



# *Evangelical Presbyterian Church Medical Plan*

*Material in this booklet  
is located on the EPC website at  
[www.epc.org/benefits](http://www.epc.org/benefits)*

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## INTRODUCTION

This document is a description of the Evangelical Presbyterian Church Medical Plan (the “Plan”), which is sponsored by the Evangelical Presbyterian Church (“EPC”). The Plan is offered as part of the Evangelical Presbyterian Church Benefits Plan. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. EPC Benefit Resources, Inc. (“EPC Benefits”) will be the Plan Administrator for the Plan.

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

The EPC 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:

**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.

**Important Benefit Information.** Provides important information about the benefits covered under the Plan.

**Benefit Descriptions.** Explains the services covered under the Plan and the types of charges covered.

**Defined Terms.** Defines those Plan terms that have a specific meaning. The Defined Terms section includes a definition of the capitalized terms used in this benefits summary.

**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 Plan payment order when a person is covered by 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.

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

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

## I. PARTICIPATORY REQUIREMENTS

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

All ministers on the rolls of the presbytery are required by the Acts of the Assembly to be enrolled in the Plan. However, this mandatory participation requirement shall 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, ministers laboring less than 20 hours per week in a place of ministry and ministers laboring out of bounds.
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 as acceptable.

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

### **A. ELIGIBILITY**

#### **Participating Employers**

Eligible Employers may elect to participate in the Plan. Eligible Employers consisting of the EPC, its presbyteries and member churches with eligible classes of Employees become eligible on the date when they are constituted, particularized or otherwise become subject to the government of the EPC. Other eligible entities that are designated by the EPC as Eligible Employers become eligible to participate in the Plan on the date they are so designated.

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 EPC Benefits is first notified that the Employer is eligible to participate in the Plan.

A Participating Employer which withdraws its ministers and/or non-ordained employees as Plan Participants shall cease to be a Participating Employer unless it elects to participate in the Plan during a subsequent open enrollment period.

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

#### **The following classes of Employees are eligible for coverage under the Plan:**

- 1. Full-Time Employees of Participating Employers in the United States and Puerto Rico 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 (including co-operative assignments with other entities).**
- 3. An ordained or non-ordained Employee who is a Home Missionary in the United States and under the oversight of the Committee on World Outreach.**
- 4. A minister who is an active member of an Evangelical Presbyterian Presbytery in the United States or is officially in the process of coming into an Evangelical Presbyterian Presbytery.**

5. Candidates in the United States and Puerto Rico who are under care of an Evangelical Presbyterian Church Presbytery for ministry as defined in the Book of Order of the EPC.
6. EPC transitional ministers, EPC ministers without call, EPC ministers laboring out of bounds, and EPC stated supply and occasional supply ministers, provided the ministers remain in good standing with the presbytery.

Employees and dependents meeting eligibility criteria may participate in the Plan without regard to any pre-existing conditions.

### **Waiting Period for Coverage**

For medical insurance, if the employee is in a class eligible for coverage, timing of eligibility depends on Employee's existing coverage, as explained below.

For a new hire transferring from another plan who meets the eligibility criteria to participate in the Plan, the coverage begins on the date of hire.

For new hires not transferring from another plan, the waiting period ends and coverage becomes effective on the first of the month following their date of hire.

### **Effective Date of Employee Coverage**

An Employee will be covered under the Plan as of the date the Employee satisfies all of the following requirements:

1. The Employee has completed a full day of active work in a class eligible for Employee coverage.
2. The Employee timely satisfies the enrollment requirements (discussed below).
3. The Employee satisfies any waiting period for coverage.

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

The following individuals are eligible for Dependent coverage under the Plan:

1. A covered Employee's Spouse and Dependent children.

The term "Spouse" shall mean the spouse under a legally valid marriage between persons of the opposite sex in their state of residence (See EPC position paper on

the Sanctity of Marriage). “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 a 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 the last day of the month in which the Dependent has his/her 26th 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. 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.

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.

2. A covered Dependent child who is age 26 or older and Totally Disabled and 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; 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. 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. In this case, deductibles and maximum out-of-pocket amounts will be transferred.

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.

### **Effective Date of Dependent Coverage**

Dependent coverage is effective on the date the Employee satisfies the eligibility requirements for Employee coverage, the family member satisfies the requirements for Dependent coverage, and the Employee satisfies the enrollment requirements (discussed below).

### **Eligibility to transfer among the EPC Medical Plan options**

An Employee already enrolled in the Platinum, Gold, Gold HSA, or Silver coverage option may not move or be moved between coverage plans except effective January 1, provided the Plan Administrator is notified consistent with timing parameters specified in the Open Enrollment Period.

### **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**

Employees determined to be totally disabled may continue the medical coverage for themselves and their eligible Dependents for the period during which the Employee is considered totally disabled provided that the Employer timely makes the required monthly 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, the Employee must at no time engage in any occupation or employment for pay or profit and the Employee must be receiving social security disability or benefits under a long-term disability plan provided by the Employer.

### **Extended Medical Benefits**

If an Employee or any of his or her enrolled Dependents are hospitalized at the time their coverage ends, benefits will be paid for eligible Expenses Incurred in connection with that one admission. 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 Plan, his or her enrolled Dependents may continue medical coverage by paying the required contributions. A surviving widow or widower is permitted to continue coverage under the Plan by paying the required contributions until his or her death. A surviving eligible child is eligible to continue coverage by paying the required contributions until the child ceases to be an eligible Dependent (i.e., age 26).

### **Medicare Coverage**

**If you are enrolled in Medicare you are not eligible to contribute to the HSA.**

*Large Employers (20 or more employees)*

#### Covered Active Employees Age 65 and/or Older

If you are age 65 and/or older and actively employed with an Employer that has 20 or more employees, you will remain covered under the Plan for the same benefits available to Employees under age 65. As a result:

- The Plan will pay all eligible expenses first.
- If you have chosen to enroll in Medicare, then Medicare will pay for Medicare eligible expenses, if any, not paid for by the Plan.

### Spouses Age 65 and/or Older of Active Employees

Your spouse who is age 65 or older has the same choices for benefit coverage as indicated above for the Employee age 65 and older.

Regardless of the choice made by you or your spouse, each one of you may, but under certain limited circumstances are not required to apply for Medicare Part A. For those that do apply, this is generally done several months prior to becoming age 65. Under certain circumstances you may choose to wait to enroll for Medicare Part A and B. You will be able to enroll for Part A and B later during special enrollment periods without penalty. You should discuss this with the EPC Benefits.

### *Small Employers (19 or less employees)*

**Note: Employees include all full-time and part-time employees who have worked or will work at least 20 calendar weeks of the year. An employee is defined as an individual who receives a W-2 from the Employer's Tax Identification Number.**

If you are age 65 or over and actively employed with an Employer that has 19 or less employees, the Board of Directors of EPC Benefit Resources, Inc. has determined that as a condition for continued participation you must apply for Medicare Part A and B. Medicare will provide primary coverage and the Plan will then pay all eligible expenses not paid by Medicare.

### Non-Covered Active Employees Age 65 or Over

If you are age 65 or older and choose not to be covered under the Plan but to be covered under Medicare, you will not be eligible for any benefits under the Plan. Contact your Plan Administrator for specific details.

**If you have questions, please contact EPC Benefits.**

### *Medicare Part D Prescription Drug Coverage*

The Board of Directors of EPC Benefit Resources, Inc. has determined that the prescription drug coverage offered by the 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. Before making a decision about which prescription drug plan is best in your personal circumstances, a Plan Participant eligible for Medicare should consider the document he or she received in the mail titled "Important Notice from the

Evangelical Presbyterian Church about Your Prescription Drug Coverage and Medicare Part D.” A Plan Participant may also request a copy of this document from the Plan Administrator.

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

An Employee may elect to extend his or her medical coverage for up to one (1) year following the month he or she terminates employment. A Dependent may elect to extend his or her medical coverage for up to one (1) year following the month he or she loses eligibility as a Dependent. The cost is the normal premium plus an additional 2% to cover the cost of administration. Prepayment of premiums may be required.

### **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 disability ends as determined by the Employer.

2. For leave of absence or layoff only

The date when a limited-term leave of absence or layoff ends, as determined by the Employer, not to exceed one year.

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 and related 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.

### **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 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

### **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 Participating Employers. Premiums for each month of coverage are due on or before the 15th of that month.

The level of Employee contributions, if any, is set by the Participating Employers. The Participating Employers have the right to change the level of Employee contributions.

### **C. ENROLLMENT**

#### **Enrollment Requirements**

An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is also required to enroll for Dependent coverage. 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**

Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes

inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days. To be covered as a Dependent beyond the 31-day period, the newborn child must be enrolled as a Dependent under this program within such period. Refer to the General Information section for further eligibility information.

Under Federal law, your self-insured group health program generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your self-insured program can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

*If you are pregnant, now is the time to enroll in the Baby Blueprints® Maternity Education and Support Program offered by Highmark. Please refer to the Member Services section of this booklet for more information.*

#### **D. TIMELY ENROLLMENT**

##### **Timely Enrollment**

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

#### **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 eligible to participate in 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 during a special enrollment period will be effective:

- a) In the case of marriage, the date of marriage. In the case of a Dependent's birth, as of the date of birth; or
- b) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

### **3. Medicaid or CHIP Coverage**

An Employee, Spouse or Dependent who is eligible, but not enrolled in the Plan, may enroll if either of the following conditions is met:

- a) If you decline enrollment for yourself, your Spouse or your Dependent while Medicaid or CHIP coverage is in effect, you may be able to enroll yourself, your Spouse or your Dependent in the Plan if you, your Spouse's or your Dependent's coverage is terminated as a result of loss of eligibility for such other coverage, provided that you request enrollment within 60 days after you, your Spouse's or your Dependent's coverage ends under Medicaid or CHIP; or
- b) If you, your Spouse or your Dependent become eligible for a state premium assistance subsidy from Medicaid or through a CHIP (including under any waiver or demonstration project conducted under or in relation to such a plan) with respect to coverage under the Plan, you may be able to enroll yourself, your Spouse or your Dependent in the Plan, provided that you request enrollment within 60 days after you, your Spouse's or your Dependent's determination of eligibility for such assistance.

## **F. TERMINATION OF COVERAGE**

### **When Employee Coverage Terminates**

Employee coverage will terminate on the earliest of the following dates, except as provided under **Retiree Medical Benefits, Coverage for Disabled Employees, Extended Medical Benefits, Continuation during Periods of Employer-Certified Disability, Leave of Absence, or Layoff, Continuation during Family and Medical Leave and Employees on Military Leave:**

1. The date the Plan is terminated.

2. The date the covered Employee's eligible class of Employees is eliminated.
3. The end of the month during which the Employee ceases to meet the eligibility requirements for this coverage.
4. The end of the period for which the Employee made his or her last contribution, if required, or, if later, the effective date of termination as contained in the notification of cancellation of coverage for lack of premium payment.

