of a hospital's regular working equipment.
- t) Radiation therapy.

### **Continuous Period of Disability**

Successive periods of hospital confinement shall be considered as occurring during one continuous period of disability unless separated by a period in excess of 60 days, regardless of conditions. After 60 days a new maximum number of days is available.

## 2. Surgical Expense Benefit

The Plan will pay a benefit for the charge made to an employee or to a dependent by a physician and assistant physician in connection with each surgical procedure performed on the employee or dependent as the case may be, while he is covered and as a result of a non-occupational illness or non-occupational injury.

The benefit shall be equal to the percentage of the actual expense or percentage of Reasonable and Customary charges, as outlined in the Appendices, by a physician:

- a) For performing the procedure.
- b) For necessary pre-operative treatment during hospital confinement, and customary post-operative treatment, furnished in connection with the procedure.
- c) For physician's services for hemodialysis in the hospital or hospital outpatient department.
- d) For routine circumcision of a newborn male child who is a covered dependent.
- e) For physician's services for removal of impacted teeth, if not covered under any other section of this Plan.
- f) For necessary pre-operative treatment and customary post-operative treatment, furnished in connection with the procedure for all pre-natal and post-natal care in connection with maternity.
- g) For charges made by an assistant surgeon where such service is deemed necessary by the Plan Administrator and where such service is not available by a hospital employee.
- h) For the administration of anesthesia in connection with surgical, medical, or obstetrical procedures when the anesthesia is administered by a doctor of medicine not in charge of the case. Fees for all anesthesia service will be paid on the basis of time involved.

The benefit shall not exceed the reasonable and customary charges for the area. If two or more surgical procedures are performed at one session, and add significant time or complexity to the patient's care, the maximum benefit amount will be the amount for the procedure with the highest limit, plus 50% of the amount of the other procedure. But, if a second procedure is only incidental, and is through the same incision, the maximum benefit will be the amount for the major procedure.

The total payment for surgical procedures due to the same or related causes will not exceed the maximum shown in the Appendices, unless the procedures are separated by a complete recovery, or unless (in the case of an employee) separated by return to full-time work.

**NOTE: Any surgery that could safely be performed outpatient but is performed on an inpatient basis will have all charges in connection with that procedure paid at 50% of what otherwise would be payable, unless written verification is submitted to the Claims Supervisor by the attending physician as to the medical necessity of the inpatient admission and is approved by an in-house physician advisor.**

Mandatory outpatient surgery provision will not apply when the patient's medical condition requires that the surgical procedure be performed on an inpatient basis.

Inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically appropriate following;

- a) A mastectomy
- b) A lumpectomy; or
- c) A lymph node dissection for the treatment of breast cancer.

In a case in which a mastectomy patient elects breast reconstruction, coverage is provided for:

- a) All stages of reconstruction of the breast on which the mastectomy has been performed; and
- b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c) Prostheses and physical complications from all stages of mastectomy, including lymphedemas...

in a manner determined by the attending physician and the patient to be appropriate, and consistent with the fee schedule contained in the Appendices.

### **3. Second and Subsequent Surgical Opinions**

Second and Subsequent Surgical opinions are not required. The Plan, however, pays the applicable percentage of eligible expenses (after the deductible and up to a maximum benefit of \$200) for second and subsequent opinions prior to surgery.

With respect to the treatment of breast cancer, full coverage is provided for secondary consultations by specialists in the appropriate fields (including pathology, radiology and oncology) to confirm or refute such diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not available from specialists operating under the Plan, within the network, coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was a network provider. This paragraph describes an approved exception. Special application must be made for claim payment.

### **4. Organ and Tissue Transplants**

**Prior approval must be obtained for benefits to be provided for Human Organ and Tissue Transplant Services, except for cornea or kidney transplant.** To obtain approval, contact the Claims Administrator as soon as a physician suggests a condition that may require a transplant.

Transplant services must be provided at one of the approved Centers of Excellence facilities for full benefits to be paid. Payment for services at other than one of the Centers of Excellence facilities may be at a reduced level.

When the recipient is the covered person, the donor's expenses will be considered expenses of the recipient and will apply toward the recipient's maximum benefit for the transplant procedure.

**Tissue Transplants:** Benefits are payable for Tissue Transplants and all related charges which are described as covered services.

Benefits are payable for the following Tissue Transplants:

- a) Cornea Transplants;
- b) Allogenic and autologous bone marrow transplants;
- c) Stem Cell Harvest without a planned transplant are payable only when in relation to a diagnosis of:
  - i. Acute Myelogenous Leukemia;
  - ii. Acute Lymphoblastic Leukemia;
  - iii. Pediatric Tumors.

**Human Organ Transplants:** Benefits are payable for Human Organ Transplants and all related charges, which are described as covered services including the acquisition, preparation, transportation and storage of the human organ.

Benefits are payable as shown in the Appendices for the following transplants only:

- a) Heart transplants;
- b) Heart/Lung transplants;
- c) Liver transplants;
- d) Lung transplants;
- e) Pancreas transplants; and
- f) Kidney transplants...

If an organ transplant other than those described above is required, contact the Claims Administrator.

#### **5. In-Patient Physician Visits Benefit**

The Plan will pay a benefit for the charge made to an employee or to a dependent by a physician for each covered visitor consultation with the employee or dependent, as the case may be, receives during a hospital confinement:

- a) Is a result of a non-occupational illness or injury.
- b) During the days of a period of hospital confinement for which benefits are payable under this Plan.

The Plan will pay for the initial examination of a newborn child when performed in the hospital by other than the delivering physician or anesthesiologist. The benefit shall be equal to the physicians Reasonable and Customary charges as defined herein.

#### **6. Continuous Period of Disability**

Treatments or consultations received during consecutive periods of hospital confinement shall be considered as having been received during a continuous period of disability unless the later period of hospital confinement is considered as occurring during a separate period of disability for purposes of hospital expense coverage under this plan.

#### **7. Limitations**

No benefits shall be payable for a charge:

- a) Which includes telephone calls or interviews in which the physician does not see the covered person for treatment.
- b) For more than one treatment on any one day.
- c) For more than one consultation on any one day.
- d) For treatment or consultation received in connection with and on or after the date of a surgical procedure for which a surgical operation expense benefit is payable under this Plan, other than a procedure performed solely for diagnostic purposes.
- e) For consultation by a physician who is not specifically recommended by the attending physician.
- f) For dental work, eye refractions, fitting of eyeglasses, fitting of hearing aids, x-rays, drugs, medicine or dressings.
- g) Which is incurred under any of the circumstances described in the provision entitled "General Exclusions" set forth in the Plan.

#### **8. Laboratory & Diagnostic X-Ray Examination Expense Benefit**

The Plan will pay a benefit for the Reasonable and Customary charge made to an employee or to a dependent by a hospital outpatient department, a physician's office or a qualified clinic for each laboratory examination which is received by the employee or dependent, as the case may be, while covered and in connection with the diagnosis of a non-occupational illness or non-occupational injury.

The benefit available shall include:

- a) X-ray Examinations
- b) Laboratory and Pathology Services
- c) Diagnostic Medical Examinations such as EKG's and EEG's
- d) Cardio graphic, encephalographic and radioisotope tests

Note: These benefits are subject to applicable Annual Deductibles, Co-Payments, and Maximums Out of Pocket.

Preventive Care exams may have a higher level of coverage. Refer to Appendices.

## **9. Pregnancy Expense Benefit**

If an eligible participant is confined in a hospital or undergoes an obstetrical procedure because of pregnancy or complications from pregnancy, the Plan will pay for such confinement or such obstetrical procedure a percentage of the amount charged as outlined in the Appendices.

All periods of hospital confinement and all obstetrical procedures due to the same pregnancy or complications from pregnancy shall be considered one period of hospital confinement. Coverage for a hospital stay following a normal vaginal delivery will be 48 hours for both the mother (if a covered person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending physician. Coverage for a hospital stay in connection with childbirth following a Caesarean section will be 96 hours for both the mother (if a covered person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending physician.

The pregnancy expense benefit shall be shown in the Appendices and shall include nursery or other charges incurred by a well baby.

### **Birth Centers**

The Plan will pay, for a covered employee or spouse only, the Reasonable and Customary charges for childbirth accomplished within the confines of a licensed Birth Center delivery. Home health care is available for a period of five (5) days following discharge from a Birth Center. This is an approved exception. Special application must be made form claim payment.

### **Infertility Treatment**

For a covered employee and spouse only, the Plan shall pay, according to all existing Plan provisions all recognized corrective medical treatment performed, except as excluded in the "General Exclusions" section, in connection with the condition of infertility; provided, however, that all such payments for procedures rendered to the covered employee and spouse shall be limited to \$5,000 maximum lifetime benefit for each covered person. This benefit does not include the reversal of male or female sterilization.

## **10. Prescription Drug Benefit**

The Plan will pay expenses for prescription drugs furnished in connection with the medical care of a non-occupational illness or non-occupational injury. All eligible prescription drugs ordered by a physician and dispensed by a licensed pharmacy or organization licensed to dispense drugs will be subject to the Co-Payment or Annual Deductibles as described in the Appendices.

### **Co-Payment**

The co-payment is applied to each covered pharmacy drug charge and is shown in the Appendices. Any co-payment amount is the responsibility of the employee.

## Covered Prescription Drugs

- a) All drugs prescribed by a Physician that require a prescription either by federal or state law, except injectables (other than insulin), including birth control pills.
- b) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- c) Insulin when prescribed by a Physician.

## Limits to this Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- a) Refills only up to the number of times specified by a Physician.
- b) Refills up to one year from the date of order by a Physician.

