

**BOARD OF PENSIONS
ADMINISTRATIVE RULES**

Section:	5	Subject:	PPO/PPO/HMO
OPTIONS			
Rule Number:	501		
Reference:		Resource:	Benefits
Article XIII, Sec. 13.4 (d)		Original Date:	1/95
		Revision Date:	1/97, 4/97, 3/98, 8/99, 1/03, 2/05

Effective 1/1/03, all PPO/HMOs will be discontinued except for the managed care offering in Mid-Kentucky Presbytery, and the provisions that are outlined in this rule will apply to all members who enroll in the BlueCard® PPO or Anthem Blue Preferred® Primary PPO/HMO.

Eligibility for PPO/PPO/HMO Option

- a. **Active Members, unemployed Members, disabled Members¹, early retirees and Continuation subscribers** will be eligible to select this option. Retired Members who are Medicare eligible when the PPO/PPO/HMO Option is offered and seminary students are not eligible to participate. Active Members who are Medicare eligible may elect this coverage.
- b. Election forms will be provided to each Member who has a current eligible status (defined in “a.” above). The forms are usually generated twelve weeks prior to the effective date of PPO/PPO/HMO coverage during the annual open enrollment period. A Member whose status undergoes a change prior to the effective date of the PPO/PPO/HMO coverage may:
- Request an Election Form if the status change continues and the member is eligible for the option
- OR,
- terminate the option if the status change is to an ineligible classification.

¹Between 1995 & 1997 inclusive, all disabled Members were eligible to elect the HMO/PPO option at open enrollment. Effective 1/1/98 disabled Members (and their spouses and dependent family members) who had not elected HMO/PPO coverage previously are ineligible to enroll on 1/1/98 or after.

In the latter case, the Member remains covered under the Medical provisions of the Plan until a status change. If such a change occurs, the Member may have the option to select the PPO/PPO/HMO coverage at that time, according to the rules of the Benefits Plan.

For a Member who is covered by this option and **subsequently** experiences a status change to an otherwise ineligible classification, the coverage will be maintained unless the Member elects otherwise as permitted by the rules for life event changes. An exception to this is retirement with eligibility for Medicare, in which case the Member reverts to eligibility for the Medicare supplement and PPO/PPO/HMO coverage is discontinued.

Member Couples

The Board refers to married couples who are both enrolled in the traditional coverage as active Members as “Member Couples”. Member Couples are eligible to choose between the following two options based on place of residence.

1. Member Couples maintaining residence at the same address cannot elect the same option. One Member must elect the PPO/PPO/HMO and the other Member must elect the medical coverage. We recommend that the member with the higher salary elect the PPO/PPO/HMO option. The medical deductible will then be determined on the basis of the lower salary. The PPO/PPO/HMO coverage is primary for the Member with this option.

If the family elects PPO/PPO/HMO medical coverage, each family member is covered once through the PPO/PPO/HMO and once through the Medical provisions of the Benefits Plan. A family member accessing care through the PPO/PPO/HMO network should use his/her PPO/PPO/HMO card. The medical card of the Benefits Plan should only be used for services outside the PPO/HMO network. No secondary coverage is available through the PPO/HMO if the services are delivered outside the PPO/HMO network.

Medical Continuation

Those Members (divorced spouses, spouses of retired members, ex-dependent children and terminated members) currently subscribing for Medical Continuation coverage **will** be offered the opportunity to participate in the PPO/PPO/HMO option, if applicable. The provisions of the Benefits Plan permit the following coverage periods for medical continuation subscribers:

- Voluntary or involuntary termination - 18 months
- Dependent children ceasing to be a dependent - 36 months
- Divorced Spouses - Coverage can be continued to age 65 at which time the Spouse reverts to eligibility for Medicare Supplement.
- Spouses of Deceased Members - Coverage can be continued to age 65 at which time the Spouse reverts to eligibility for Medicare Supplement.
- Member or Eligible family member becomes disabled – coverage can be extended from 18 months to 29 months, during first sixty days of the subscription period.
- Members ending Eligible Service and Eligible family members – 18 months, unless at the time the service ended the Member had minimum of 5 years of plan participation and is vested, age 55 years of age or older and the sum of years of plan participation (including free coverage period) and age equal 70 or greater then the member may continue to subscribe for medical coverage until he/she becomes eligible for Medicare.

A Member who experiences a status change while participating in a traditional plan will have the option to continue the PPO/PPO/HMO coverage through the Medical Continuation plan, assuming the Member is eligible for such Continuation. Also, Medical Continuation subscribers (e.g. divorced spouses or early retirees) are eligible to elect the PPO/PPO/HMO during an open enrollment period if previously enrolled under the medical plan. A newly divorced spouse may also elect the PPO/PPO/HMO option if the plan Member was covered through the Medical plan.

The subscription rate for PPO/PPO/HMO coverage through the Medical Continuation plan will be the same as the medical provision coverage, without regard to the actual PPO/PPO/HMO premium requirements. This policy aligns with the community nature of the Plan's funding design.

Enrollment Process - Initial and Annual Open Enrollment Period

Members (living in Mid-Kentucky Presbytery) will complete an Election Form for the Board of Pensions, specifying whether coverage under a PPO/HMO or the Medical provisions has been chosen. This form, together with the PPO/HMO enrollment form, if applicable, will be returned to the Member Services area at the Board for processing. Member Services will verify the completeness and accuracy of the form, update the Board's eligibility records, and forward the PPO/HMO enrollment form to the Anthem for processing.