An Employee may elect to extend his or her medical coverage after a loss of eligibility as provided under **Medical Coverage Available After Termination** or **Loss of Eligibility as a Dependent**.

### **When Dependent Coverage Terminates**

A Dependent's coverage will terminate on the earliest of these dates except as provided under **Extended Medical Benefits and Coverage for Dependents of Deceased, Disabled or Retired Employees, Continuation during Periods of Employer-Certified Disability, Leave of Absence, or Layoff, Continuation during Family and Medical Leave and Employees on Military Leave**:

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.
3. For surviving widows or widowers, the date of their death.
4. The date of death of the Dependent.
5. On the first date that the Dependent ceases to be a Dependent as defined by the Plan.
6. The end of the period for which the Employee made his or her last contribution, if required, or, if later, the effective date of termination as contained in the notification of cancellation of coverage for lack of premium payment.

A Dependent may elect to extend his or her medical coverage after a loss of eligibility as provided under **Medical Coverage Available After Termination, Loss of Eligibility as a Dependent**.

## **Rescissions of Coverage for Fraud or Intentional Misrepresentations**

The Plan prohibits a Covered Person from performing an act, practice, or omission that constitutes fraud and from making intentional misrepresentations of material fact. If a Covered Person engages in a fraudulent act, practice or omission or makes an intentional misrepresentation of material fact, the Plan may retroactively rescind coverage provided that the Plan provides at least 30 days advance written notice to each Covered Person who would be affected by the rescission. Rescissions of coverage are subject to the Plan's claim and appeal procedures, which are described below.

### **III. IMPORTANT BENEFIT INFORMATION**

#### **Verification of Eligibility**

Call the Highmark 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, must 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.

The service provider will determine the number of days of Medical Care Facility admission authorized for payment. If the attending Physician feels that it is Medically Necessary and

Appropriate for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

**If these pre-certification requirements are not satisfied, the Covered Person will be subject to a penalty in the amount specified in the Plan Benefit Schedule, in Appendices 1, 2, 3, 4 or 8, as applicable.**

### **Medical Benefits**

All benefits covered under the Plan 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 and Appropriate; that charges are Reasonable and Customary; and 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 whose terms of call are provided by the Committee on World Outreach and who are enrolled in the Platinum, Gold, or Silver coverage options 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 and Co-payments payable by Plan Participants**

Deductibles and 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 option and it must be paid before any

money is paid by the Plan for any covered services. Each January 1st, a new deductible accumulation period begins.

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.

### **Primary Care Provider**

The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Highmark at (866) 472-0928.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Highmark at (866) 472-0928.

## **IV. 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.

#### **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 in the Appendices. No benefits will be paid in excess of the Reasonable and Customary Charges. 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 Maximum**

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 maximums under the Plan.

When a Family Unit reaches the Two Person or Family out-of-pocket limit (as applicable), Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year. For the Platinum, Gold, or Silver coverage options, when an individual in the Family Unit reaches the individual out-of-pocket limit, Covered Charges for that individual will be payable at 100% (except for the charges excluded) for the rest of the calendar year. For the Gold HSA coverage option, Covered Charges for an individual with Two Person or Family coverage will not be payable at 100%

until the Family Unit has satisfied the Two Person or Family out-of-pocket limit (as applicable).

**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.

**Hospital Expense Benefit**

The Claims Supervisor will pay the benefits described in this paragraph (1) and paragraph (2) below for the charges described therein which are made to an Employee or Dependent in connection with a Hospital Admission:

- a) Which result directly from a Non-Occupational Illness or Non-Occupational Injury of the Employee or Dependent, as the case may be; and
- b) Which commence while such Employee and Dependent are 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 are covered. Coverage is also provided when special units are required such as Intensive Care Units, burn or cardiac care units. Private rooms are limited to the Reasonable and Customary charge for a semi-private room rate. The maximum room and board benefit is 365 days.

**Emergency Accident and Medical Treatment**

For the Platinum, Gold and Silver coverage options, 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. For the Gold HSA coverage option, if a

Covered Person is injured in an accident or experiences a Medical Emergency, the Plan pays the applicable percentage of eligible expenses after the deductible has been satisfied.

### **Benefits for Special Services**

A benefit, equal to the Reasonable and Customary charges incurred, in connection with a Hospital Admission in which room and board benefits are paid, will be provided for the following:

- a) Charges 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 tests 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 Admission).
- 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 Agency 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) Electroseshock 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 Pharmaceopeia, 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.

### **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.

**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 that applies to other medical and surgical benefits covered under the Plan.

### **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.

### **Transplant Services**

Benefits will be provided for covered services furnished by a Hospital which are directly and specifically related to the transplantation of organs, bones, tissue or blood stem cells.

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are both Plan Participants, each is entitled to the benefits of their program;
- when only the recipient is a Plan Participant, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this Plan to the extent that benefits remain and are available under this Plan after benefits for the recipient's own expenses have been paid;
- when only the donor is a Plan Participant, the donor is entitled to the benefits of this Plan, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the transplant recipient who is not a Plan Participant; and
- if any organ, tissue or blood stem cell is sold rather than donated to the recipient and the recipient is a Plan Participant, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the recipient's program limit.

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

The Plan will pay a benefit for Physician charges for each covered visitor consultation with the Employee or Dependent, as the case may be that is received during a Hospital Admission:

- a) As a result of a Non-Occupational Illness or Injury; and
- b) During the days of a period of Hospital Admission 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 Physician's Reasonable and Customary charges as defined herein.

### **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.

### **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 out-of-pocket maximums.

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

## **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 a percentage of the amount charged for such admission or such obstetrical procedure as outlined in the Appendices.

All periods of Hospital Admission and all obstetrical procedures due to the same Pregnancy or complications from Pregnancy shall be considered one period of Hospital Admission. 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.

## **Birthing 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 Birthing Center delivery. Home Health Care Services and Supplies are available for a period of five (5) days following discharge from a Birthing Center.

## **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. Unless considered an "essential health benefit" in the patient's state of residence, this benefit does not include the reversal of male or female sterilization.

## **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, and

exclusions and limitations as described in Appendix 5 – Prescription Drug Expense Benefit.

## **Co-Payment**

The co-payment is applied to each covered Pharmacy drug charge and is shown in the Appendix 5. Any co-payment amount is the responsibility of the employee. Prescription drug expenses and co-payments count toward the combined medical and pharmacy benefit plan annual deductible and maximum out-of-pocket expense.

## **Covered Prescription Drugs**

- a) All drugs prescribed by a Physician that require a prescription either by federal or state law, except drugs specifically excluded in Appendix 5 – Prescription Drug Expense Benefit
- 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; and
- 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) **37FDA.** 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 and certain preventive care drugs.

For additional information on the Prescription Drug benefit, see "C: Prescription Drug Management under Section VII. Healthcare Management", and Appendix 5.

### **Skilled Nursing Home Benefits Following Hospitalization**

The Plan shall pay charges incurred or made during a covered Skilled Nursing Home admission after a Hospital stay that was covered by the Hospital Expense or Major Medical Expense coverage. The admission must be recommended by a Physician for the condition causing the hospitalization, and prior authorization by the Plan must be obtained.

The eligible expenses are the Skilled 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 Skilled Nursing Home for necessary care (other than personal items and professional services) are covered under this benefit. For any day of Skilled Nursing Facility admission 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 Skilled Nursing Home expenses.

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

### **Home Health Care Expense Benefit**

Covered Home Health Care Services and Supplies 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 Hospital Admission as an inpatient, and are for a cause that is the same or related to the cause of the Hospital Admission; or following discharge from a licensed Birthing Center.

If a covered Employee or covered Dependent incurs covered Home Health Care Services and Supplies, 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 Services and Supplies shall be limited to 60 visits in a Calendar Year.

Period of Home Health Care Services and Supplies shall mean a period during which covered Home Health Care Services and Supplies are provided for any cause which:

- a) Commences following termination of the covered Employee's or covered Dependent's Hospital Admission for the same or related cause to a Hospital; or following discharge from a licensed Birthing Center; and
- 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 or Supplies 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.

## **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 deductible, while covered under the Plan.

- a) Satisfying the deductible: The 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.
- b) Covered Expenses: Reasonable and Customary charges made for any of the services or supplies in the following list shall be considered covered expenses:
  - 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 or accident or as the result of 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 operate the dialysis equipment for the Covered Person.
- 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 and Appropriate 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 the 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 and Appropriate.
- 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 admission 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 and Supplies).
- xx. Treatment of keratoconus with contact lenses to a maximum of \$500 annually, if there are changes in prescription. Routine physical examinations, including any testing or screening charges, up to the maximum limits outlined in the Appendices.

#### **Preventive Care Benefits.**

See Appendix 6 for a description of the preventive care benefits covered under the Plan.

### **V. DEFINED TERMS**

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

**Administrator or Plan Administrator** shall mean the person or entity 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 EPC Benefit Resources, Inc.

**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 admission.

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

**Chiropractic** 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.

**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.

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

**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.

**Employee** means a person who is an active, regular Employee of the Employer on the regular payroll 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 per week. For purposes of Plan participation, an Employee also includes: (1) EPC ordained ministers active in the presbytery, (2) EPC transitional ministers, EPC ministers without call, EPC ministers laboring out of bounds and EPC stated supply and occasional supply ministers, provided the ministers remain in good standing with the presbytery, and (3) ordained or non-ordained Employees who are missionaries in cross-cultural placement and under the oversight of the Committee on World Outreach (including co-operative assignments with other entities).

**Eligible Employer** means a judicatory (a session, presbytery or general assembly), a particular member church of the Evangelical Presbyterian Church, or other eligible entity designated by the EPC. A not-for-profit corporation or organization that is legally controlled by a judicatory, a particular church or the officers of a church (as identified in the EPC Book of Government) shall be considered as an Eligible Employer under the Plan. Subject to designation by the EPC, an "Eligible Employer" shall also include any organization that employs an ordained, licensed or commissioned minister who is properly credentialed by the Evangelical Presbyterian Church and who is performing duties in the exercise of his ministry, but solely with respect to participation in the Plan by such minister.

**Enrollment Date** is the 1st day of coverage or, if a waiting period exists, the 1st 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 the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined to be medically effective

for the condition being treated. An intervention is considered to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Medical researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

Decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with a nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered “experimental/investigative” and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing Network Physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

Situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the Hospital and/or professional provider may contact Highmark's Member Service at the toll-free telephone number on the back of your ID card to determine coverage.

**Extended Care Facility** shall mean an institution (or a distinct part of an institution) which satisfies all of the following requirements:

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. Requires the health care of every patient to 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 administering 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 and Appropriate.

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** 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.