## Expenses not covered

This benefit will not cover a charge for any of the following:

- a) **Administration.** Any charge for the administration of a covered Prescription Drug.
- b) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- c) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- d) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- e) **FDA.** Any drug not approved by the Food and Drug Administration.
- f) **Injectables.** A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin).
- g) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use."
- h) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- i) **No charge.** A charge for Prescription Drugs, which may be properly received without charge under local, state or federal programs.
- j) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

## 11. Convalescent Nursing Home Benefits Following Hospitalization

The Plan shall pay charges incurred or made during a Covered Convalescent Nursing Home confinement after a hospital stay that was covered by the Hospital Expense or Major Medical Expense coverage. The confinement must be recommended by a physician for the condition causing the hospitalization, and prior authorization by the Plan has been obtained.

The eligible expenses are the nursing home charges for the following services and supplies furnished while the patient is under the continuous care of his physician and requires 24 hour nursing care:

Room and Board and other services and supplies furnished by the home for necessary care (other than personal items and professional services) are covered under this benefit. For any day of Skilled Nursing Facility confinement in a private room, the benefit shall not include that portion which is more than the Skilled Nursing Facility's most common rate for a semi-private room. A 60-day limit applies to all nursing home expenses.

Benefits are available for covered services in a Skilled Nursing Facility as are included for inpatient hospital services and inpatient medical services. No coverage is provided in a Skilled Nursing Facility for custodial care or care for senile deterioration, mental deficiency or mental retardation.

## 12. Home Health Care Expense Benefit

Covered home health care expenses shall mean Reasonable and Customary charges made by a home health care agency for necessary services and supplies that are furnished to a covered employee or covered dependent in the individual's home that are for care which begins at the end of a confinement as a hospital inpatient, and are for a cause that is the same or related to the cause of the hospital confinement; or following discharge from a licensed birthing center.

If a covered employee or covered dependent incurs covered home health care expenses, the Plan will pay a benefit determined by multiplying the reasonable and customary fee by the co-insurance factor shown in the Appendices. However, the maximum payment for covered home health care expenses shall be limited to 60 visits in a calendar year.

Period of home health care services shall mean a period during which covered home health care expenses are provided for any cause which:

- a) Commences following termination of the covered employee's or covered dependent's confinement for the same or related cause to a hospital; or following discharge from a licensed birthing center.
- b) Terminates on the earliest of the following:
  - i. Sixty (60) days after the period begins (not counting any days during which the covered employee or covered dependent was confined to a hospital or extended care facility for more than 18 hours); or
  - ii. The expiration of seven (7) consecutive days during which the individual receives no home health care services and is not confined in a hospital or an extended care facility; or
  - iii. The day on which the covered employee's or covered dependent's physician requests that these services be discontinued.

If a hospital confinement charges due to an accidental bodily illness or injury are excluded from major medical expense benefits by a limitation regarding medical care or treatment received before becoming a covered employee or covered dependent, no home health care expense benefits will be payable for subsequent home health care due to the same accidental bodily illness or injury.

## 13. Major Medical Expense Benefit

The Plan will pay a benefit for covered expenses (as defined below) incurred by an employee or by a dependent during a calendar year following satisfaction of the cash deductible, while covered under the Plan.

- a) Satisfying the Cash Deductible: The cash deductible is the amount of covered expenses for which no benefit will be paid by the Plan. It applies to each covered person in each calendar year. The amount and types of expenses subject to the deductible are shown below. Benefits are then based upon the person's covered expenses that exceed the deductible.

If any two members of the family unit (consisting of the employee and his covered dependents) are injured in the same accident only one cash deductible will be applied each year against all expenses incurred as a result of such accident.

- b) Covered Expenses: Charges made for any of the services or supplies in the following list shall be considered covered expenses only to the extent of the applicable maximum covered expense for daily room and board shown for this coverage; and
  - i. Medical treatment, home, office and hospital visits, or surgical procedures by a physician and other medical care and treatment.
  - ii. Private duty nursing service furnished in a hospital or elsewhere by a registered graduate nurse who is entitled to use the suffix RN after his or her name, or by a licensed practical nurse if such service is recommended by the physician, provided he or she is not a member of the employee's immediate family (which for purposes of this coverage, consists of the employee's wife

- or husband and the children, brothers, sisters and parents of the employee and of the employee's wife or husband).
- iii. Charges made for private duty nursing care will be payable at the rate shown in the Appendices.
  - iv. Charges made by a psychiatrist or physician for medical treatment of mental/nervous conditions, alcoholism, or legal substance abuse as found in the Appendices.
  - v. The following services and supplies:
    - Anesthetics and oxygen and the administration thereof.
    - Rental (or, at the Plan's option, purchase, if the Claims Supervisor determines that cost of purchase is less than anticipated total rental charges) of iron lung, oxygen tent, hospital bed, wheelchair and similar durable medical equipment designed primarily for use in a hospital for therapeutic purposes.
    - Blood and blood derivatives and the administration thereof.
    - X-ray examinations and laboratory tests.
    - Physiotherapy treatment by a licensed physiotherapist.
    - X-ray and radium treatments and treatments with other radioactive substances.
    - Surgical dressings, artificial limbs, larynx and eyes, electronic heart pacemaker, casts and splints, trusses, braces and crutches, drugs and medicines dispensed by a licensed pharmacist.
  - vi. Treatment by a licensed, qualified speech therapist, when medically prescribed, for the purpose of restoring speech loss or correcting an impairment following a stroke, accident or congenital and developmental problems.
  - vii. Circumcisions for newborn males.
  - viii. Rental of dialysis equipment, for dialysis equipment supplies and maintenance of dialysis equipment, including hospital or dialysis center training of the covered person or of the person who will attend the covered person in the operation of the dialysis equipment.
  - ix. Charges for a diabetes instruction program which is: 1) designed to teach the patient and his or her family about the disease process and the daily management of diabetic therapy; and 2) supervised by a doctor.
  - x. Charges for medically necessary services as the result of a cardiac event. It must be expected that the therapy will result in a significant improvement in the level of cardiac function. All cardiac rehabilitation services must be provided by a hospital.
  - xi. Charges for pap smears and prostate tests, including office visit.
  - xii. Charges for voluntary sterilization.
  - xiii. Drugs, biologicals and solutions are covered only to the extent administered and used in the hospital and only when administered in connection with the use of operating or surgical treatment rooms, anesthesia, laboratory examinations, or other covered hospital services listed above.
  - xiv. Laboratory expenses.
  - xv. Physical therapy treatments are covered if medically necessary.
  - xvi. Hemodialysis in the hospital outpatient department or at the home of the covered person receiving hemodialysis. Certain necessary, reasonable and customary expenses for installation, maintenance, and repair of equipment and supplies used in the home in connection with hemodialysis are also covered.
  - xvii. X-ray or laboratory examinations are performed in the hospital on an outpatient basis if the examinations are within the 7 days immediately prior to a hospital stay as a bed patient or outpatient surgery, and performed in connection with the illness or injury requiring that confinement for surgery.
  - xviii. Physician's charges for outpatient treatment of an accidental injury or life threatening medical emergency, if not covered under any other section of this Plan.

- xix. Outpatient charges in connection with treatment of chronic conditions requiring hospital visits (except as provided in connection with hospice services).
- xx. Treatment of keratoconus with contact lenses to a maximum of \$500 annually, if there are changes in prescription. This coverage is an approved exception to the Plan; special application must be made to Highmark.
- xxi. Routine physical examinations, including any testing or screening charges, up to the maximum limits outlined in the Appendices.

### **C. PRE-EXISTING CONDITIONS**

**NOTE:** The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has creditable coverage from another health plan. Pre-Existing Conditions Limitations are waived for people leaving another denominational plan.

An eligible person may request a certificate of creditable coverage from his or her prior plan and the Employer will assist any eligible person in obtaining a certificate of creditable coverage from a prior plan.

If, after creditable coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months after the person's Enrollment Date. This time may be offset if the Employee has creditable coverage from his or her previous plan.

Effective January 1, 2011, there is a prohibition on pre-existing condition exclusions for eligible children under the age of 19.

**A Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy

## **VI. DEFINED TERMS**

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time basis.

**Administrator or Plan Administrator** shall mean the person responsible for the day-to-day functions and management of the Plan. The Administrator may employ persons or firms to process claims and perform other Plan-connected services. The Plan Administrator is the employer. The Plan is administered through the local office of the company to which the employee reports to work.

**Basic Benefits** shall mean hospital, surgical and related benefits available to a covered employee and/or covered dependents but not including Major Medical Expense coverage.

**Benefit Year** shall mean a twelve (12) month period commencing with the effective date of this Plan or a Plan Anniversary thereof, and terminating prior to the next succeeding Plan Anniversary.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (RN) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Calendar Year** means January 1st through December 31st of the same year.

**Convalescent Nursing Home** shall mean a legally operated institution that:

1. For a fee provides convalescents with room, board and 24-hour care by one or more professional nurses and other nursing personnel needed to provide adequate medical care.
2. Is under full-time supervision of a physician or registered graduate nurse (RN)
3. Keeps adequate medical records.
4. If not operated by a physician, has the services of one available under an established agreement.
5. Is not an institution, or part of one, used mainly as a rest facility or a facility for the aged, but is eligible to receive payments under and in accordance with the provisions of the United States Medicare Program.

**Coverage** shall mean all of the terms and provisions appearing under a particular caption of this Plan providing the particular kind of coverage.

**Covered Person** is an Employee or Dependent who is covered under this Plan.

**Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Dentist** shall mean a person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

**Dependent or Eligible Dependent** shall be as defined under the Subsection titled Eligible Classes of Dependents of this document.

**Dependent Disability** shall mean disability of a covered dependent to the extent that such individual is unable to perform the normal activities of a person in good health of like age and sex.