Enrollments during the Plan Year (Calendar Year)

New Members

When the enrollment material for the Benefits Plan as a whole is sent to a potential Member, it will include the PPO/HMO enrollment form. The new Member's Election Form and PPO/HMO Enrollment form will be processed in the same way as the initial enrollment.

Transferring Members

When a Member **moves into** Mid-Kentucky Presbytery area, he/she will be offered the opportunity to participate in the available PPO/HMO. Member Services will send an Election Form to the Member when it receives notification of the transfer.

When a Member **moves out** of Mid-Kentucky Presbytery service area, he/she will be automatically transferred to the Medical provisions effective the first of the calendar month following date of notification.

Life Event Changes

If a Member experiences a qualifying life event change (marriage, divorce, birth or adoption of a child, change of employment, or loss of significant deterioration in current coverage), he/she may be able to choose between PPO/HMO and Medical coverage. When Member Services receives notification of the life event change, the team will generate a new election form if appropriate and send it to the Member, along with information about how to obtain the detailed PPO/HMO package, if applicable.

Annual Re-Enrollment Opportunity

Each Member residing in PPO/HMO service area will have the option once a year (most likely each October with coverage effective the following January) to choose coverage through the Medical provisions or through the PPO/HMO. The Board will provide each eligible Member with a new election form and information about how to obtain detailed PPO/HMO materials as needed.

Coverage Effective Date

PPO/HMO election made during any open enrollment will be effective on January 1 of the following year. For those newly eligible, PPO/HMO coverage will become effective on the first of the calendar month following the date of election. The PPO/HMO premiums will be paid on that basis. Similarly, when PPO/HMO coverage terminates, it will be at the end of the calendar month in which the Member Service Team was notified and the full monthly premium will be paid. The Medical provisions that automatically apply when no PPO/HMO election is in place will cover any gap in coverage because of the delayed effective date.

All changes relating to status changes, etc. will be effective on the first of the month following date of notification to the Board.

When a Member elects PPO/HMO coverage, he/she agrees to receive all medical benefits through the PPO/HMO rather than under the Medical provisions. A Member with PPO/HMO coverage **is not** eligible for any benefit under the Medical provisions of the Plan while the PPO/HMO election is in effect.

A Member with PPO/HMO coverage may not use the Express Scripts Pharmaceutical Services program nor is he/she eligible for any other benefit under the Medical provisions.

PPO/PPO/HMO Service Types

The types of services provided in the PPO/HMO packages being offered to Members are intended to reasonably parallel the services covered by the Medical provisions of the Plan. Limitations, exclusions and benefits payable differ between the programs. However, the PPO/HMO rules govern for any Member electing PPO/HMO coverage.

To the extent that dental, vision, or other services not covered by the Medical provisions are part of the PPO/HMO's basic package, they are included.

Deductible/Out-of-Pocket/Co-payment Credits

No credit is given for deductible, out-of-pocket or co-payment expenses when moving between the Medical provisions and the PPO/HMO option. For example, expenses incurred through March for a Member who elected PPO/PPO/HMO coverage effective April 1 are not subject to a prorated deductible, nor is anything credited toward the deductible going to have any impact on the PPO/HMO's co-payment requirements. If he/she elects PPO/HMO coverage, the credits are not considered in determining the co-payments due to the PPO/HMO. The same rules apply for Members who are transferred or have other life event changes and move between the Medical provisions and the Anthem PPO/HMO during the year.

If a Member moves from the Medical provisions to the PPO/HMO and then back to the Medical provisions during the course of a calendar year, then those expenses incurred toward the deductible etc. during the first period of Medical coverage will be considered in determining benefits during the second period of coverage.

Flexible Spending Accounts

Members may continue to use Flexible Spending Accounts as a means of pre-funding eligible out-of-pocket costs with pretax money. Deductible and co-payments amounts may be reimbursed through such vehicles. Because these are plans subject to IRC Sec. 125, Members **may not** change their FSA contribution levels mid year. This restriction applies to Members electing PPO/HMO coverage during the year.

Annual and Lifetime Limits under the Medical Provisions

Annual and lifetime limits under the Medical provisions of the Plan are cumulative. A Member who returns to the Medical provisions after a period of PPO/HMO coverage will be subject to the annual and lifetime limits applicable at the time he/she elected the PPO/HMO option

Preexisting Conditions Limitation

The Anthem PPO/HMO being offered to Members do not apply preexisting condition exclusions at initial enrollment or subsequent enrollment during the annual re-enrollment period. The Medical provisions will not apply any preexisting condition exclusion to a Member who elects this coverage after a period of PPO/HMO coverage **unless** the Member has not yet been covered through the Plan for a 12-month period. Coverage under a PPO/HMO Option is counted toward the 12-month requirement.

Contract Holder

The Board of Pensions and not the individual employing organizations will be the PPO/HMO contract holder.

Employing Organization Financial Responsibility

Each employing organization with Members enrolled the Anthem PPO/HMO will be liable for continued payment of the medical dues for that Member **until** the Board has been notified that the Member is no longer employed by that organization. **Retroactive notification cannot be accepted for any Member who is enrolled this PPO/HMO.** The Board will be remitting eligibility information and premium for the Member to the PPO/HMO until the Member Service Team is notified of the change in the Member's employment status. These premiums cannot be recovered and therefore the dues cannot be forgiven.

Premium Payment to the PPO/HMO

Premiums for the month will be paid promptly. Monthly premiums will be remitted on a self-bill basis. The Board of Pensions will remit a check for the monthly premium with our record of current monthly subscribers and in accordance with the agreed upon rates.