**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.

**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; and
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 admission 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 Admission** is an admission to the Hospital that (i) continues for 23 consecutive hours or longer, (ii) where a room and board charge is made in connection with the admission; (iii) where the admission results from a Non-Occupational Injury requiring emergency care and commences prior to midnight of the day following the date of the Injury; or (iv) where the admission is required because of a surgical procedure. A person shall be deemed confined to a Hospital if a Hospital Admission occurs.

**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** means 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, in the jurisdiction where the person resides, 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**, means 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 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 the 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.

**Network** means a Hospital, Physician or other Health Care Provider that has agreed to charge reduced fees to persons covered under the Plan. The Plan reimburses a higher percentage of the fees charged by a Network Hospital, Physician or other Health Care Provider. 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.

**Non-Occupational** means 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.

**Out-of-Network** means a Hospital, Physician or other Health Care Provider that is not a Network Provider.

**Outpatient** means 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 Facility** means 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, or place for the aged, alcoholics, or drug addicts.

**Participating Employer** means an Employer that elects to participate in and be subject to the provisions of the EPC Medical Plan.

**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 Medical Plan, which is a medical plan for certain Employees of the EPC, its presbyteries and member churches and is described in this document. The Plan is offered as part of the Evangelical Presbyterian Church Benefits Plan.

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

**Plan Year** is the 12-month period beginning each January 1.

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

**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; or
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 and Appropriate in the treatment of a Sickness or Injury.

**Reasonable and Customary** means a charge 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, Intellectually Disabled, 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.

**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.

**Totally Disabled (or Total Disability)** – A condition resulting from illness or injury as a result of which, and as certified by a Physician, for an initial period of 24 months, you are continually unable to perform all the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, “Totally Disabled” or “Total Disability” means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training, or experience; (ii) during the entire period of total disability you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a Physician, other than your immediate family. If you do not usually engage in any occupation for wages or profits, “Totally Disabled” or (Total Disability) mean you are substantially unable to engage in normal activities of an individual of the same age and sex.

**TMJ** - syndrome is the treatment of a 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, and any appliance that is attached or rests on teeth.

## **VI. PLAN EXCLUSIONS**

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

Except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges:

<b><u>Key Word</u></b>	<b><u>Exclusion</u></b>
Abortion	For elective abortions except those abortions necessary to avert the death of the mother or terminate pregnancies caused by rape or incest.
Allergy Testing	For allergy testing, except as provided herein.
Ambulance	For ambulance services, except as provided herein.
Assisted Fertilization	Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization. (However, the Plan does cover treatment to correct the condition of infertility up to a \$5,000 lifetime benefit).
Comfort/Convenience Items	For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Contraceptive Medications, Devices and Implants	For contraceptive services, including contraceptive prescription drugs, contraceptive devices, implants and injections, and all related services.
Cosmetic Surgery	For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are:

	a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered disease or injury.
Court Ordered Services	For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
Custodial Care	For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
Dental Care	Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.
Effective Date	Rendered prior to your effective date of coverage.
Enteral Formulae	For any food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
Experimental/ Investigative	Which are Experimental/Investigative in nature.
Eyeglasses/Contact Lenses	For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).

Felonies	For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
Foot Care	For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
Healthcare Management Program	For any care, treatment, prescription drug or service which has been disallowed under the provisions of Healthcare Management program.
Hearing Care Services	For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
Home Health Care	For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
Immunizations	For immunizations required for foreign travel or employment.
Inpatient Admissions	For inpatient admissions which are primarily for diagnostic studies or physical medicine services.
Learning Disabilities	For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change including the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning

	disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time.
Legal Obligation	For which you would have no legal obligation to pay.
Medically Necessary and Appropriate	Which are not medically necessary and appropriate as determined by Highmark.
Medicare	To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program.
Methadone Hydrochloride	For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
Military Service	To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
Miscellaneous	For telephone consultations which do not involve telemedicine services, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
	For any other medical or dental service or treatment or prescription drug except as provided herein.
Motor Vehicle Accident	For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law.
Nutritional Counseling	For nutritional counseling, except as provided herein.
Obesity	For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined

	preventive schedule. Please refer to the Preventive Services section in Appendix 6 for more information.
Oral Surgery	For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face and except as provided herein.
Physical Examinations	For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.
Prescription Drugs (Medical Program)	For prescription drugs which were paid or are payable under a freestanding prescription drug program.
Preventive Care Services	For preventive care services, wellness services or programs, except as provided herein.
Provider of Service	Which are not prescribed by or performed by or upon the direction of a professional provider.
	Rendered by other than ancillary providers, facility providers or professional providers.
	Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
	Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same Plan Participant.
	Rendered by a provider who is a member of your immediate family.
	Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
Respite Care	For respite care.
Sexual Dysfunction	For treatment of sexual dysfunction that is not related to organic disease or injury.
Skilled Nursing	For Skilled Nursing Facility services after you have reached the maximum level of recovery possible for your particular condition

and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.

Smoking (nicotine) Cessation	For nicotine cessation support programs and/or classes.
Sterilization	For reversal of sterilization.
Termination Date	Incurred after the date of termination of your coverage except as provided herein.
Therapy	For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless Medically Necessary and Appropriate.
Transsexual Surgery	For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery.
Vision Correction Surgery	For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
War	For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
Weight Reduction	For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
Well-Baby Care	For well-baby care visits, except as provided herein.
Workers' Compensation	For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

## VII. HEALTHCARE MANAGEMENT

### A. MEDICAL MANAGEMENT

For your benefits to be paid under your program, at either the Network or Out-of-Network level, services and supplies must be considered Medically Necessary and Appropriate.

Highmark, or its designated agent, is responsible for determining whether care is medically necessary and provided in the appropriate setting.

A Highmark nurse will review your request for an inpatient admission to ensure it is appropriate for the treatment of your condition, Illness, Disease or Injury, in accordance with standards of good medical practice, and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition and you cannot receive safe or adequate care as an Outpatient.

#### **Network Care**

When you use a Network provider for inpatient care, the provider will contact Highmark for you to receive authorization for your care.

If the Network provider is located outside the Plan service area, you are responsible for contacting Highmark at the toll-free number listed on the back of your ID card to confirm Highmark's determination of medical necessity and appropriateness.

Out-of-Network providers are not obligated to abide by any determination of medical necessity and appropriateness rendered by Highmark. You may, therefore, receive services which are not Medically Necessary and Appropriate for which you will be solely responsible.

#### **Out-of-Network Care**

When you are admitted to an Out-of-Network facility provider, **you are responsible** for notifying Highmark of your admission. However, some facility providers will contact Highmark and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for preauthorization. If not, you are responsible for contacting Highmark.

You should call 7 to 10 days prior to your planned admission. For emergency admissions, call Highmark within 48 hours of the admission, or as soon as reasonably possible. You

can contact Highmark via the toll-free Member Service telephone number located on the back of your ID card.

If you do not notify Highmark of your admission to an Out-of-Network facility provider, Highmark may review your care after services are received to determine if it was Medically Necessary and Appropriate. **If your admission is determined not to be Medically Necessary and Appropriate, you will be responsible for all costs not covered by your program.**

**Remember:**

**Out-of-Network providers are not obligated to contact Highmark or to abide by any determination of medical necessity or appropriateness rendered by Highmark. You may, therefore, receive services which are not Medically Necessary and Appropriate for which you will be solely responsible.**

**B. CARE UTILIZATION REVIEW PROCESS**

In order to assess whether care is provided in the appropriate setting, Highmark administers a care utilization review program comprised of prospective, concurrent and/or retrospective reviews. In addition, Highmark assists Hospitals with discharge planning. These activities are conducted by a Highmark nurse working with a physician advisor. Here is a brief description of these review procedures:

**Prospective Review**

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information.

After receiving the request for care, Highmark:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is Medically Necessary and Appropriate;
- authorizes care and assigns an appropriate length of stay for inpatient admissions

**Concurrent Review**

Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

## **Discharge Planning**

Discharge planning is a process that begins prior to your scheduled Hospital Admission. Working with you, your family, your attending Physician(s) and Hospital staff, Highmark will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

## **Procedure or Covered Service Precertification**

Precertification may be required to determine the medical necessity and appropriateness of certain procedures or covered services as determined by Highmark. Network providers in the Highmark Blue Shield service area and the Plan Service area are responsible for the precertification of such procedures or covered services and you will be held harmless whenever certification for such procedures or covered services is not obtained. If the procedure or covered service is deemed not to be Medically Necessary and Appropriate, you will be held harmless, except when Highmark provides prior written notice to you that charges for the procedure or covered service will not be covered. In such case, you will be financially responsible for such procedure or covered service.

## **Retrospective Review**

Retrospective review may occur when a service or procedure has been rendered without the required precertification.

## **Case Management Services**

Case Management is a voluntary program in which a case manager, with input from you and your health care providers, assists when you are facing and/or recovering from a Hospital Admission, dealing with multiple medical problems or facing catastrophic needs. Highmark case managers can provide educational support, assist in coordinating needed health care services, put you in touch with community resources, assist in addressing obstacles to your recovery such as benefit and caregiver issues and answer your questions.

Highmark case managers are a free resource to all Highmark members. If you have an inpatient Hospital Admission, you may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, you may be contacted by a case manager from our Complex program. In either case, you are always free to call and request case management if you feel you need it by contacting Member Services at the telephone number listed on the back of your ID card.

## **C. PREScription DRUG MANAGEMENT**

Your prescription drug program through Express Scripts Inc. (ESI) provides the following provisions which will determine the medical necessity and appropriateness of covered medications and supplies.

### **Early Refill Authorization**

#### *Unexpected Event*

If your prescription is lost or stolen due to an event such as a fire or theft, you may be able to get an early refill. Call Customer Service at 1-800-753-2851 for help. You will need a copy of the report from the fire department, police department or other agency.

*Please note: The early refill authorization does not apply to events that can be controlled, such as spilling or losing the medicine.*

#### *Traveling Abroad*

If you will be out of the country when it is time to refill your prescription, call ESI Member Service for help. Be sure to have your ESI member ID card and your prescription information. Please allow at least five business days to complete the request.

### **Quantity Level Limits**

Quantity level limits may be imposed on certain Prescription Drugs by ESI. Such limits are based on the manufacturer's recommended daily dosage or as determined by ESI. Quantity level limits control the quantity covered each time a new prescription order or refill is dispensed for selected Prescription Drugs. Each time a prescription order or refill is dispensed, the Pharmacy provider may limit the amount dispensed.

### **Quantity Level Limits for Initial Prescription Orders**

Additional quantity level limits may be imposed for your initial prescription order for certain covered medications. In such instances, the quantity dispensed will be reduced to the level necessary to establish that you can tolerate the covered medication. Consequently, the applicable cost-sharing amount will be adjusted according to the quantity level dispensed for the initial prescription order.

### **Managed Prescription Drug Coverage**

A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied by ESI when presented to the pharmacy provider. ESI may contact the prescribing Physician to determine if the prescription drug

is Medically Necessary and Appropriate. If it is determined by ESI that the prescription is Medically Necessary and Appropriate, the prescription drug will be dispensed.