**Designated Health Care Provider** shall mean a physician, group of physicians, hospitals, or service providers whom the employer has contracted for the provision of professional services to covered employees and covered dependents.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

**Effective Date** shall mean the date the Plan was put into effect.

**Elective Surgical Procedures** shall mean a non-emergency surgical procedure scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

**Emotional Support Services** are programs for meeting the special physical, psychological, spiritual and social needs of a person.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship and who works regularly scheduled weeks of thirty hours or more.

**Employer** is the Evangelical Presbyterian Church (EPC), its presbyteries and member churches.

**Enrollment Date** is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

**Expenses Incurred** shall mean a charge, which shall be deemed to be incurred on the day the purchase is made, or on the day the service is rendered for which a charge is made.

**Experimental and/or Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Claims Supervisor must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Claims Supervisor shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Claims Supervisor will be final and binding on the Plan. The Claims Supervisor will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

**Extended Care Facility** shall mean an institution (or a distinct part of an institution) which:

1. Is primarily engaged in providing for in-patients:
  - a) Skilled nursing care and related services for patients who require medical or nursing care, or
  - b) Rehabilitation service for the rehabilitation of injured or sick persons.
2. Has policies which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides.
3. Has a physician, a registered professional nurse, or medical staff responsible for the execution of such policies.
4. Has requirement that the health care of every patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of emergency.
5. Maintains clinical records on all patients.
6. Provides 24-hour nursing care in accordance with the policies developed as provided in subparagraph (2) above, and has at least one registered professional nurse employed full-time.
7. Provides appropriate methods and procedures for the dispensing and administration of drugs and biologicals.
8. Has in effect a utilization review plan which provides for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished:

- a) With respect to the medical necessity of the services, and
  - b) For the purpose of promoting the most efficient use of available health facilities and services and with such review to be made by either a staff committee of the institution composed of two or more physicians, personnel, or a group similarly composed which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality; and which review provides for prompt notification to the facility, the individual, and his attending physician of any finding by the physician members of such committee or group that any further stay in the facility is not medically necessary.
9. Is licensed pursuant to any applicable state or local law or is approved by the appropriate state or local agency as meeting the standards established for such licensing.
10. Is not an institution which is primarily for custodial care.

**Family Unit** is the covered Employee and the family members who are covered as Dependents under the Plan.

**Full-Time Employee** shall mean an employee of the Employer that works not less than thirty hours per week.

**Generic Drug** means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

**Home Health Care Agency** is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (RN); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RNs); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
2. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (RN); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Hospital Confinement** a person shall be deemed to be confined in a hospital, for the purpose of this Plan, if his confinement continues for 23 consecutive hours or longer, or a room and board charge is made in connection with his confinement; or if the confinement results from a non-occupational injury requiring emergency care and commences prior to midnight of the day following the date of the injury; or if the confinement is required because of a surgical procedure.

**Illness** shall mean only sickness or disease, including mental infirmity, which requires treatment by a physician. For purposes of determining benefits payable, illness shall include pregnancy, childbirth, miscarriage, and complications thereof. An illness shall not include abortion unless the mother's life would be endangered if the child were carried to the full term

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Intensive Care Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (RN) in continuous and constant attendance 24 hours a day.

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Emergency** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medically Necessary and Appropriate** Services, supplies or covered medications that a Provider, exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease and (iii) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service, supply or covered medication is medically necessary and appropriate.

**Medicare** is Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**Non-Occupational** shall mean with respect to injury, an injury which does not arise out of or in the course of any employment for wage or profit; and with respect to disease, shall mean a disease in connection with which the person is entitled to no benefits under any Worker's Compensation law or similar legislation.

**Outpatient Care** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Outpatient Treatment Facility** shall mean a legally operated outpatient medical facility which provides diagnosis, minor surgery, nursing care and supervision by a staff of physicians, which is primarily engaged in the provision of medical care, including diagnostic and therapeutic facilities, and which is operated on a basis other than as a rest home, nursing home, convalescent home, place for the aged, alcoholics, or drug addicts.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician** means a Doctor of Medicine (MD), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (DDS), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (DC), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (OD), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means the Evangelical Presbyterian Church Employee Benefits Plan, which is a benefits plan for certain Employees of the Evangelical Presbyterian Church, its presbyteries and member churches and is described in this document.

**Plan Participant** is any Employee or Dependent who is covered under this Plan.

**Plan Year** is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

**Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

Effective January 1, 2011, there is a prohibition on pre-existing condition exclusions for eligible children under the age of 19.

The Pre-Existing Condition does not apply to pregnancy.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Psychiatric Treatment** shall mean treatment and/or care for a mental disease or disorder or a functional nervous disorder.

**Psychologist** shall mean a person who specializes in clinical psychology and fulfills the requirements specified below, whichever is applicable:

1. A person who is licensed or certified as a psychologist by the appropriate governmental authority having jurisdiction over such licensure or certification, as the case may be, in the jurisdiction where such person renders service to the covered person.
2. A person who is a member or Fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where such person renders service to the covered person.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Reasonable and Customary Charge.** A charge shall be considered Reasonable and Customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals of the same sex and of comparable age and income, for a similar illness or injury. The term "locality" means a county or such greater area as is necessary to establish a representative cross section of persons or other entities regularly furnishing the type of treatment, services or supplies for which the charge was made.

**Semi-Private Accommodations** shall mean a two-bed room accommodation.

**Sickness or Disease** shall include disease, mental, emotional, or nervous disorders, and covered pregnancy. A recurrent sickness shall be considered as one sickness or disease. All related sicknesses or diseases shall be considered one sickness or disease. Concurrent sicknesses or diseases shall be deemed to be one sickness or disease unless such sickness or disease is totally unrelated.

**Skilled Nursing Facility** is a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar nomenclature.

**Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Substance Abuse** is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Temporomandibular Joint (TMJ) syndrome** is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to, orthodontics, crowns, inlays, physical therapy, and any appliance that is attached to or rests on the teeth.

## VII. PLAN EXCLUSIONS

**Note: All exclusions related to Prescription Drugs are shown in the Appendices.**

The calculation of benefits payable under this Plan shall not include or be based upon any charge made for or in connection with any hospital confinement, or any examination, or any surgical, medical or other treatment or any service or supply:

1. Which was furnished before the date on which the individual on whose account the charge was made became covered or which was furnished in connection with or during a hospital confinement, which commenced before that date.
2. Which is furnished without the prescription or professional order of a physician acting within the scope of his license.
3. Which is not medically necessary to the care and treatment of any injury, disease or pregnancy of the covered individual on whose account the charge is made.
4. An injury or illness for which the covered person is eligible for benefits under any worker's compensation.
5. For charges or benefits prohibited by any law or regulation.
6. Which is in excess of Reasonable and Customary charge (the charge usually made by the service provider when there is no coverage, not to exceed the prevailing charge in the area for a service of the same nature and duration and performed by a person of similar training and experience, or for a substantially equivalent supply).
7. Which is for elective abortion or complications thereof.
8. Which is for routine vision examinations, eyeglasses, eye refractions, or examinations for prescriptions or fitting of eyeglasses, unless there are vision expense benefits.
9. Which is for routine hearing examinations, hearing aids, or examinations for prescription or fitting of hearing aids.
10. Which is for pre-marital examinations, pre-employment examinations, or reduction of weight by diet control.
11. Which is for an injury incurred while engaged in any activity which violates any federal, state, or municipal statute, ordinance or regulation, including the perpetration of a felony or misdemeanor except as required by law with respect to domestic violence or medical conditions.
12. Which is for treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, except for certain dental treatment required for an accident, as previously described.
13. Which is for services or supplies received as a result of an act of war, whether declared or undeclared, occurring while the individual is covered.
14. Which is for charges, which the covered person is not legally required to pay or for charges which would not have been made if no coverage had existed.
15. Which is for reversal of male or female sterilization.
16. Which is for charges made by a hospital to the extent that they are allocable to scholastic education or vocational training of the covered person.
17. Which is for artificial insemination or invitro fertilization, or any procedure to achieve conception that would be considered experimental; however, a resulting pregnancy will be covered as any other pregnancy.
18. Which is for education, training, and bed and board while confined to an institution which is primarily a school or other institution for training, a place of rest, a place for the aged, a nursing home, or for custodial care.
19. Services for which there is no charge received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
20. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are enrolled in Medicare even if you do not apply for or claim Medicare benefits. However, if under law, you may elect this coverage, instead of Medicare, to pay first and if you so elect, then this exclusion will not apply.
21. For expenses incurred for cosmetic or beautifying purposes unless as a result of accidental injury occurring while covered under the Plan, or for a congenital anomaly.
22. Which are for any chiropractic expenses that exceed the annual per person per calendar year maximum as shown in the Appendices.

23. For charges to which a pre-existing condition applies.
24. For any charges for treatment to correct the condition of infertility incurred beyond the \$5,000 maximum lifetime benefit.
25. For any treatment or surgery that is considered to be experimental unless prior approval is received from the Plan Supervisor.
26. For expenses incurred outside the United States except for accidental bodily injury or life-threatening emergency illness occurring outside the United States. Note: This exclusion does not apply to foreign based missionaries appointed by World Outreach while assigned outside the United States of America.
27. For any charges incurred for medical care or treatment received from a member(s) of the immediate family of a covered person. For purposes of this provision immediate family shall mean a parent(s), brother(s), sister(s), son(s), daughter(s), aunt(s), or uncle(s).
28. No benefits are payable for expenses incurred after the date that coverage terminates.
29. No hospital benefits will be paid under this Plan for dental treatment, extractions of teeth, other than multiple extractions or removal of unerupted teeth under general anesthesia where a concurrent hazardous medical condition exists, unless there are dental expense benefits.
30. Which is for convalescent nursing home benefits for a confinement that does not meet the requirements found in the section named "Convalescent Nursing Home Benefit Following Hospitalization".
31. Which is for transportation that is not on an emergency basis only.
32. Medical treatment covered in whole or in part by any auto insurance or homeowners policy, including but not limited to:
33. No-fault insurance policy;
  - a) An uninsured/underinsured motorist policy provision; or
  - b) A medical expense benefit.
  - c) Expenses in connection with treatment of teeth or periodontium except for oral surgery for repair of accidental injury while covered under this Plan, to sound natural teeth or for the removal of impacted wisdom teeth.
34. Treatment of illness or injury, or services or supplies not listed as covered medical expenses.
35. To the extent those expenses are in any way reimbursable through any public program, other than Medicare.
36. Charges which would not have been made had coverage not existed.
37. Charges for appliances or restorations to increase the vertical dimension of the mouth or to restore the occlusion (bite).
38. Unnecessary care or treatment as determined by a review board.
39. Services and/or supplies furnished during periods when the patient is temporarily absent from the hospital.
40. Services and/or supplies for personal comfort items such as television, telephone, admission kits, lotion, powder, etc.
41. Services or supplies not specifically listed under Your Covered Medical Expenses.
42. Exercise equipment.
43. Nutritional supplements.
44. Services rendered or billed for by a school or halfway house or by a member if its staff.
45. Any procedures to diagnose or treat the condition of a fetus prior to birth; except ultrasound or amniocentesis.
46. Treatment of sexual problems not caused by organic disease.
47. Food supplements.
48. Equipment or supplies made or used for physical fitness, athletic training or general health maintenance.
49. Usual and normal home medical supplies or first aid items.
50. Radial keratotomy, except when the physician verifies that myopia cannot be corrected by either glasses or contact lenses.
51. Chelation therapy.
52. Telephone consultations, missed appointments, or completion of claim forms.
53. Foot care only to improve comfort or appearance such as arch supports, corrective shoes, or care of flat feet, subluxation, corns, bunions, calluses, or toenails (except capsular bone surgery).
54. Charges billed by a massotherapist.
55. Charges in excess of a 50% benefit for a surgery that was performed inpatient when the surgery could have safely been performed on an outpatient basis.

56. Charges and/or services relating to temporomandibular joint dysfunction (TMJ).
57. Biofeedback.
58. Charges in connection with weekend hospital admissions unless deemed medically necessary or unless surgery is performed on the date of admission.
59. Charges made in connection with any surrogate parenting arrangement.
60. Charges for completing a claim form.
61. Charges made for the professional services of a resident physician or intern.
62. Charges made in connection with surgery rendered to accomplish sex reassignment (sex change) nor for complications arising out of such a procedure.
63. Charges for services or supplies rendered during any period in which the covered employee or covered dependent is not under the continuing care of a physician.

## VIII. CLAIMS SUBMISSION

### HOW TO SUBMIT A CLAIM

In most cases, providers of medical services will bill the Claims Supervisor directly for services rendered. In the event the provider does not submit the claim on behalf of the Covered Person, that person must submit written proof of claim to the Claims Supervisor.

1. Obtain a claim form from the Personnel Office or the Plan Administrator.
2. Complete the Employee portion of the form. **ALL QUESTIONS MUST BE ANSWERED.**
3. Have the Physician complete the provider's portion of the form.
4. For Plan reimbursements, attach bills for services rendered. **ALL BILLS MUST SHOW:**

Name of Plan  
 Employee's name and identification number  
 Name of patient  
 Name, address, telephone number of the provider of care  
 Diagnosis  
 Type of services rendered, with diagnosis and/or procedure codes  
 Date of services  
 Charges

Send the above to the Claims Supervisor at this address:

Highmark, Inc.  
 PO Box 890062  
 Camp Hill, PA 17089

### WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Supervisor within 20 days of the date charges, for the service, were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced. Claims submitted after twelve months following the date of service will not be paid.

The Claims Supervisor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Supervisor will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

1. The specific reason or reasons for the denial;
2. Specific reference to those Plan provisions on which the denial is based;
3. A description of any additional information or material necessary to correct the claim and an

- explanation of why such material or information is necessary; and
4. Appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Supervisor shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

**APPEALS PROCESS – See Appendix 7**

## **IX. COORDINATION OF BENEFITS**

**Coordination of the benefit plans.** Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans --including Medicare--are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

**Benefit plan.** This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes Medicare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

**Allowable Charge.** For a charge to be allowable it must be a Reasonable and Customary Charge and at least part of it must be covered under this Plan.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

**Benefit Plan Payment Order.** When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans without a coordination provision will pay their benefits by these rules up to the allowable charge.
3. Plans with a coordination provision will pay their benefits by the following rules, up to the Allowable Charge:
  - a) The benefits of the plan, which covers the person directly (that is, as an employee, member or subscriber) ("Plan A"), are determined before those of the plan, which covers the person as a dependent ("Plan B").

**Special Rule.** If: (1) the person covered directly is a Medicare beneficiary, and (2) Medicare is secondary to Plan B, and (3) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

- b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
  - c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
  - d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
    - i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
    - ii. If both parents have the same birthday, the benefits of the benefit plan, which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
  - e) When a child's parents are divorced or legally separated, these rules will apply:
    - i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
    - ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the step-parent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
    - iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
    - iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
  - f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.
4. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
  5. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

**No-fault or other vehicle insurance plan.** Notwithstanding any other paragraph of this Coordination of Benefits provision, this Plan will coordinate benefits with any no-fault auto or other vehicle (including motorcycle) insurance plan, any individual, blanket or group accident or disability plan, and/or any other form of liability insurance under which a Covered Person is or may be eligible for medical/hospitalization benefits. In all cases, this Plan will be secondary to the no-fault auto or other vehicle insurance, individual or group disability insurance or other form of liability insurance under which a Covered Person is or may be eligible for medical/hospitalization benefit. Such other plan, i.e. the no-fault auto or other vehicle insurance, individual or group disability insurance or other form of liability insurance under which a Covered Person is or may be eligible for medical/hospitalization benefit, will be primarily responsible to pay the medical/hospitalization benefit for a Covered Person regardless of any coordination of benefits language contained in such other plan.

**Claims Determination Period.** Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

**Right to Receive or Release Necessary Information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

**Facility of Payment.** This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of Recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

## **X. THIRD PARTY RECOVERY PROVISION**

### **RIGHT OF SUBROGATION AND REFUND**

**When this provision applies.** The Covered Person may incur medical or dental charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim which the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

1. Automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and
2. Must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

Amount subject to subrogation or refund. The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate.

**Defined terms:** "Recovery" means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect medical or dental charges covered by the Plan.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for medical or dental charges against the other person.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

**Recovery from another plan under which the Covered Person is covered.** This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

## **XI. RESPONSIBILITIES FOR PLAN ADMINISTRATION**

### **PLAN ADMINISTRATOR**

Evangelical Presbyterian Church, Employee Benefits Plan is the benefit plan of the Evangelical Presbyterian Church, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by the Evangelical Presbyterian Church to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, the Evangelical Presbyterian Church shall appoint a new Plan Administrator as soon as reasonably possible. The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

### **DUTIES OF THE PLAN ADMINISTRATOR.**

1. To administer the Plan in accordance with its terms
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions
3. To decide disputes which may arise relative to a Plan Participant's rights
4. To prescribe procedures for filing a claim for benefits and to review claim denials
5. To keep and maintain the Plan documents and all other records pertaining to the Plan
6. To appoint a Claims Supervisor to pay claims
7. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate

Highmark provides only administrative claims payment services and does not assume any financial risk or obligation with respect to claims. Benefits are funded entirely by EPC. Highmark shall not be considered an insurer, guarantor, or underwriter of any Benefits under the Plan.

### **PLAN IS NOT AN EMPLOYMENT CONTRACT**

The Plan is not to be construed as a contract for or of employment.

### **CLERICAL ERRORS**

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

## **AMENDING AND TERMINATING THE PLAN**

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

## **XII. GENERAL PLAN INFORMATION**

### **TYPE OF ADMINISTRATION**

The Plan is a self-funded health plan and the administration is provided through a third party Claims Supervisor. The funding for the benefits is derived from the funds of the Employer.

**PLAN NAME** Evangelical Presbyterian Church, Employee Benefits Plan

**TAX ID NUMBER:** 38-2329622

**PLAN EFFECTIVE DATE:** January 1, 2004

**LAST REVISION DATE:** January 1, 2012

**PLAN YEAR ENDS:** December 31 each year

### **EMPLOYER INFORMATION**

Evangelical Presbyterian Church  
17197 N. Laurel Park Drive, Suite 567  
Livonia, MI 48152

### **PLAN ADMINISTRATOR**

Evangelical Presbyterian Church  
17197 N. Laurel Park Drive, Suite 567  
Livonia, MI 48152

### **AGENT FOR SERVICE OF LEGAL PROCESS**

Evangelical Presbyterian Church  
17197 N. Laurel Park Drive, Suite 567  
Livonia, MI 48152

### **CLAIMS SUPERVISOR**

Highmark, Inc.  
PO Box 890062  
Camp Hill, PA 17089  
866/472-0928

### **PRE-CERTIFICATION CONTACT**

Highmark, Inc.  
PO Box 1210  
Pittsburgh, PA 15230  
866/472-0928

### **PRIVACY CONTACTS**

Highmark Privacy Department  
1800 Center Street  
Camp Hill, PA 17089  
Telephone Number: 866-228-9424  
Fax Number: 717-731-2633

## **XIII. MEMBER SERVICES**

### **Blues on Call**

Blues on Call is a comprehensive health information and support program which provides up-to-date, easy to understand information about medical conditions and treatment options.