### **Preauthorization**

The prescribing Physician must obtain authorization from ESI prior to prescribing certain Prescription Drugs. The specific drugs or drug classifications which require preauthorization may be obtained by calling the toll-free Member Service telephone number appearing on your ESI ID card.

## **VIII. CLAIMS SUBMISSION**

### **A. HOW TO SUBMIT A CLAIM**

If you receive services from a Network provider, you will not have to file a claim. If you receive services from an Out-of-Network provider, you may be required to file the claim yourself.

If you receive medications from a Network Pharmacy and present your ESI ID card, you will not have to file a claim. If you forget your ESI ID card when you go to a Network Pharmacy, the Pharmacy may ask you to pay in full for the prescription.

The procedure is simple. Just take the following steps:

- Know Your Benefits. Review this information to see if the services you received are eligible under your medical program.
- Get an Itemized Bill. Itemized bills must include:
  - The name and address of the service or Pharmacy provider;
  - The patient's full name;
  - The date of service or supply or purchase;
  - A description of the service or medication/supply;
  - The amount charged;
  - For a medical service, the diagnosis or nature of Illness;
  - For durable medical equipment, the doctor's certification;

- For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
- For ambulance services, the total mileage;
- Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

Please note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- **Copy Itemized Bills.** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- **Complete a Claim Form.** Make sure all information is completed properly, and then sign and date the form. Medical claim forms can be downloaded from [blog.highmark.com](http://blog.highmark.com) by entering "forms" in the search box. Claim forms are also available from your employee benefits department, or call the Member Service telephone number on the back of your ESI ID card.
- **Attach Itemized Bills to the Claim Form and Mail.** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

***Remember: Multiple services or medications for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.***

***Your claims must be submitted no later than the end of the benefit period following the benefit period for which benefits are payable.***

### **Your Explanation of Benefits Statement**

When you submit a claim, you will receive an Explanation of Benefits (EOB) statement that lists:

- the provider's actual charge;
- the allowable amount as determined by ESI or Highmark;
- the copayment; deductible and coinsurance amounts, if any, that you are required to pay;

- total benefits payable; and
- the total amount you owe.

In those instances where you are not required to submit a claim because, for example, the Network provider will submit the bill as a claim for payment under its contract with ESI or Highmark, you will receive an EOB only when you are required to pay amounts other than your required copayment.

If you do not have access to a computer or prefer to continue receiving printed EOBS, please notify Member Service by calling the number on the back of your ID card.

### **How to Voice a Complaint**

In the event that you are dissatisfied with any aspect of your health care benefits or you have an objection regarding participating Health Care Providers, coverage, operations or management policies, please contact ESI or Highmark via the toll-free Member Service telephone number located on the back of your ID card or by mail at the address listed below. Please include your identification and group numbers as displayed on your ID card.

Highmark Blue Cross Blue Shield  
P.O. Box 226  
Pittsburgh, PA 15222

Express Scripts Inc.  
PO Box 66587  
St. Louis, MO 63166-6587

A representative will review, research and respond to your inquiry as quickly as possible. If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed by our Member Grievance and Appeals Department. For details about how this process works, please refer to the Appeals Process section of this booklet or call Member Service at the number on your member ID card.

### **Fraud or Provider Abuse**

If you think that a provider is committing fraud, please let us know. Examples of fraud include: Submitting claims for services that you did not get; Adding extra charges for services that you did not get; Giving you treatment for services you did not need. Please call the local state toll-free Fraud Hotline.

## **Additional Information on How to File a Claim**

### **Member Inquiries**

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting the Member Service Department using the telephone number on your ID card.

### **Authorized Representatives**

You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. ESI and Highmark reserve the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

### **Timing of Notice of Claim**

The Claims Supervisor will notify the claimant of any benefit determination within a reasonable period of time, but not later than the timeframe specified below depending on the type of claim.

### **Group Health Plan Claims**

Group health plan claims may involve urgent care, concurrent care claims, pre-service care claims or post-service care claims. Each has different timeframes that may apply and is described below.

**Urgent care.** The Claims Supervisor will notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the Claims Supervisor will notify the claimant as soon as possible, but no later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Supervisor will notify the claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the Plan's receipt of the specified information, or (B) the end of the period afforded the claimant to provide the specified additional information.

**Concurrent care** (a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments). The Plan will notify a claimant of any reduction or termination of a course of treatment (other than by Plan amendment or

termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care that will be decided as soon as possible, taking into account the medical exigencies, and the Claims Supervisor will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service claims (including requests for precertification). The Claims Supervisor will notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Supervisor both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Supervisor expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service claims. The Claims Supervisor will notify the claimant, of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Supervisor both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

## **B. CONTENT OF NOTICE OF DENIED CLAIM**

If a claim is wholly or partially denied, the Claims Supervisor will provide the claimant with a notice identifying:

1. Information sufficient to allow the claimant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if

- applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. the reason or reasons for such denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
  3. the pertinent Plan provisions on which the denial is based;
  4. any material or information needed to perfect the claim and an explanation of why the additional information is necessary;
  5. a description of the Plan's internal appeal and external review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review;
  6. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request;
  7. If the adverse benefit determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
  8. Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process; and
  9. In the case of an adverse benefit determination for a claim involving urgent care, a description of the expedited review process applicable to such claim. In addition, for urgent care claims, the notice of adverse benefit determination must be provided to the claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

**C. APPEALS PROCESS MEDICAL CLAIMS (SEE APPENDIX 5 FOR RX APPEAL PROCESS)**

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) and an external review for certain types of claims. The second and third levels of review are voluntary for pre-service claims. The third level of review is voluntary for all other types of claims eligible for a third level of review. In other words, you are not required to pursue a voluntary level of review before pursuing a claim for benefits in court. 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 without affording any deference to the initial adverse benefit determination. 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. If a health care professional is consulted, you may request the identity of such person.

In the case of a claim involving urgent care, the claimant may submit a request for an expedited appeal of an adverse benefit determination either orally or in writing. In addition, all necessary information, including the benefit determination, shall be transmitted between the Appeal Review Department and the claimant by telephone, facsimile, or other similarly expeditious method.

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 the following:

- The specific reason or reasons for the denial, including the denial code and its corresponding meaning, the standard, if any, that was used in denying the claim,

and a discussion of how that standard was applied in denying the claim. A discussion of the decision must also be included for final adverse benefit determinations.

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
- Reference to the specific Plan provision on which the denial was based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- A statement describing the internal appeal and external review procedures (including any voluntary appeal procedures) offered by the Plan, including information about the claimant's right to obtain the information about those procedures and how to initiate an appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the benefit denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the benefit denial is based on Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the person's special medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes.

## **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.

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 be tolled (i.e., not run) during the second level review; and
- Will not impose any additional fee or cost in connection with the second level review.

You are required to proceed with a second level of review for a post-service claim.

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 without affording any deference to the initial adverse benefit determination. 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. If a health care professional is consulted, you may request the identity of such person.

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 the following:

- The specific reason or reasons for the denial, including the denial code and its corresponding meaning, the standard, if any, that was used in denying the claim, and a discussion of how that standard was applied in denying the claim. A discussion of the decision must also be included for final adverse benefit determinations.
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
- Reference to the specific Plan provision on which the denial was based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- A statement describing internal appeal and external review procedures (including any voluntary appeal procedures) offered by the Plan, including information about the claimant's right to obtain the information about those procedures and how to initiate an appeal.

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the benefit denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the benefit denial is based on Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the person's special medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes.

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.

### **Third Level Review**

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. 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 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 will be tolled (i.e., not run) during the third level review; and
- Will not impose any additional fee or cost in connection with the third level review.

If you are dissatisfied with the decision following the second level review of your appeal, you may request to have the decision reviewed by the Benefit Plans Committee of the Board of Directors (BOD) of EPC Benefit Resources, Inc. A written request for review must be submitted to the Benefit Plans Committee of the BOD within 30 days after the decision on the second level appeal. Submit the request to:

EPC Benefit Resources Inc.  
Executive Director  
5850 T G Lee Blvd, Suite 510  
Orlando, FL 32822

In considering and deciding the appeal, the Benefit Plans Committee has the authority:

- To interpret the Plan, and to resolve ambiguities, inconsistencies and omissions in accordance with the intent of the Plan;
- To decide on questions concerning the Plan, in accordance with the provisions of the Plan; and
- To find facts and to grant or deny claims relating to enrollment, eligibility or the payment or nonpayment of benefits under the claims and appeals procedures described herein.

All decisions of the Benefit Plans Committee with respect to interpretations of the Plan, benefit determinations, and claims decisions, shall be made by the Benefit Plans Committee (or its delegate) in its sole discretion, and all such determinations and decisions shall be conclusive and binding on all persons to the maximum extent permitted by law.

If you are not satisfied with the decision of the Benefit Plans Committee of the BOD, you may request an external review for eligible appeals. Or you may choose not to review the appeal with the Benefit Plans Committee of the BOD and proceed directly to an external review for eligible appeals. If you have further questions regarding third level review of claims, you should contact Member Service using the telephone number on your ID card.

### **External Review**

You may request an external review after receiving a notice of final adverse benefit determination under the Plan's internal claim and appeals procedures. You may only request an external review if the appeal involves medical judgment or a rescission of coverage. You may not request an external review for a denial, reduction, termination or failure to provide payment for a benefit based on a determination that a Covered Person fails to meet the eligibility requirements under the terms of the Plan.

You have four months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. If there is not a corresponding date that is four months after receipt of the final adverse benefit determination, then the external review must be filed by the first day of the fifth month following receipt of the notice. If the filing deadline falls on a Saturday, Sunday or Federal

holiday, then the filing deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

## **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 the 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. If the request is complete but not eligible for review, the notice will state the reasons for the ineligibility for review 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 it considered when making its 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 forward any information you submit to the Plan within one business day so the Plan may reconsider the benefits denial. If the Plan decides to reverse its denial and provide coverage or payment, then the Plan must provide written

notice to you and the IRO within one business day after making this decision and the external review process will end.

In addition to the information and documents that you timely provide, the IRO will consider the following information, to the extent the information is available and appropriate for purposes of the review:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or insurer, claimant, or the claimant's treating provider;
- The terms of the Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan terms or applicable law; and
- The opinion of the IRO's clinical reviewer(s).

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:

- A general description of the reason for the external review request, including information sufficient to identify the claim;
- 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 the 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:

- 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
- the final internal adverse benefit determination involves (1) 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 (2) 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.

Upon receipt of your request for an expedited external review, Highmark will immediately conduct a preliminary review and will immediately notify send you the notice required for a standard external review (see the "External Review" section above).

### **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 is 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 it considered when making its final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.).