A registered nurse Health Coach is available online at your Highmark Blue Cross / Blue Shield member web site or at a toll-free telephone number, 1-888-BLUE-428, 24-hours a day, seven days a week to help you make informed health care decisions, optimize your self-care capabilities, and follow your prescribed treatment plans to improve your health outcomes. Using the patient-centered approach, Shared Decision-

Making, Blues on Call offers three levels of health coaching and support:

1. General information and support regarding medical procedures, treatment decisions and questions following a doctor's visit, plus access to audio tapes on hundreds of health-related topics and targeted mailings of printed materials
2. Treatment decision support for making medical and surgical decisions that reflect personal values and preferences, talking with physicians regarding treatment options, and receiving ongoing support and follow-up throughout treatment plans, plus links to information sources, free videotapes and web-based education
3. Chronic condition management for those at greater risk for hospitalization, complications or an increase in the severity of their disease, including needs assessments, information on effectively managing a chronic condition, and referrals to appropriated resources, such as case managers, home health services, or community resources. Blues on Call also provides targeted mailings relative to specific risks, free equipment or tools to support self-management goals and help to improve clinical and quality of life outcomes and reduce ongoing risks associated with chronic disease

## Services

Whether it's for help with a claim or a question about your benefits, you can call your Member Service toll-free number on the back of your ID card or long onto Highmark web site, [www.highmarkbcbs.com](http://www.highmarkbcbs.com). A Highmark Member Service representative can also help you with any inquiry. Representatives are trained to answer your questions, quickly, politely, and accurately.

## Highmark Web Site

The Highmark web site, [www.highmarkbcbs.com](http://www.highmarkbcbs.com), engages Plan members in their coverage, care and health. By logging onto the site, you can manage your coverage more efficiently and make more informed, appropriate and affordable health care decisions.

Online "self service" tools let you:

- Locate network physicians and pharmacies
- Review Preventive Care Guidelines
- Check eligibility information
- Order ID cards
- Order claim forms

Online health tools let you:

- Learn your health status and identify goals for health improvement
- Refer to the comprehensive, full-color Health Encyclopedia
- Access the Healthwise Knowledgebase with information on every kind of medical condition
- Take Lifestyle Improvement courses on stress management, smoking cessation and nutrition
- Use Health Crossroads to access treatment options for condition such as back pain, breast cancer and coronary artery disease
- Follow step-by-step Care Guides for a variety of conditions, including high cholesterol and high blood pressure
- E-mail Blues on Call for confidential health decision support from a specially-trained Health Coach

**Online cost and quality tools help you:**

- Look up typical medical expenses using Cost by Condition and Price by Procedure Guidelines
- Keep track of your care expenses conveniently through My Expense Summary
- Review claims and Explanation of Benefits (EOB) information
- Access provider quality information, such as how well hospitals care for patients with certain medical conditions and how often providers perform certain services

## Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection

**APPENDIX 1**

**PREMIUM COVERAGE PLAN**

**Calendar Year Deductible:**

Individual, Network Provider .....	\$390
Two Person, Network Provider.....	\$780
Family, Network Provider.....	\$1,170
Individual, Out-of-Network Provider.....	\$780
Two Person, Out-of-Network Provider.....	\$1,560
Family, Out-of-Network Provider.....	\$2,340

**Maximum out of pocket per calendar year:**

Individual, Network Provider .....	\$1,690
Two Person, Network Provider.....	\$2,535
Family, Network Provider.....	\$3,380
Individual, Out-of-Network Provider.....	\$3,380
Two Person, Out-of-Network Provider.....	\$5,070
Family, Out-of-Network Provider.....	\$6,760

**Maximum Benefit Amounts:**

Lifetime, while covered .....	unlimited
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**NOTE 1:** The maximums listed below are the total for Network and Out-of-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year Maximum is 60 days total, which may be split between Network and Out-of-Network providers.

**NOTE 2:** All approved claims submitted on behalf of foreign based missionaries and their eligible dependents are deemed to be submissions by a Network Provider.

<b>BASIC BENEFITS</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
Hospital Expense Benefit		
Daily Room and Board, Semi-private Room Rate	90%	60%
Maximum Number of Days	365	365
Mental Health, inpatient	90%	60%
Calendar Year Maximum	365 Days	365 Days
Substance Abuse, inpatient	90%	60%
Pre-admission / Pre-surgical testing	100%	100%
Birth Centers	90%	60%

**NOTE: Hospital admissions must be pre-certified. Emergency admission must be reported within 48 hours of admission. A \$150.00 per admission deductible will be applied to hospital expense benefits when certification is not obtained.**

Surgical Expense Benefit	90%	60%
Inpatient Assistant Surgeon Expense	90%	60%
Optional second and subsequent surgical opinions	90%	60%
Maximum per opinion	\$200	\$200
Consultations	90%	60%
Anesthesia	90%	60%

**NOTE: Surgery that can be safely performed outpatient will have benefits reduced to 50% of eligible charges when performed inpatient for both Network Physicians and Out-of-Network Physicians.**

<b><u>BASIC BENEFITS</u></b>	<b><u>NETWORK</u></b>	<b><u>OUT-OF-NETWORK</u></b>
Organ Transplants	80%	60%
Lifetime maximum	unlimited	unlimited
Pregnancy Expense Benefit	90%	60%
Midwife	90%	60%
Infertility Counseling, Testing and Treatment Expense	90%	60%
Lifetime maximum	\$5,000	\$5,000
Inpatient Physician Visits	90%	60%
Blood Services	90%	60%
Emergency Accident and Medical Treatment (Deductible does not apply)	90%	60%
Ambulance Service	90%	60%

<b><u>MAJOR MEDICAL BENEFITS</u></b>	<b><u>NETWORK</u></b>	<b><u>OUT-OF-NETWORK</u></b>
Primary Physician Office Visit	90%	60%
Specialist Office Visit	90%	60%
Home Health Care Benefits	90%	60%
Calendar year maximum	60 days	60 days
Hospice Care Benefits (deductible does not apply)	100%	100%
Lifetime Maximum	unlimited	unlimited
Services rendered by Doctor of Chiropractic (DC)	50%	50%
Calendar Year Maximum	\$750	\$750

**NOTE: Benefits for x-rays received in connection with non-surgical spinal treatment are payable in the same manner as they are for other covered x-rays.**

Mental Health, outpatient	90%	60%
Substance Abuse, outpatient	90%	60%
Skilled Nursing Facility	90%	60%
Calendar Year Maximum	60 days	60 days
Orthotics (with Medical Necessity)	90%	60%
Therapy Services (with Medical Necessity)	90%	60%
Impacted Wisdom Teeth	90%	60%
Family and Marriage Counseling	90%	60%
Contact lenses for treatment of keratoconus	90%	60%
Calendar Year Maximum (if there are changes in prescription)	\$500	\$500

Above coverages for keratoconus are approved exceptions to the Plan. Special application must be made to Highmark.

#### **PRESCRIPTION DRUG EXPENSE BENEFIT - See Appendix 4**

#### **PREVENTIVE CARE – PREMIUM PLAN**

You are encouraged to take advantage of the EPC Plan's extensive preventive care benefits, including periodic physical examinations, well child visits, immunizations, and a full scope of diagnostic testing. These benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. All qualified preventive services will be covered without cost sharing on your part. The 2012 Preventive schedule, which can be found on the EPC website in the Benefits section, is based on recommendations of highly recognized, credentialed professionals such as the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, and the American College of Obstetricians and Gynecologists. The schedule is reviewed and updated periodically; therefore, the frequency and eligibility of services is subject to change. Preventive drug measures, also identified in the 2012 Preventive schedule, except for smoking cessation, will be covered at a zero co-pay level through Express Scripts if a prescription is provided at the point of purchase.

Following is a high level summary of these benefits:

### **Adult Care**

Examinations, including a complete medical history, height and weight measurements, physical examinations including routine lab, preventive x-rays, blood cholesterol testing, urinalysis, complete blood count and electrocardiogram (EKG) are covered. Benefits are not subject to the Plan's Annual Deductible.

### **Immunizations and Therapeutic Injections**

Immunizations and therapeutic injections for members 19 years of age and older required in the diagnosis, prevention and treatment of an injury or illness are covered when recommended by a physician. Benefits are not subject to the Plan's Annual Deductible or maximums.

### **Routine Gynecological Examination and Pap Test**

All female members, regardless of age, are covered for one (1) routine gynecological examination, including a pelvic and clinical breast examination, and one (1) Papanicolaou smear (pap test) per calendar year. Benefits are not subject to the Plan's Annual Deductible or maximums.

### **Mammographic Screening**

- Women are covered for one routine mammographic screening annually, beginning at age 40.
- Mammographic examinations are covered for all female members regardless of age when services are prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified. Benefits are not subject to the Plan's Annual Deductible or maximums.

### **Colonoscopy**

Starting at age 50, and at 10 year intervals, Plan Members are eligible for a colonoscopy examination. There is no cost for this procedure when it is provided by a participating provider. The first colonoscopy and all related services are covered and are not subject to the Plan's Annual Deductible or maximums.

- Subsequent colonoscopies are covered at 90%

### **Pediatric Care and Immunizations**

This program covers the following services:

- Routine physical examinations for members who are under 19 years of age and selected diagnostic services. Benefits are provided for a medical history, height and weight measurement, physical examination including routine lab, preventive x-rays and counseling, where appropriate. Benefit is not subject to the Plan's Annual Deductible.
- Pediatric immunizations, when performed by a hospital, facility, physician or other professional provider, are covered. Benefits are provided to members under 19 years of age and dependent children for those pediatric immunizations. Benefit is not subject to the Plan's Annual Deductible or maximums.

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**APPENDIX 2**

**BASIC COVERAGE PLAN**

**Calendar Year Deductible:**

Individual, Network Provider .....	\$780
Two Person, Network Provider.....	\$1,560
Family, Network Provider.....	\$2,340
Individual, Out-of-Network Provider.....	\$1,560
Two Person, Out-of-Network Provider.....	\$3,120
Family, Out-of-Network Provider.....	\$4,680

**Maximum out of pocket per calendar year:**

Individual, Network Provider .....	\$3,380
Two Person, Network Provider.....	\$6,760
Family, Network Provider.....	\$10,140
Individual, Out-of-Network Provider.....	\$6,760
Two Person, Out-of-Network Provider.....	\$13,520
Family, Out-of-Network Provider.....	\$20,280

**Maximum Benefit Amounts:**

Lifetime, while covered .....	unlimited
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**NOTE 1:** The maximums listed below are the total for Network and Out-of-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year Maximum is 60 days total that may be split between Network and Out-of-Network providers.

**NOTE 2:** All approved claims submitted on behalf of foreign based missionaries and their eligible dependents are deemed to be submissions by a Network Provider.

<b>BASIC BENEFITS</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Hospital Expense Benefit *</b>		
Daily Room and Board, Semi-private Room Rate	80%	60%
Maximum Number of Days	365	365
Co-pay, per confinement	\$250	\$250
<b>Mental Health, inpatient *</b>	80%	60%
Calendar Year Maximum	365 Days	365 Days
Co-pay, per confinement	\$250	\$250
<b>Substance Abuse, inpatient *</b>	80%	60%
Calendar Year Maximum	365 Days	365 Days
Co-pay, per confinement	\$250	\$250
Pre-admission / Pre-surgical testing	80%	60%
Birthing Centers	80%	60%

\*Medical and Mental Health/Substance Abuse days have a combined 365 day limit

**NOTE: Hospital admissions must be pre-certified. Emergency admission must be reported within 48 hours of admission. A \$150.00 per admission deductible will be applied to hospital expense benefits when certification is not obtained.**

Surgical Expense Benefit	80%	60%
Inpatient Assistant Surgeon Expense	80%	60%
Optional second and subsequent surgical opinions	80%	60%
Maximum per opinion	\$200	\$200
Consultations	80%	60%
Anesthesia	80%	60%

**NOTE: Surgery that can be safely performed outpatient will have benefits reduced to 50% of eligible charges when performed inpatient for both Network Physicians and Out-of-Network Physicians.**

<b><u>BASIC BENEFITS</u></b>	<b><u>NETWORK</u></b>	<b><u>OUT-OF-NETWORK</u></b>
Organ Transplants	80%	60%
Lifetime maximum	unlimited	unlimited
Pregnancy Expense Benefit	80%	60%
Co-pay, per confinement	\$250	\$250
Midwife	80%	60%
Infertility Counseling, Testing and Treatment	80%	60%
Lifetime maximum	\$5,000	\$5,000
Inpatient Physician Visits	80%	60%
Blood Services	80%	60%
Emergency Accident and Medical Treatment	80%*	60%*
* After \$125 co-pay		
Ambulance Service	80%	60%

<b><u>MAJOR MEDICAL BENEFITS</u></b>	<b><u>NETWORK</u></b>	<b><u>OUT-OF-NETWORK</u></b>
Primary Physician Office Visit	100% after \$20 Co-pay per visit*	60%
*Office visit co-pay is not credited toward annual Deductible or Maximum Out-of-Pocket		
Specialist Office Visit	100% after \$30 Co-pay per visit*	60%
*Office visit co-pay is not credited toward annual Deductible or Maximum Out-of-Pocket		
Home Health Care Benefits	80%	60%
Calendar year maximum	60 days	60days
Hospice Care Benefits (deductible does not apply)	100%	100%
Lifetime Maximum	unlimited	unlimited
Services rendered by Doctor of Chiropractic (DC)	50%	50%
Calendar Year Maximum	\$750	\$750

NOTE: Benefits for x-rays received in connection with non-surgical spinal treatment are payable in the same manner as they are for other covered x-rays.

Mental Health, outpatient	100% after \$30 co-pay/visit*	60%
*Deductible does not apply		
Substance abuse, outpatient	100% after \$30 co-pay/visit*	60%
*Deductible does not apply		
Skilled Nursing Facility	80%	60%
Co-pay, per confinement	\$250	\$250
Calendar Year Maximum	60 days	60 days
Orthotics (with Medical Necessity)	80%	60%
Therapy Services (with Medical Necessity)	80%	60%
Impacted Wisdom Teeth	80%	60%
Family and Marriage Counseling	100% after \$30 co-pay/visit*	60%
*Deductible does not apply		
Contact lenses for treatment of keratoconus	80%	60%
Calendar Year Maximum (if there are changes in prescription)	\$500	\$500

Above coverages for keratoconus are approved exceptions to the Plan. Special application must be made to Highmark.

#### **PRESCRIPTION DRUG EXPENSE BENEFIT - See Appendix 4**

#### **PREVENTIVE CARE - BASIC PLAN**

You are encouraged to take advantage of the EPC Plan's extensive preventive care benefits, including periodic physical examinations, well child visits, immunizations, and a full scope of diagnostic testing. These benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. All qualified preventive services will be covered without cost sharing on your part. The 2012 Preventive schedule, which can be found on the EPC website in the Benefits section, is based on

recommendations of highly recognized, credentialed professionals such as the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, and the American College of Obstetricians and Gynecologists. The schedule is reviewed and updated periodically; therefore, the frequency and eligibility of services is subject to change. Preventive drug measures, also identified in the 2012 Preventive schedule, except for smoking cessation, will be covered at a zero co-pay level through Express Scripts if a prescription is provided at the point of purchase.

Following is a high level summary of these benefits:

### **Adult Care**

Examinations, including a complete medical history, height and weight measurements, physical examinations including routine labs and preventive x-rays, Blood Cholesterol Testing, Urinalysis, Complete Blood Count and Electrocardiogram (EKG) are also covered. Benefits are not subject to the Plan's Annual Deductible.

### **Immunizations and Therapeutic Injections**

Immunizations and therapeutic injections for members 19 years of age and older required in the diagnosis, prevention and treatment of an injury or illness are covered when recommended by a physician. Benefits are not subject to the Plan's Annual Deductible or maximums.

### **Routine Gynecological Examination and Pap Test**

All female members, regardless of age, are covered for one (1) routine gynecological examination, including a pelvic and clinical breast examination, and one (1) Papanicolaou smear (pap test) per calendar year. Benefits are not subject to the Plan's Annual Deductible or maximums.

### **Mammographic Screening**

- Women are covered for one routine mammographic screening annually, beginning at age 40.
- Mammographic examinations are covered for all female members regardless of age when services are prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified. Benefits are not subject to the Plan's Annual Deductible or maximums.

### **Colonoscopy**

Starting at age 50, and at 10 year intervals, Plan Members are eligible for a colonoscopy examination. There is no cost for this procedure when it is provided by a participating provider. The first colonoscopy and all related services are covered and are not subject to the Plan's Annual Deductible or maximums.

- Subsequent colonoscopies are covered at 80%

### **Pediatric Care and Immunizations**

This program covers the following services:

- Routine physical examinations for members who are under 19 years of age and selected diagnostic services. Benefits are provided for a medical history, height and weight measurement, physical examination including routine labs, preventive x-rays and counseling, where appropriate. Benefit is not subject to the Plan's Annual Deductible.
- Pediatric immunizations, when performed by a hospital, facility, physician or other professional provider, are covered. Benefits are provided to members under 19 years of age and dependent children for those pediatric immunizations. Benefit is not subject to the Plan's Annual Deductible or maximums.

## APPENDIX 3

### HIGH DEDUCTIBLE HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT

#### **Persons eligible for Medicare Primary are not eligible for this Plan due to Federal Regulations.**

##### **Calendar Year Deductible:**

Individual, Network & Out-of-Network Provider .....	\$3,500
Two People, Network & Out-of-Network Provider .....	\$7,000 combined
Family, Network & Out-of-Network Provider .....	\$7,000 combined

**NOTE:** No one in the “two people” or “family” categories is eligible for benefits until the full deductible has been satisfied.

##### **Maximum out of pocket per calendar year:**

Individual, Network Provider.....	\$1,400
Two Person, Network Provider.....	\$2,800
Family, Network Provider.....	\$2,800

Individual, Out-of-Network Provider.....	\$2,800
Two Person, Out-of-Network Provider.....	\$5,600
Family, Out-of-Network Provider.....	\$5,600

##### **NOTE:**

- For services obtained from Network Providers
  - The Plan generally pays 90% after the deductible is met, based on the Provider’s reasonable charge, until the out-of-pocket maximum is satisfied
  - Then the Plan generally pays 100%.
- For services obtained from Out-of-Network Providers
  - The Plan generally pays 80% after the deductible is met, based on the Provider’s reasonable charge, until the out-of-pocket maximum is satisfied
  - Then the Plan generally pays 100%.

##### **Maximum Benefit Amounts:**

Lifetime, while covered.....unlimited

**NOTE:** The maximums listed below are the total for Network and Out-of-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year Maximum is 60 days total that may be split between Network and Out-of-Network providers.