The IRO will consider the same documents and information applicable to the standard external review process described above. 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 the date it provides the non-written notice. The IRO's written notice must include the same information as the notice required for decisions during a standard external review (see the "External Review" section above).

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

## **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, 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 Reasonable and Customary 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. See the description of Medicare coverage included in the Eligibility, Funding, Effective Date and Termination Provisions section of this summary for additional information.
  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**

### **A. 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**

### **A. PLAN ADMINISTRATOR**

An individual, a committee, or a corporation may be appointed by the EPC to be Plan Administrator. The EPC has appointed EPC Benefit Resources Inc. as the Plan Administrator of the Plan. If the Plan Administrator resigns or is otherwise removed from the position, the EPC 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.

### **B. 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

As the EPC's Claims Supervisor, Highmark and ESI provides only administrative claims processing and payment services and does not assume any financial risk or obligation with respect to claims. Benefits are funded entirely by the EPC Benefits Plan Trust. Highmark

and ESI shall not be considered insurers, guarantors, or underwriters of any benefits under the Plan.

**C. PLAN IS NOT AN EMPLOYMENT CONTRACT**

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

**D. 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.

**E. AMENDING AND TERMINATING THE PLAN**

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

The EPC 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. PRIVACY STANDARDS**

**A. DEFINITIONS**

For purposes of this Article XII, words and phrases not otherwise defined herein which are defined in the Health Insurance Portability and Accountability Act of 1996, as amended, (“HIPAA”), and the regulations issued thereunder as set forth in 45 C.F.R. Parts 160, 162 and 164, as amended, (the “HIPAA Regulations”) shall have the meanings assigned therein when used herein. In the event of a conflict between the meaning of a word or phrase used herein with the definition given thereto in the Plan, the meaning given in this Article IX shall control.

**B. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

The Plan will use and disclose Protected Health Information without an authorization from the Individual only to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the HIPAA Regulations, including the following uses and disclosures:

1. **Payment**: For this purpose, Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits under the Plan or to obtain or to provide reimbursement for the provisions of Health Care that relate to an Individual to whom Health Care is provided. These activities include, but are not limited to, the following:
  - a) determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts) and adjudication or subrogation of benefit claims;
  - b) risk adjusting amounts due based on enrollee health status and demographic characteristics;
  - c) billing, claims management, collection activities, obtaining Payment under a contract for reinsurance (including stop-loss insurance and excess of loss coverage) and related Health Care data processing;
  - d) review of Health Care services with respect to medical necessity, coverage under a Health Plan, appropriateness of care or justification of charges;
  - e) utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services; and
  - f) disclosures to consumer reporting agencies of any of the following Protected Health Information relating to collection or premiums or reimbursement: name and address, date of birth, social security number, payment history, account number and name and address of Health Care Provider and/or Health Plan.
2. **Health Care Operations**: For this purpose, Health Care Operations include, but are not limited to, the following activities:
  - a) conducting quality assessment and improvement activities, including outcomes and evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;

- b) conducting population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, disease management, contacting Health Care Providers and patients with information about Treatment alternatives and related functions that do not include Treatment;
- c) reviewing the competence or qualifications of Health Care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of Health Care learn under supervision to practice or improve their skills as Health Care Providers, training of non-health care professionals, accreditation, certification, licensing or credentialing activities;
- d) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits and ceding, securing or placing a contract for reinsurance of risk relating to claims for Health Care (including stop-loss insurance and excess of loss insurance) provided certain requirements are met if applicable;
- e) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance review programs;
- f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration and development or improvement of Payment methods or coverage policies; and
- g) business management and general administrative activities of the Plan, including, but not limited to:
  - i. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
  - ii. customer service, including the provision of data analyses for policyholders, Plan Sponsors or other customers, provided the Protected Health Information is not disclosed to such policy holder, Plan Sponsor or customer;
  - iii. resolution of internal grievances;

- iv. the sale, transfer, merger or consolidation of all or part of the Plan with another Plan, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
  - v. consistent with the applicable requirements of 45 C.F.R. § 164.514, creating de-identified health information or a limited data set and fundraising for the benefit of the Plan.
3. **Treatment:** For this purpose, Treatment means the provision, coordination or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party, or consultation between Health Care Providers relating to a patient or the referral of a patient for Health Care from one Health Care Provider to another.

### **C. DISCLOSURE TO THE PLAN SPONSOR**

The Plan may disclose Protected Health Information to the Plan Sponsor or Plan Administrator as provided herein. However, the Plan may disclose Summary Health Information to the Plan Sponsor or Plan Administrator if the Plan Sponsor or Plan Administrator requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan or modifying, amending or terminating the Plan. In addition, the Plan may disclose to the Plan Sponsor information on whether an Individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

### **D. ADDITIONAL AGREEMENTS OF PLAN SPONSOR**

With respect to Protected Health Information, the Plan Sponsor and Plan Administrator further agree to:

1. not use or further disclose the information other than as permitted or required by the Plan document or as Required By Law;
2. ensure that any agents, including a subcontractor, to whom the Plan Sponsor or Plan Administrator provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor or Plan Administrator 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 Plan Sponsor or Plan Administrator unless authorized by an Individual;

4. report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. make available Protected Health Information to an Individual in accordance with HIPAA's access requirements and 45 C.F.R. § 164.524;
6. make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with HIPAA and 45 C.F.R. § 164.526;
7. make available the information required to provide an accounting of disclosures in accordance with HIPAA and 45 C.F.R. § 164.528;
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 Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;
9. if feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor or Plan Administrator 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 not feasible;
10. ensure that adequate separation between the Plan and Plan Sponsor and Plan Administrator (as described in subsection E below) is established and is supported by reasonable and appropriate security measures;
11. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan (except with respect to enrollment and disenrollment information and Summary Health Information and Protected Health Information disclosed pursuant to an authorization under 45 C.F.R. § 164.508) and ensure that any agents (including subcontractors) to whom it provides such Electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect such information; and

12. Report to the Plan any Security Incident of which it becomes aware.

**E. ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR AND PLAN ADMINISTRATOR**

In accordance with HIPAA and the HIPAA Regulations, only the following employees or classes of employees or other persons may be given access to Protected Health Information:

1. Stated Clerk
2. Chief Operating Officer
3. Board of Directors BRI
4. Executive Director BRI
5. Benefits Administrator BRI

The persons identified in this subsection E may only have access to Protected Health Information for Plan administration functions that the Plan Sponsor or Plan Administrator performs for the Plan. If the persons identified in this subsection E do not comply with the restrictions set forth in this Plan document and otherwise under HIPAA and the HIPAA Regulations, the Plan Sponsor or Plan Administrator shall respond to such noncompliance in accordance with the requirements of applicable law and the Plan Sponsor's policies, including as appropriate, the imposition of disciplinary sanctions.

**F. CONSISTENCY WITH HIPAA AND HIPAA REGULATIONS**

In the event any amendment of HIPAA or the HIPAA Regulations is adopted which renders any provision of this Article IX inconsistent therewith, this Article XII shall be deemed amended to be consistent therewith.

**G. OTHER USES AND DISCLOSURES OF HEALTH INFORMATION**

In addition to the above uses and disclosures, the Plan Sponsor or Plan Administrator may use and disclose Protected Health Information to the fullest extent permitted under HIPAA or the HIPAA Regulations.

### **XIII. GENERAL PLAN INFORMATION**

#### **A. 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 paid under the Plan is derived from the funds of the EPC Benefits Plan Trust.

**PLAN NAME:** Evangelical Presbyterian Church Medical Plan (which is offered as part of the Evangelical Presbyterian Church Benefits Plan)

**TAX ID NUMBER:** 81-4662231

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

**LAST REVISION DATE:** January 1, 2018

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

**PLAN SPONSOR:**

Evangelical Presbyterian Church  
5850 T.G. Lee Blvd., Suite 510  
Orlando, FL 32822

**PLAN ADMINISTRATOR:**

EPC Benefit Resources Inc.  
5850 T.G. Lee Blvd., Suite 510  
Orlando, FL 32822

**BENEFITS ADMINISTRATIVE OFFICE:**

Evangelical Presbyterian Church – Benefits Administrative Office  
60 Boulevard of the Allies, Fifth Floor  
Pittsburgh, PA 15222  
877-578-8707 | Fax 412-201-2250 | Email [EPC@cdsadmin.com](mailto:EPC@cdsadmin.com)

**AGENT FOR SERVICE OF LEGAL PROCESS:**

CSC  
601 Abbott Road  
East Lansing, MI 48823

**CLAIMS SUPERVISOR:**

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

Express Scripts, Inc.  
PO Box 66587  
St Louis, MO 63166-6587  
877-328-9660

**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

Express Scripts, Inc.  
Kim Piant, Privacy Officer  
Telephone Number: 314-692-1995

**PRIVACY OFFICIAL:**

Phil Edwards  
Evangelical Presbyterian Church - Benefits Administrative Office  
60 Boulevard of the Allies, Fifth Floor  
Pittsburgh, PA 15222  
877-578-8707

**XIV. MEDICAL - MEMBER SERVICES****Highmark - 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 appropriate 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 log onto Highmark's 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 Participants 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 conditions 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 Participants**

Non-English-speaking Participants 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**

### **PLATINUM COVERAGE OPTION**

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

Individual, In-Network Provider .....	\$450
Two Person, In-Network Provider.....	\$900
Family, In-Network Provider.....	\$1,350
Individual, Out-of-Network Provider.....	\$900
Two Person, Out-of-Network Provider.....	\$1,800
Family, Out-of-Network Provider.....	\$2,700

#### **Maximum out of pocket per Calendar Year:**

Individual, In-Network Provider .....	\$2,000
Two Person, In-Network Provider.....	\$3,000
Family, In-Network Provider.....	\$4,000
Individual, Out-of-Network Provider.....	\$4,000
Two Person, Out-of-Network Provider.....	\$6,000
Family, Out-of-Network Provider.....	\$8,000

**NOTE 1:** The maximums listed below are the total for In-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 In-Network and Out-of-Network providers.

**NOTE 2:** Prescription Drug expenses are included in the total needed to satisfy the out-of-pocket maximums per Calendar Year.

**NOTE 3:** Hospital Admissions must be pre-certified. Emergency admission must be reported within 48 hours of admission. A \$150.00 per admission penalty will be applied to Hospital expense benefits when certification is not obtained.

<b>BASIC BENEFITS (AFTER DEDUCTIBLE IS MET)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Pre-admission / Pre-surgical testing	90%	60%
Hospital Expense Benefit		
Daily Room and Board, Semi-Private Room Rate	90%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250
Mental Health, inpatient	90%	60%
Maximum Number of Days *	365 Days	365 Days
Co-Pay per Admission	\$250	\$250

<b>BASIC BENEFITS</b> <u>(AFTER DEDUCTIBLE IS MET)</u>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Substance Abuse, inpatient	90%	60%
Maximum Number of Days *	365 Days	365 Days
Co-Pay per Admission	\$250	\$250
Pregnancy Expense Benefit	90%	60%
Midwife	90%	60%
Co-Pay per Admission	\$250	\$250
Birthing Centers	90%	60%
Co-Pay per Admission	\$250	\$250

\*Inpatient care has a combined 365 day limit.