<u>BASIC BENEFITS</u>	<u>NETWORK</u>	<u>OUT-OF-NETWORK</u>
Hospital Expense Benefit *		
Daily Room and Board, Semi-private Room Rate	90%	80%
Maximum Number of Days	365	365
Mental Health, inpatient*	90%	80%
Calendar Year Maximum	365 Days	365 Days
Substance Abuse, inpatient	90%	80%
Pre-admission / Pre-surgical testing	100%	100%
Birthing Centers	100%	80%

\* Medical and Mental Health/Substance Abuse days have a combined 365 day limit

**NOTE: Hospital admissions must be pre-certified. Emergency admission must be reported within 48 hours of admission. A \$150 per admission deductible will be applied to hospital expense benefits when certification is not obtained.**

<b><u>BASIC BENEFITS</u></b>	<b><u>NETWORK</u></b>	<b><u>OUT-OF-NETWORK</u></b>
Surgical Expense Benefit	90%	80%
Inpatient Assistant Surgeon Expense	90%	80%
Optional second and subsequent surgical opinions	90%	80%
Maximum per opinion	\$200	\$200
Consultations	90%	80%
Anesthesia	90%	80%

**NOTE: Surgery that can be performed outpatient will have benefits reduced to 50% of eligible charges when performed inpatient for both Network Physicians and Out-of-Network Physicians.**

Organ Transplants	90%	80%
Lifetime maximum	unlimited	unlimited
Pregnancy Expense Benefit	90%	80%
Midwife	90%	80%
Infertility Counseling, Testing and Treatment	90%	80%
Lifetime maximum	\$5,000	\$5,000
Inpatient Physician Visits	90%	80%
Blood Services	90%	80%
Emergency Accident and Medical Treatment	90%	80%
Ambulance Service	90%	80%

<b><u>MAJOR MEDICAL BENEFITS</u></b>	<b><u>NETWORK</u></b>	<b><u>OUT-OF-NETWORK</u></b>
Primary Physician Office Visit	90%	80%
Specialist Office Visit	90%	80%
Home Health Care Benefits	90%	80%
Calendar year maximum	60 days	60days
Hospice Care Benefits (deductible does not apply)	90%	90%
Lifetime Maximum	unlimited	unlimited
Services rendered by Doctor of Chiropractic (DC)	50%	50%
Calendar Year Maximum	\$750	\$750

**NOTE: Benefits for x-rays received in connection with non-surgical spinal treatment are payable in the same manner as they are for other covered x-rays.**

Mental Health, outpatient	90%	80%
Substance Abuse, outpatient	90%	80%
Skilled Nursing Facility	90%	80%
Calendar Year Maximum	60 days	60 days
Orthotics (with Medical Necessity)	90%	80%
Therapy Services (with Medical Necessity)	90%	80%
Impacted Wisdom Teeth	90%	80%
Family and Marriage Counseling	90%	80%
Contact lenses for treatment of keratoconus	100%	80%
Calendar Year Maximum (if there are changes in prescription)	\$500	\$500

Above coverage for keratoconus are approved exceptions to the Plan. Special application must be made to Highmark.

**PRESCRIPTION DRUG COVERAGE (After Annual Deductible has been satisfied)**

	<b><u>Premier National Pharmacy Network</u></b>	<b><u>Non-Premier Network</u></b>
Retails Drugs, 31 day supply	90%	not covered
Maintenance Drugs through mail order, 90-day supply	90%	not covered

**Plan Exclusions**

The drugs or drug categories listed below are not covered by the HDDP prescription program:

1. Photo-aged skin products
2. Hair growth agents
3. Depigmentation products
4. Injectable contraceptive agents
5. Contraceptive implants and devices
6. Emergency contraceptive agents (including the “morning after pill”)
7. Drugs used to treat infertility
8. Injectable drugs used to treat erectile dysfunction
9. Injectable drugs used to treat Yohimbine
10. Weight management agents
11. Injectable drugs (a select list of Injectable drugs is covered; questions in this regard should be directed to Highmark)
12. Allergens
13. Serums, toxoids and vaccines
14. Prescription multivitamins
15. Dental pasts, gels and mouth washes containing Fluoride, as well as other Fluoride tablets and drops
16. Smoking cessation agents
17. Drugs equivalent to over-the-counter drugs
18. Alcohol swaps
19. Blood glucose monitors
20. Durable medical equipment
21. Respiratory therapy peak flow meters
22. Homeopathic prescription drugs
23. Over-the-counter drugs except insulin
24. Experimental drugs and medicines

In some cases, items excluded by the Prescription Plan might be covered by the Medical Benefits Plan when administered in a physician’s office or hospital. Questions in this regard should be directed to Highmark.

To appeal a denial for a prescription drug claim, send the appeal to:

Highmark, Inc.  
 PO Box 890062  
 Camp Hill, PA 17089  
 866-472-0978

**PREVENTIVE CARE- HDHP**

You are encouraged to take advantage of the EPC Plan’s extensive preventive care benefits, including periodic physical examinations, well child visits, immunizations, and a full scope of diagnostic testing. These benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. All qualified preventive services will be covered without cost sharing on your part. The 2012 Preventive schedule, which can be found on the EPC website in the Benefits section, is based on recommendations of highly recognized, credentialed professionals such as the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, and the American College of Obstetricians and Gynecologists. The schedule is reviewed and updated periodically; therefore, the frequency and eligibility of services is subject to change. Preventive drug measures, also identified in the 2012 Preventive schedule, except for smoking cessation, will be covered at a zero co-pay level through Express Scripts if a prescription is provided at the point of purchase.

**Adult Care**

Note that Colonoscopy, first exam including related services	100%
Colonoscopy, subsequent exams including related services	90% in-network 80% out-of-network

The Annual Deductible does not apply to the following benefits:

**Pediatric Care**

Routine physical exam	100%
Immunizations	100%

## **HEALTH SAVINGS ACCOUNT**

Your Health Savings Account (HSA) is a tax-advantaged medical savings plan that is an integral part of the EPC's federally qualified, High Deductible Health Plan. It is a tax-advantaged medical saving account that works similarly to an IRA, and is used for setting aside money to pay for medical expenses. Plan members administer their account and make fund selections for investment purposes.

### **Mandatory Church Contribution to your Health Savings Account**

Churches that enroll an individual in the High Deductible Health Plan **are required** to make two payments for that person **each month**:

1. The health insurance premium
2. A payment to the individual's Health Saving Account as follows:
  - a. Individual – 50% of the \$3,500 Annual Deductible payable monthly at \$145.83
  - b. All other categories – 50% of the \$7,000 Annual Deductible payable monthly at \$291.67

**As noted, these payments occur each month; pre-payments of the church's contribution may not be deposited in advance, or prepaid, to your account.**

### **Additional Contributions to your Health Saving Account**

You or your church may make additional contributions into your HSA. A flat dollar amount or a set percentage of your pay may be automatically deposited into your account through payroll deduction. Or, you can make deposits at your own convenience. These deposits are tax advantaged: they lower your federal taxable income; and in appropriate states, they lower your state taxable income. The IRS maximum annual contribution to an HSA for 2012 is \$3,100 for an individual, or \$6,250 for a family. Individuals age 55 and older can also make additional "make-up" contributions; the maximum for each eligible person in 2012 is \$1,000.

In order to make additional contributions through payroll deduction, contact our third party billing administrator, Central Data Services (CDS) at 877-578-8707.

You may make contributions directly to your HSA. To do this, follow the instructions provided by the bank that administers your Health Savings Account (see "Enrollment" below).

### **Qualified Expenditures from your Health Savings Account**

You may pay for qualified medical expenses (including qualified vision and hearing expenses) with funds from your HSA. These payments are tax advantaged in that they are not considered to be taxable income.

You may elect to have Highmark automatically send unpaid claims to your HSA; or you can electronically submit only the claims that you want to be paid from your HSA. Additionally, you may specify that your provider be paid directly or reimbursement may be sent to you by check, or deposited directly to your bank account.

You may withdraw funds for non-qualified expenses, but generally, such withdrawals are subject to income tax, as well as a 10% penalty.

### **Rollover and Portability of Savings**

Plan members don't lose their dollars if they don't spend them by the end of the year. That is, unused money rolls over to the next year and into future years if not used. Also, you retain your savings even if you enroll in another health plan or change employers.

### **Investment Possibility**

Once you have accumulated at least \$50 in a FDIC-insured, interest-bearing bank account, you will have an opportunity to invest in a variety of mutual funds. You can invest for ready access to these funds, or invest for fund growth to help offset future health expenses.

## **Enrollment**

As soon as your church has enrolled you in the High Deductible Health Plan, you should open your Health Savings Account online at [www.highmarkbcbs.com](http://www.highmarkbcbs.com). To enroll, click the “members” tab. Register to obtain a User ID and Password. Then scroll down to the Your Spending header and click on the Open a Health Savings Account entry. At that point you will be transferred to the Bank of New York Mellon Health Savings Account Services site where the account is actually opened. The process will take about 15 minutes and you will receive electronic confirmation as soon as your account is established. **It is essential that you open this account immediately after being enrolled in the HDHP so that the monthly contributions from your church may be properly deposited and accounted for.**

**Additional information about the Health Savings Account is available on the EPC website at <http://www.epc.org/benefits>**

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## **PRESCRIPTION DRUG EXPENSE BENEFIT FOR PREMIUM COVERAGE AND BASIC COVERAGE PLANS**

For Participants in the Evangelical Presbyterian Church's Premium and Basic Coverage Plans:

The prescription drug benefit is administered by Express Scripts. In order to receive the highest level of benefits, prescription drugs must be obtained from a pharmacy in the Express Scripts national network of pharmacies or directly from Express Scripts via the **Express Scripts Mail Service Pharmacy**. For additional information, please go to the Express Scripts website at [www.express-scripts.com](http://www.express-scripts.com). Pay particular attention the FAQ section on the website.

If a prescription is obtained from a pharmacy NOT in the Express Scripts Network, participants must submit a claim to Express Scripts. Reimbursement will be made according to the Express Scripts rates for the prescription drug. Participants will be responsible for any portion over that amount plus a claims handling fee.