Surgical Expense Benefit	90%	60%
Inpatient Assistant Surgeon Expense	90%	60%
Optional second and subsequent surgical opinions	90%	60%
Consultations	90%	60%
Anesthesia	90%	60%
Organ Transplants	90%	60%
Infertility Counseling, Testing and Treatment Expense	90%	60%
Lifetime maximum	\$5,000	\$5,000
Inpatient Physician Visits	90%	60%
Outpatient Facility	90%	60%
Blood Services	90%	60%
Ambulance Service	90%	60%
Emergency Room Accident & Medical Treatment	100% after Co-Pay is not credited towards annual deductible. Co-Pay waived if admitted as an inpatient.	100% after \$150 Co-Pay
Urgent Care	100% after Co-Pay is not credited towards annual deductible.	60% \$35 Co-Pay
Retail Clinic	90%	60%

<b>MAJOR MEDICAL BENEFITS</b> <u>(AFTER DEDUCTIBLE)</u>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Primary Physician Office Visit	100% after Co-Pay is not credited towards annual deductible.	60%
\$25 Co-Pay	\$25 Co-Pay	
Specialist Office Visit	100% after Co-Pay is not credited towards annual deductible.	60%
\$50 Co-Pay	\$50 Co-Pay	
Home Health Care Services and Supplies	90%	60%
Maximum Number of Days	60 Days	60 Days
Hospice Care Services and Supplies	100%	100%
Deductible does not apply.		
Services rendered by Doctor of Chiropractic (DC)	50%	50%
<b>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.</b>		
Mental Health, Outpatient	90%	60%

<b><u>BASIC BENEFITS</u></b> <b><u>(AFTER DEDUCTIBLE IS MET)</u></b>	<b><u>IN-NETWORK</u></b>	<b><u>OUT-OF-NETWORK</u></b>
Substance Abuse, Outpatient	90%	60%
Skilled Nursing Facility	90%	60%
Maximum Number of Days	60 Days	60 Days
Co-Pay per Admission	\$250	\$250
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 5**

## **APPENDIX 2**

### **GOLD COVERAGE OPTION**

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

Individual, In-Network Provider .....	\$900
Two Person, In-Network Provider.....	\$1,800
Family, In-Network Provider.....	\$2,700
Individual, Out-of-Network Provider.....	\$1,800
Two Person, Out-of-Network Provider.....	\$3,600
Family, Out-of-Network Provider.....	\$5,400

#### **Maximum out of pocket per Calendar Year:**

Individual, In-Network Provider .....	\$4,000
Two Person, In-Network Provider.....	\$8,000
Family, In-Network Provider.....	\$12,000
Individual, Out-of-Network Provider.....	\$6,000
Two Person, Out-of-Network Provider.....	\$12,000
Family, Out-of-Network Provider.....	\$12,000

**NOTE 1:** The maximums listed below are the total for In-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 In-Network and Out-of-Network providers.

**NOTE 2:** Prescription Drug expenses are included in the total needed to satisfy the out-of-pocket maximums per Calendar Year.

**NOTE 3:** Hospital Admissions must be pre-certified. Emergency admission must be reported within 48 hours of admission. A \$150.00 per admission penalty will be applied to Hospital expense benefits when certification is not obtained.

<b>BASIC BENEFITS (AFTER DEDUCTIBLE IS MET)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Pre-admission / Pre-surgical testing	80%	60%
Hospital Expense Benefit		
Daily Room and Board, Semi-Private Room Rate	80%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250
Mental Health, inpatient	80%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250

<b>BASIC BENEFITS</b> <b>(AFTER DEDUCTIBLE IS MET)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Substance Abuse, inpatient	80%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250
Pregnancy Expense Benefit	80%	60%
Midwife	80%	60%
Co-Pay per Admission	\$250	\$250
Birthing Centers	80%	60%
Co-Pay per Admission	\$250	\$250

\*Inpatient care has a combined 365 day limit.

Surgical Expense Benefit	80%	60%
Inpatient Assistant Surgeon Expense	80%	60%
Optional second and subsequent surgical opinions	80%	60%
Consultations	80%	60%
Anesthesia	80%	60%
Organ Transplants	80%	60%
Infertility Counseling, Testing and Treatment Expense	80%	60%
Lifetime Maximum	\$5,000	\$5,000
Inpatient Physician Visits	80%	60%
Outpatient Facility	80%	60%
Blood Services	80%	60%
Ambulance Service	80%	60%
Emergency Room Accident & Medical Treatment	100% after	100% after
Co-Pay is not credited towards annual deductible.	\$150 Co-Pay	\$150 Co-Pay
Co-Pay waived if admitted as an inpatient.		
Urgent Care	100% after	60%
Co-Pay is not credited towards annual deductible.	\$35 Co-Pay	
Retail Clinic	100% after	60%
Co-Pay is not credited towards annual deductible.	\$30 Co-Pay	

<b>MAJOR MEDICAL BENEFITS</b> <b>(AFTER DEDUCTIBLE)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Primary Physician Office Visit	100% after	60%
Co-Pay is not credited towards annual deductible.	\$25 Co-Pay	
Specialist Office Visit	100% after	60%
Co-Pay is not credited towards annual deductible.	\$50 Co-Pay	
Home Health Care Services and Supplies	80%	60%
Maximum Number of Days	60 Days	60 Days
Hospice Care Services and Supplies	100%	100%
Deductible does not apply.		
Services rendered by Doctor of Chiropractic (DC)	50%	50%

**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.**

<b>MAJOR MEDICAL BENEFITS (AFTER DEDUCTIBLE)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Mental Health, Outpatient Co-Pay is not credited towards annual deductible.	100% after \$30 Co-Pay	60%
Substance Abuse, Outpatient Co-Pay is not credited towards annual deductible.	100% after \$30 Co-Pay	60%
Skilled Nursing Facility Maximum Number of Days	80% 60 Days	60%
Co-Pay per Admission	\$250	\$250
Orthotics (with Medical Necessity)	80%	60%
Therapy Services (with Medical Necessity)	80%	60%
Impacted Wisdom Teeth	80%	60%
Family and Marriage Counseling Co-Pay is not credited towards annual deductible.	100% after \$30 Co-Pay	60%
Contact lenses for treatment of keratoconus Calendar Year Maximum (if there are changes in prescription)	80% \$500	60% \$500
Above coverages for keratoconus are approved exceptions to the Plan. Special application must be made to Highmark.		

**PREScription DRUG EXPENSE BENEFIT -See Appendix 5**

## **APPENDIX 3**

### **GOLD HSA COVERAGE OPTION HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH A HEALTH SAVINGS ACCOUNT (HSA)**

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

Individual, In-Network & Out-of-Network Provider.....	\$2,700
Two People, In-Network & Out-of-Network Provider.....	\$5,400 combined
Family, In-Network & Out-of-Network Provider.....	\$5,400 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, In-Network Provider.....	\$6,000
Two Person, In-Network Provider.....	\$12,000
Family, In-Network Provider.....	\$12,000
Individual, Out-of-Network Provider.....	\$6,000
Two Person, Out-of-Network Provider.....	\$12,000
Family, Out-of-Network Provider.....	\$12,000

**NOTE 1:** The maximums listed below are the total for In-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 In-Network and Out-of-Network providers.

**NOTE 2:** Prescription Drug expenses are included in the total needed to satisfy the out-of-pocket maximums per Calendar Year.

**NOTE 3:** Hospital Admissions must be pre-certified. Emergency admission must be reported within 48 hours of admission. A \$150.00 per admission penalty will be applied to Hospital expense benefits when certification is not obtained.

<b>BASIC BENEFITS (AFTER DEDUCTIBLE IS MET)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Pre-admission / Pre-surgical testing	80%	60%
Hospital Expense Benefit		
Daily Room and Board, Semi-Private Room Rate	80%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250

<b>BASIC BENEFITS</b> <b>(AFTER DEDUCTIBLE IS MET)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Mental Health, inpatient	80%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250
Substance Abuse, inpatient	80%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250
Pregnancy Expense Benefit	80%	60%
Midwife	80%	60%
Co-Pay per Admission	\$250	\$250
Birthing Centers	80%	60%
Co-Pay per Admission	\$250	\$250

\*Inpatient care has a combined 365 day limit.

Surgical Expense Benefit	80%	60%
Inpatient Assistant Surgeon Expense	80%	60%
Optional second and subsequent surgical opinions	80%	60%
Consultations	80%	60%
Anesthesia	80%	60%
Organ Transplants	80%	60%
Infertility Counseling, Testing and Treatment Expense	80%	60%
Lifetime maximum	\$5,000	\$5,000
Inpatient Physician Visits	80%	60%
Outpatient Facility	80%	60%
Blood Services	80%	60%
Ambulance Service	80%	60%
Emergency Room Accident & Medical Treatment	80%	60%
Urgent Care	80%	60%
Retail Clinic	80%	60%

<b>MAJOR MEDICAL BENEFITS</b> <b>(AFTER DEDUCTIBLE)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Primary Physician Office Visit	80%	60%
Specialist Office Visit	80%	60%
Home Health Care Services and Supplies	80%	60%
Maximum Number of Days	60 Days	60 Days
Hospice Care Services and Supplies	80%	60%
Deductible does not apply.		
Services rendered by Doctor of Chiropractic (DC)	50%	50%
<b>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.</b>		
Mental Health, Outpatient	80%	60%
Substance Abuse, Outpatient	80%	60%

<b>MAJOR MEDICAL BENEFITS (AFTER DEDUCTIBLE)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Skilled Nursing Facility	80%	60%
Maximum Number of Days	60 days	60 days
Co-Pay per Admission	\$250	\$250
Orthotics (with Medical Necessity)	80%	60%
Therapy Services (with Medical Necessity)	80%	60%
Impacted Wisdom Teeth	80%	60%
Family and Marriage Counseling	80%	60%
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 5**

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## **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 HRA, and is used for setting aside money to pay for medical expenses. Plan Participants 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 – \$1,000 of the \$2,700 Annual Deductible payable monthly at \$83.33
  - b. All other categories – \$2,000 of the \$5,400 Annual Deductible payable monthly at \$166.67

**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 certain states, they lower your state taxable income. The IRS maximum annual contribution to an HSA for 2018 is \$3,450 for an individual, or \$6,900 for a family. Individuals age 55 and older can also make additional "make-up" contributions; the maximum for each eligible person in 2018 is \$1,000.

In order to make additional contributions through payroll deduction, contact our third party 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 Participants 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 America 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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## **APPENDIX 4**

### **SILVER COVERAGE OPTION**

**Calendar Year Deductible:**

Individual, In-Network Provider .....	\$1,350
Two Person, In-Network Provider.....	\$2,700
Family, In-Network Provider.....	\$4,050
Individual, Out-of-Network Provider.....	\$2,700
Two Person, Out-of-Network Provider.....	\$5,400
Family, Out-of-Network Provider.....	\$8,100

**Maximum out of pocket per Calendar Year:**

Individual, In-Network Provider .....	\$6,000
Two Person, In-Network Provider.....	\$12,000
Family, In-Network Provider.....	\$12,000
Individual, Out-of-Network Provider.....	\$10,140
Two Person, Out-of-Network Provider.....	\$12,000
Family, Out-of-Network Provider.....	\$12,000

**NOTE 1:** The maximums listed below are the total for In-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 In-Network and Out-of-Network providers.

**NOTE 2:** Prescription Drug expenses are included in the total needed to satisfy the out-of-pocket maximums per Calendar Year.

**NOTE 3:** Hospital Admissions must be pre-certified. Emergency admission must be reported within 48 hours of admission. A \$150.00 per admission penalty will be applied to Hospital expense benefits when certification is not obtained.

<b>BASIC BENEFITS (AFTER DEDUCTIBLE IS MET)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Pre-admission / Pre-surgical testing	70%	60%
Hospital Expense Benefit		
Daily Room and Board, Semi-Private Room Rate	70%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250
Mental Health, inpatient	70%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250

**BASIC BENEFITS**  
**(AFTER DEDUCTIBLE IS MET)**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Substance Abuse, inpatient	70%	60%
Maximum Number of Days*	365 Days	365 Days
Co-Pay per Admission	\$250	\$250
Pregnancy Expense Benefit	70%	60%
Midwife	70%	60%
Co-Pay per Admission	\$250	\$250
Birthing Centers	70%	60%
Co-Pay per Admission	\$250	\$250

\*Inpatient care has a combined 365 day limit.

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Surgical Expense Benefit	70%	60%
Inpatient Assistant Surgeon Expense	70%	60%
Optional second and subsequent surgical opinions	70%	60%
Consultations	70%	60%
Anesthesia	70%	60%
Organ Transplants	70%	60%
Infertility Counseling, Testing and Treatment Expense	70%	60%
Lifetime maximum	\$5,000	\$5,000
Inpatient Physician Visits	70%	60%
Outpatient Facility	70%	60%
Blood Services	70%	60%
Ambulance Service	70%	60%
Emergency Room Accident & Medical Treatment	100% after	100% after
Co-Pay is not credited towards annual deductible.	\$150 Co-Pay	\$150 Co-Pay
Co-Pay waived if admitted as an inpatient.		
Urgent Care	100% after	60%
Co-Pay is not credited towards annual deductible.	\$35 Co-Pay	\$35 Co-Pay
Retail Clinic	70% after	60%
Co-Pay is not credited towards annual deductible.	\$125 Co-Pay	\$125 Co-Pay

**MAJOR MEDICAL BENEFITS**  
**(AFTER DEDUCTIBLE)**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Primary Physician Office Visit	100% after	60%
Co-Pay is not credited towards annual deductible.	\$25 Co-Pay	\$25 Co-Pay
Specialist Office Visit	100% after	60%
Co-Pay is not credited towards annual deductible.	\$50 Co-Pay	\$50 Co-Pay
Home Health Care Services and Supplies	70%	60%
Maximum Number of Days	60 Days	60 Days
Hospice Care Services and Supplies	100%	100%
Deductible does not apply.		
Services rendered by Doctor of Chiropractic (DC)	50%	50%

**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.**

<b>BASIC BENEFITS</b> <b>(AFTER DEDUCTIBLE IS MET)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Mental Health, Outpatient	100% after \$50 Co-Pay	60%
Substance Abuse, Outpatient	70%	60%
Skilled Nursing Facility	70%	60%
Maximum Number of Days	60 Days	60 Days
Co-Pay per Admission	\$250	\$250
Orthotics (with Medical Necessity)	70%	60%
Therapy Services (with Medical Necessity)	70%	60%
Impacted Wisdom Teeth	70%	60%
Family and Marriage Counseling	70%	60%
Contact lenses for treatment of keratoconus	70%	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 5**

## **APPENDIX 5**

### **PRESCRIPTION DRUG EXPENSE BENEFIT**

Welcome to the Prescription Drug benefit, administered by Express Scripts, Inc. (ESI). To receive the highest level of benefits prescription drugs must be obtained from a Pharmacy in their national pharmacy network or directly via the Express Scripts Mail Service or Specialty Pharmacy. It is highly recommended that you take a moment and go to the ESI website at [www.expressscripts.com](http://www.expressscripts.com) and register; be sure to have your member ID number handy. Once registered you can access your plan details, the drug formulary, pharmacy network and other beneficial information. To minimize your out-of-pocket and co-pay costs ask your doctor or prescriber to consider generic drugs or when a generic is not available to consider formulary brand drugs on ESI's National Preferred Formulary (NPF) as may be medically appropriate. Once you have registered with ESI you can go to the ESI website and type in the name of any medication to determine if it is on the Formulary, if it is not there is a list of alternative medications that are on the Formulary that you can discuss with your doctor or prescriber.

Prescriptions dispensed for acute care (short-term) medications and initial fills of maintenance (long-term) medications may be obtained through any retail pharmacy for up to a 30-day supply. Short-term drugs include antibiotics and other medications that you take for short periods of time. Long-term drugs, also called maintenance medications, are those you take on an ongoing basis, such as drugs that treat high blood pressure, cholesterol or chronic diseases. Beginning January 1, 2018 maintenance medications are only available under the Smart90 program. For those using Specialty Medications, these are dispensed through Accredo Health Group, Inc. ESI's preferred Specialty Pharmacy under the Specialty Medication program. Each program is described below.

**Co-Payments for Short Term Medications** - Plan Participants are responsible for a retail co-payment for each 30- day supply according to the following schedule:

<b>For Participants in the Platinum, Gold, and Silver Coverage Options:</b>	
Co-payment, Generic:	\$10 for 30-day supply
Co-payment, Formulary Brand:	\$35 for 30-day supply
Co-payment, Non-Formulary Brand:	\$80 for 30-day supply
Participants pay 100% until full deductible is met, then are only responsible for the co-payment.	
<b>For Participants in the Gold HSA Coverage Options for 30-Day Supply:</b>	
Co-payment, Generic	Member pays 100% until full deductible
Co-payment, Formulary Brand	has been met, then participant is
Co-payment, Non-Formulary Brand	responsible for 20% co-payment.

**Long-Term Maintenance Medications Smart90 Program** - The Express Scripts Smart90 program allows you to pay less for each 90-day supply of maintenance medications than you would pay for three 30-day supplies at nonparticipating retail pharmacies. If you are currently receiving home delivery through the Express Scripts Mail Order Pharmacy you do not need to do anything further for those prescriptions. For new and existing prescriptions of maintenance medications you may receive up to two 30-day courtesy fills at any retail pharmacy that is not participating in Smart90 and pay the 30-day retail co-pay as stated above for each fill; however, you will receive notice from Express Scripts upon your first fill that you will need to move the prescription to a participating Smart90 network pharmacy prior to your third fill or the refill will be denied.

You can conveniently fill your maintenance prescriptions under the Smart90 program either by home delivery through the Express Scripts Mail Order Pharmacy or at any Walgreens or Walgreens owned retail pharmacy in the Smart90 network. If you are not currently using a Smart90 participating pharmacy you will need to obtain a new prescription from your doctor. Make sure your physician writes the prescription for a 90-day supply with up to a year's refills if allowed.

**Co-Payment for Long Term Maintenance Medications Smart90 Program** - Plan Participants using the Smart90 program will be dispensed up to a 90-day supply per fill and are responsible for a co-payment according to the following schedule:

<b>For Participants in the Platinum, Gold, and Silver Coverage Options:</b>	
Co-payment, Generic:	\$20 for 90-day supply
Co-payment, Formulary Brand:	\$70 for 90-day supply
Co-payment, Non-Formulary Brand:	\$160 for 90-day supply
Participants pay 100% until full deductible is met, then are only responsible for the co-payment.	
<b>For Participants in the Gold HSA Coverage Options:</b>	
Co-payment, Generic:	Member pays 100% of long-term medication until full deductible has been met, then participant is responsible for 20% co-payment.
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

You can review your 90-day options by logging in to express-scripts.com or calling Express Scripts at 866-890-1419. If you are a first-time visitor to express-scripts.com, take a minute to register (be sure you have your member ID number handy). You can also use the Express Scripts mobile app on your digital device to locate a participating pharmacy.

**Specialty Medications** are high-cost medications dispensed exclusively by Accredo Health Group, Inc. ESI's preferred Specialty Pharmacy. To determine if a medication you take is part of the Specialty Program you may review the list of impacted medications on the ESI website where you registered, or call the number on your ESI ID card, or by calling Accredo directly at 800-922-8279. Under this program specialty medications ordered for you or a covered family member by your physician or prescriber that are on the list will be covered only when ordered through Accredo and will no longer be covered through Highmark or when obtained from an outpatient clinic, a home infusion company, a doctor's office, or from another pharmacy. Should you be already receiving a Specialty Medication from a provider other than Accredo two refills will be permitted to allow time for you and your physician time to transfer your prescription after which you will be required to fill your prescription through Accredo. Please note that this program does not affect medications supplied by an emergency room or during an inpatient hospital stay.

Due to the high cost and special handling required of these medications each fill is limited to a maximum of a 30-day supply.

#### **Co-Payments for Specialty Medications dispensed through Accredo**

<b>For Participants in the Platinum, Gold, and Silver Coverage Options:</b>	
Co-payment, Generic:	Participant pays 20% of specialty medication up to a \$500 Maximum for up to a 30-day supply.
Co-payment, Formulary Brand:	Each fill is limited to a 30-day supply.
Co-payment, Non-Formulary Brand:	Participants pay 100% until full deductible is met, then are only responsible for the co-payment.
<b>For Participants in the Gold HSA Coverage Options:</b>	
Co-payment, Generic:	Member pays 100% of long-term medication until full deductible has been met, then participant is responsible for 20% of specialty medication up to a \$500 Maximum for up to a 30-day supply. Each fill is limited to a 30-day supply.
Co-payment, Formulary Brand:	
Co-payment, Non-Formulary Brand:	

All prescription drug coinsurance and co-payments count toward the combined medical and pharmacy maximum out-of-pocket expense.