Prescriptions obtained through a retail pharmacy are dispensed in a 30-day supply. Plan participants are responsible for a co-payment according to the following schedule:

Co-payment, Generic	\$9
Co-payment, Formulary Brand	\$35
Co-payment, Non-Formulary Brand	\$58

Prescriptions obtained through the **Express Scripts Mail Service** are dispensed in a 90-day supply. Plan participants using the mail program are responsible for a co-payment according to the following schedule:

Co-payment, Generic	\$18
Co-payment, Formulary Brand	\$70
Co-payment, Non-Formulary Brand	\$116

Specialty medications are dispensed by Express Scripts' subsidiary, CuraScript. CuraScript provides injection supplies at no cost to members. Due to the high cost of these prescriptions, the co-payment is \$100 for up to a 30 day supply and each fill is limited to a 30 day supply. An initial 30-day supply may be obtained from a local pharmacy, but all subsequent fills must be obtained from CuraScript.

**Prescription drugs are NOT subject to the medical plan deductible or to the maximum out-of-pocket expense.**

### **PLAN EXCLUSIONS**

The drugs or drug categories listed below are not covered by the Prescription Drug Program:

1. Photo-aged skin products.
2. Hair growth agents.
3. Depigmentation products.
4. Injectable contraceptive agents.
5. Contraceptive implants and devices.
6. Emergency contraceptive agents (including the "morning after pill").
7. Drugs used to treat infertility.
8. Injectable drugs used to treat erectile dysfunction.
9. Injectable drugs used to treat Yohimbine.
10. Weight management agents.
11. Injectable drugs (a select list of injectable drugs is covered; questions in this regard should be directed to Express Scripts, Inc.).
12. Allergens.
13. Serums, toxoids and vaccines.
14. Prescription multivitamins.

15. Dental pastes, gels and mouth washes containing Fluoride, as well as other Fluoride tablets and drops.
16. Smoking cessation agents.
17. Drugs equivalent to over-the-counter drugs.
18. Alcohol swabs.
19. Blood glucose monitors.
20. Durable medical equipment.
21. Respiratory therapy peak flow meters.
22. Homeopathic prescription drugs.
23. Over-the-counter drugs except insulin.
24. Experimental drugs and medicines.

In some cases, items excluded by the Prescription Drug Plan might be covered by the Medical Benefits Plan when administered in a physician's office or hospital. Questions in this regard should be directed to Highmark, Inc.

**Contact Express Scripts at 877-534-3717 ( member services) to discuss questions about your coverage or medications.**

Should Express Scripts deny coverage, you will receive a denial letter with instructions about how to appeal the denial. Note that the appeal process is fully compliant with the requirements of the Patient Protection and Affordable Care Act.

Regarding Medicare Part D, prescription drug coverage, The Board of Benefits of The Evangelical Presbyterian Church has deemed that the prescription drug coverage offered by the Benefits Plan is better for the majority of Plan participants and, on average for all Plan participants, is expected to pay out more than the standard Medicare Part D prescription drug plan. Plan Participants eligible for Medicare should obtain and consider "Important Notice from The Evangelical Presbyterian Church About Your Prescription Drug Coverage And Medicare Part D" before making a decision about which prescription drug plan is best in their personal circumstances.

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## **APPENDIX 5**

### **EPC WELLNESS PROGRAM**

What is a wellness program?

A wellness program is essentially a systematic approach to healthcare that emphasizes employee health and disease prevention instead of the treatment of an illness. Studies show that employees who participate in such a program are:

- Absent from work less often
- More engaged in managing their health
- More productive
- And less costly to the healthcare system.

The EPC Wellness Program is voluntary and there is no cost to participate. To encourage participation, eligible individuals who complete a health risk assessment (HRA) will receive an incentive award.

**Question:** What is a health risk assessment?

**Answer:** It is a comprehensive confidential survey that covers many aspects of an individual's health, including personal fitness, nutrition, stress, safety, heart health, etc. and takes about 20-30 minutes to complete.

**Question:** How do I complete a health risk assessment?

**Answer:** Go to the Highmark Blue Cross Blue Shield website, enter your login ID/password, navigate to the health risk assessment and then complete the HRA online.

**Question:** Who is eligible to participate in the EPC Wellness Program?

**Answer:** Participants in the EPC Medical Plan who are:

- Full-time employees
- The spouse of a full-time employee
- EPC retirees

**Question:** Must the health risk assessment be completed during a particular time period to receive an incentive award?

**Answer:** Yes – you must complete the health risk assessment during an “open window” period of time. The “open windows” are:

- January 1 through April 30
- August 1 through November 30

Additional information about the Wellness Program may be found on the EPC website at the following address: <http://www.epc.org/benefits> under Medical Plan

## **APPENDIX 6**

### **LIFE INSURANCE (INCLUDING AD&D) / LONG TERM DISABILITY INSURANCE**

#### **Term Life Insurance**

The EPC offers eligible employees a \$50,000 Term Life insurance policy as part of the EPC Benefits Program. An Accidental Death and Dismemberment (AD&D) insurance policy is also included and is equal to the amount of the life insurance benefit.

To learn more about the Term Life insurance, please visit the EPC website at the following address:

<http://www.epc.org/benefits> under Life (AD&D) & Long Term Disability Insurance

#### **LONG TERM DISABILITY INSURANCE (LTD)**

The EPC offers eligible employees Long-Term Disability Insurance coverage as part of the EPC Benefits Program. This coverage provides sixty per cent (60%) of qualified earnings after ninety days (90) of total disability.

To learn more about the Long Term Disability insurance, please visit the EPC website at the following address:

<http://www.epc.org/benefits> under Life (AD&D) & Long Term Disability Insurance

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## **APPENDIX 7**

### **Appeals Procedure – Medical Claims**

Your benefit program maintains an appeal process involving three levels of review with the exception of urgent care claims (which are subject to one level of review). At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

For purposes of the appeal process, “you” includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

At any time during the appeal process, you may contact the Member Service Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

#### ***Initial Review***

If you receive notification that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

A representative from the Appeal Review Department will review the initial appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the Appeal Review Department will take into account all evidence, comments, testimony, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;
- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a pre-service claim, a statement regarding your right to request an external review or pursue legal action.

Your decision to proceed with a second level review of a pre-service claim (other than an urgent care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a pre-service claim before pursuing a claim for benefits in court. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;
- Agrees that any statute of limitations applicable to the claim for benefits will not commence (i.e. run) during the second level review; and
- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of pre-service claims, you should contact Member Service using the telephone number on your ID card.

### ***Second Level Review***

If you are dissatisfied with the decision following the initial review of your appeal (other than an urgent care claim), you may request to have the decision reviewed by Highmark. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date of an adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

A representative from the Appeal Review Department will review the second level appeal. The representative will be an individual who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the matter under review.

In rendering a decision on the second level appeal, the Appeal Review Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the matter under review.

In rendering a decision on a second level appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

Your second level appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 business days following receipt of the appeal; or
- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a post-service claim, a statement regarding your right to request an external review or pursue legal action.

Your decision to proceed with a third level review of a claim is voluntary. In other words, you are not required to pursue the third level review of a claim before pursuing a claim for benefits in court under §502 of ERISA. Should you elect to pursue the third level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action ~~under §502 of ERISA~~ that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a third level review) prior to the filing of the lawsuit;
- Agrees that any statute of limitations applicable to the claim for benefits ~~under §502 of ERISA~~ will not commence (i.e. run) during the third level review; and
- Will not impose any additional fee or cost in connection with the third level review.

If you have further questions regarding third level reviews of claims, you should contact Member Service using the telephone number on your ID card.

### ***Third Level Review***

If you are dissatisfied with the decision following the third level review of your appeal, you may request to have the decision reviewed by the Board of Benefits. A written request for review must be submitted to The Medical Review subcommittee of the Board of Benefits within 30 days after the third level appeal. Submit the request to:

EPC – Office of the General Assembly  
Director of Benefits  
17197 N. Laurel Park Drive, Suite 567  
Livonia, MI 48152

If you are not satisfied with the decision of the Board of Benefits, you may request an external review. Or you may choose not to review the appeal with the Board of Benefits and proceed directly to an external appeal.

### ***External Review***

You have four months from the date you receive notice of a final Highmark adverse benefit determination (except a determination that you failed to meet the eligibility requirements of your benefit program) to file a request for an external review with Highmark. Note that for pre-service claims, the four month period begins to run from the date you received Highmark's first-level adverse benefit determination.

#### **Preliminary Review**

Highmark will conduct a preliminary review of your external review request within five business days following the date on which Highmark receives the request. Highmark's preliminary review will determine whether:

- You were covered by your plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your plan's eligibility requirements;
- You exhausted the above-described appeal process; and
- You submitted all required information or forms necessary for processing the external review.

Highmark will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or

materials needed to make the request complete. You will then have the balance of the four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review; whichever is later.

#### Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select one of at least three IROs to perform an external review of your claim if your request found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the 5-day time frame.

The IRO will timely notify you in writing of your eligibility for the external review and will provide you with at least 10 business days following receipt of the notice to provide additional information.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and Highmark. The IRO's notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

#### ***Expedited External Review***

You are entitled to the same procedural rights to an external review as described above on an expedited basis if:

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- A final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

In the above circumstances, Highmark will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not

complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

#### Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select one of at least three IROs to perform an external review of your claim if your request found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, Highmark will immediately provide the IRO with documents and information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc..).

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than 72 hours from the time the IRO received the request for the external review. The IRO must provide written notice of its final external review decision to you and to Highmark, if not originally in writing, within 48 hours of its original decision. The IRO's written notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination

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