## **PREScription PLAN EXCLUSIONS**

The drugs or drug categories listed below are not covered by the Prescription Drug part of the Plan:

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. Weight management agents.
10. Injectable drugs (a select list of injectable drugs are covered with prior authorization; questions in this regard should be directed to ESI).
11. Allergens.
12. Serums, toxoids and vaccines.
13. Prescription multivitamins, except pre-natal.
14. Dental pastes, gels and mouth washes except those containing Fluoride.
15. Drugs equivalent to over-the-counter drugs.
16. Alcohol swabs.
17. Blood glucose monitors.
18. Durable Medical Equipment.
19. Respiratory therapy peak flow meters.
20. Homeopathic Prescription Drugs.
21. Over-the-counter drugs except insulin and certain preventive care drugs specified herein.
22. Experimental drugs and medicines.

Contact ESI member services to discuss questions about your coverage of medications.

Should ESI 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 BOD has deemed that the Prescription Drug coverage offered by the 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 from <http://www.epc.org/benefits/forms/> a document titled "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.

In some cases, items excluded by the Prescription Drug portion of the Plan might be covered by the medical benefits portion of the 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 please follow the appeal procedure as outlined under "Express Scripts Reviews and Appeals Overview" below.

# **Express Scripts Reviews and Appeals Overview**

## **Purpose**

The purpose of this document is to outline the Express Scripts Reviews and Appeals procedures for Commercial clients.

## **Coverage review description**

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

**Clinical coverage review request:** A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

**Administrative coverage review request:** A request for coverage of a medication that is based on the Plan's benefit design.

## **How to request an initial coverage review**

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at [www.express-scripts.com/PA](http://www.express-scripts.com/PA).

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing. A Benefit Coverage Request Form, used to submit the request, is obtained by calling the Customer Service phone number on the back of your prescription card. Complete the form and mail or fax it to Express Scripts Attn: Benefit Coverage Review Department PO Box 66587 St Louis, MO 63166-6587. Fax 877 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone at 1 800-753-2851.

## **How a coverage review is processed**

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe  Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (Retail)  5 days (home delivery)	<u>Patient:</u> automated call (letter if call not successful)  <u>Prescriber:</u> Electronic or Fax (letter if not successful)	<u>Patient:</u> letter  <u>Prescriber:</u> Electronic or Fax (letter if not successful)
Standard Post-Service*	30 days	<u>Patient:</u> automated call and letter  <u>Prescriber:</u> Electronic or Fax (letter if fax not successful)	<u>Patient:</u> live call and letter  <u>Prescriber:</u> Electronic or Fax (letter if fax not successful)
Urgent	72 hours**	<u>Patient:</u> automated call and letter  <u>Prescriber:</u> Electronic or Fax (letter if fax not successful)	<u>Patient:</u> live call and letter  <u>Prescriber:</u> Electronic or Fax (letter if fax not successful)

\*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

\*\*Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

### **How to request a level 1 appeal or urgent appeal after an initial coverage review has been denied**

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical review requests: Express Scripts Attn: Clinical Appeals Department PO Box 66588 St Louis, MO 63166-6588. Fax 1 877- 852-4070

Administrative review Requests: Express Scripts Attn: Administrative Appeals Department PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone 1 800-753-2851 or fax 1 877- 852-4070. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

### **How a level 1 appeal or urgent appeal is processed**

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or an independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe  Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful)  Prescriber: Electronic or Fax (letter if fax not successful)	Patient: letter  Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 days	Patient: automated call and letter  Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter  Prescriber: Electronic or Fax (letter if fax not successful)
Urgent*	72 hours	Patient: automated call and letter  Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter  Prescriber: Electronic or Fax (letter if fax not successful)

\*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

### **How to request a level 2 appeal after a level 1 appeal has been denied**

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical review requests: Express Scripts Attn: Clinical Appeals Department PO Box 66588 St Louis, MO 63166-6588. Fax 877- 852-4070

Administrative review Requests: Express Scripts Attn: Administrative Appeals Department PO Box 66587 St Louis, MO 63166-6587. Fax 1 877-328-9660

An urgent level 2 appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone 1 800-753-2851 or fax 1 877- 852-4070. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

## **How a level 2 appeal is processed**

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a Pharmacist, Physician, panel of clinicians or an independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe	Notification of Decision	
Decisions are completed as soon as possible from receipt of request but no later than:			
		Approval	Denial
Standard Pre-Service	15 days	<u>Patient:</u> automated call (letter if call not successful)	<u>Patient:</u> letter
Standard Post-Service	30 days	<u>Prescriber:</u> Electronic or Fax (letter if fax not successful)	<u>Prescriber:</u> Electronic or Fax (letter if fax not successful)
Urgent*	72 hours	<u>Patient:</u> automated call and letter  <u>Prescriber:</u> Electronic or Fax (letter if fax not successful)	<u>Patient:</u> live call and letter  <u>Prescriber:</u> Electronic or Fax (letter if fax not successful)

\*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

## **When and How to request an External Review**

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to: MCMC IIc Attn: Express Scripts Appeal Program, 300 Crown Colony Drive. Suite 203, Quincy, MA 02169-0929. Phone: 1 617- 375- 7700 ext. 28253 Fax: 1 617- 375- 7683 and the request must be received within 4

months of the date of the final Internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

## **How an External Review is processed**

**Standard External Review:** MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

**Urgent External Review:** Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

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## **APPENDIX 6**

### **PREVENTIVE CARE SERVICES**

Below is a summary of the preventive care services covered under the Platinum, Gold, Gold HSA, and Silver coverage options.

#### **Preventive Care Services**

Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. The schedule of covered services is periodically reviewed based on the requirements of the Patient Protection Affordable Care Act of 2010, and advice from organizations such as the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto your Highmark member website, [www.highmarkbcbs.com](http://www.highmarkbcbs.com), or call Member Service at the toll-free telephone number listed on the back of your ID card.

#### **Adult and Pediatric Care**

Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history for adults, and other items and services. Well-woman benefits are provided for female members for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes and breastfeeding support and counseling.

#### **Adult Immunizations**

Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease.

#### **Diagnostic Services and Procedures**

Benefits are provided for routine screening tests and procedures, regardless of medical necessity and appropriateness.

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

All female members, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year.

## **Mammographic Screening**

Benefits are provided for the following:

- An annual routine mammographic screening for all female members.
- Mammographic examinations for all female members when such services are prescribed by a Physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified.

## **Pediatric Immunizations**

Benefits are provided to members through 18 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services.

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## **APPENDIX 7**

### **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 Wellness Profile will receive an incentive award.

**Question:** What is a Wellness Profile?

**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 Wellness Profile?

**Answer:** Go to the Highmark Blue Cross Blue Shield website, enter your login ID/password, and on the Member Home Page click on the Rewards program link.

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

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

- Full-Time Employees
- The covered spouse of a Full-Time Employee
- EPC retirees

**Question:** Must the Wellness Profile be completed during a particular time period to receive an incentive award to be determined each year by EPC Benefits

**Answer:** Yes – you must complete the Wellness Profile during the period January 1 – September 30, 2018.

**Question:** What is the amount of the incentive award?

**Answer:** You may contact EPC Benefits for the amount of the incentive award. The amount of the award is subject to change.

Additional information about the Wellness Program may be found on the EPC website at the following address under Medical Plan: <http://www.epc.org/benefits>. You may also contact EPC Benefits for information about the Wellness Program and the amount of the incentive award.

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## **APPENDIX 8**

### **EX -PAT GOLD COVERAGE OPTION**

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

Individual, Network Provider .....	\$900
Two Person, Network Provider.....	\$1,800
Family, Network Provider.....	\$2,700

Individual, International Provider.....	\$0
Two Person, International Provider.....	\$0
Family, International Provider.....	\$0

#### **Maximum out of pocket per Calendar Year:**

Individual, Network Provider .....	\$4,000
Two Person, Network Provider.....	\$8,000
Family, Network Provider.....	\$12,000

Individual, International Provider.....	\$0
Two Person, International Provider.....	\$0
Family, International Provider.....	\$0

**NOTE 1:** International claims paid will not be credited or accumulated for network deductible or out of packet maximums.

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#### **BASIC BENEFITS (AFTER DEDUCTIBLE IS MET)    NETWORK    INTERNATIONAL**

##### **Hospital Expense Benefit\***

Daily Room and Board, Semi-private Room Rate	80%	100%
Maximum Number of Days	365 Days	365 Days
Co-pay, per admission	\$250	\$0
Mental Health, inpatient*	80%	100%
Calendar Year Maximum	365 Days	365 Days
Co-pay, per admission	\$250	\$0
Substance Abuse, inpatient*	80%	100%
Calendar Year Maximum	365 Days	365 Days
Co-pay, per admission	\$250	\$0
Pre-admission / Pre-surgical testing	80%	100%
Birthing Centers	80%	100%

\*Inpatient care has a combined 365 day limit.

**BASIC BENEFITS (AFTER DEDUCTIBLE IS MET) NETWORK INTERNATIONAL**

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

Surgical Expense Benefit	80%	100%
Inpatient Assistant Surgeon Expense	80%	100%
Optional second and subsequent surgical opinions	80%	100%
Consultations	80%	100%
Anesthesia	80%	100%
Organ Transplants	80%	100%
Pregnancy Expense Benefit	80%	100%
Co-pay, per admission	\$250	\$0
Midwife	80%	100%
Infertility Counseling, Testing and Treatment Expense	80%	100%
Lifetime maximum	\$5,000	\$5,000
Inpatient Physician Visits	80%	100%
Outpatient Facility	80%	100%
Blood Services	80%	100%
Ambulance Service	80%	100%
Emergency Room Accident & Medical Treatment	100% after *Co-pay waived if admitted.	100%
Urgent Care or Retail Clinic	100% after *Deductible does not apply	100%
	\$150 co-pay per visit	
	\$35 co-pay per visit	

**MAJOR MEDICAL BENEFITS (AFTER DEDUCTIBLE)****NETWORK INTERNATIONAL**

Primary Physician Office Visit	100% after	100%
*Office visit co-pay is not credited toward annual deductible	\$25 co-pay per visit*	
Specialist Office Visit	100% after	100%
*Office visit co-pay is not credited toward annual deductible	\$50 co-pay per visit*	
Home Health Care Services and Supplies	80%	100%
Calendar Year maximum	60 days	
Hospice Care Services and Supplies (deductible does not apply)	100%	100%
Services rendered by Doctor of Chiropractic (DC)	50%	100%

**MAJOR MEDICAL BENEFITS (AFTER DEDUCTIBLE)****NETWORK    INTERNATIONAL**

**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 per visit*	100%
Substance Abuse, Outpatient	100% after \$30 co-pay per visit*	100%
Skilled Nursing Facility	80%	100%
Co-pay, per admission	\$250	\$0
Calendar Year Maximum	60 days	60 Days
Orthotics (with Medical Necessity)	80%	100%
Therapy Services (with Medical Necessity)	80%	100%
Impacted Wisdom Teeth	80%	100%
Family and Marriage Counseling	100% after \$30 co-pay per visit*	100%
*Deductible does not apply		
Contact lenses for treatment of keratoconus	80%	100%
Calendar Year Maximum (if 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 5**