

Healthcare Coverage

The Medical Plan of the Benefits Plan of the Presbyterian Church (U.S.A.) provides healthcare coverage for members and their eligible family members. Employers offering Traditional coverage are responsible for payment of all dues. The member is responsible for all office visit copays, deductibles, and copayment amounts. (See the charts on the reverse side for deductible and copayment information.)

Eligibility

Employers are mandated to enroll installed clergy; they may enroll other clergy and lay employees who work at least 20 hours a week in eligible church or church-related service.

The Medical Plan Traditional Program covers all eligible family members:

- spouses
- children younger than 26, regardless of their financial dependency, student status, marital status, or residency
- dependent, totally disabled children covered under the plan before they reach age 26

Medical Plan Coverage

The Medical Plan is a PPO (preferred provider organization) plan. Members are encouraged to use network physicians and hospitals.

Hospital and Medical

The BlueCard® PPO is the primary network of physicians, hospitals, and other healthcare providers available to eligible plan members. It is administered on behalf of the Board by Highmark Blue Cross Blue Shield (BCBS), one of the largest BCBS organizations in the United States. Highmark provides access to the BlueCard PPO network nationally and to claims-processing services for eligible medical expenses.

Mental Health and Substance Abuse

Similarly, Cigna Behavioral Health provides network and claims administration services for treatment of mental health and substance abuse conditions. These networks cover all members except those residing in Puerto Rico or enrolled in a Louisville-area HMO or Cigna Global Health.

Deductibles, Office Visit Copays, and Copayments

Members in the Traditional Program are not responsible for dues payments, but they do contribute to the cost of their coverage through deductibles, office visit copays, and copayments.

The deductible is the amount of eligible medical expenses that a member must pay annually before the Medical Plan starts to reimburse a share of the costs. A member may be required to pay two deductibles: one for the member and one for the rest of the family. (See chart on the reverse side.)

Except for preventive care, members are also responsible to pay a fixed copay amount for each office visit: \$25 for primary care/\$45 for specialists.

After reaching the annual deductible amount, members are still responsible to pay a share of the cost of medical care up to a maximum annual amount. These payments are referred to as copayments and are a percentage of the allowable medical costs, up to a pre-determined annual limit. Deductibles and office visit copay amounts do not count toward the annual copayment maximum.

There are separate copay requirements for the vision benefit. (See “Vision & Hearing” under “Medical Benefits” on Pensions.org.)

There are also separate copayment requirements for prescription drugs coverage. (See chart on the reverse side.)

Members can reduce their costs by using network providers, generic drugs, when available, and prescription mail-order services.

See the *Guide to Your Healthcare Benefits 2012* for further information, available in January.

2012 Healthcare Deductibles and Copayment Maximums¹

Salary Range ²	Deductible ³		Copayment Maximum ⁴	
	Network and Non-Network 1.25%	Out of Network 2.50%	Network and Non-Network 4%	Out of Network 12%
\$0 - \$42,299	\$475	\$950	\$1,520	\$4,550
\$42,300 - \$46,699	\$530	\$1,060	\$1,690	\$5,075
\$46,700 - \$51,099	\$585	\$1,170	\$1,870	\$5,605
\$51,100 - \$55,499	\$640	\$1,280	\$2,045	\$6,130
\$55,500 - \$59,899	\$695	\$1,390	\$2,220	\$6,660
\$59,900 - \$64,299	\$750	\$1,500	\$2,400	\$7,190
\$64,300 - \$68,699	\$805	\$1,610	\$2,570	\$7,715
\$68,700 - \$73,099	\$860	\$1,720	\$2,750	\$8,245
\$73,100 - \$77,499	\$915	\$1,830	\$2,925	\$8,775
\$77,500 or more	\$970	\$1,940	\$3,100	\$9,300

¹ For covered inpatient and outpatient medically necessary services, not counting prescription drug costs and office copays.

² Deductibles and copayment maximums are rounded and based on the medical minimum salary of \$38,000, up to 70% of the maximum medical participation basis (\$117,000), or \$81,900.

³ Members with dependents are responsible for two deductibles, one for the member and one for all other family members combined. These are not counted toward the copayment maximum.

⁴ After a member reaches the annual copayment maximum, the Medical Plan pays 100% of eligible expenses up to the plan allowance, except for office visits. The copayment maximum applies to the member and family combined.

Type of Pharmacy	Maximum fill	Your cost per prescription*		
		Generic	Formulary	Non-Formulary
Retail pharmacy	Up to a 30-day supply	\$8	30% of cost; min \$20 to max \$100	50% of cost; min \$50 to max \$150
Mail-order service	Up to a 90-day supply	\$20	30% of cost; min \$50 to max \$300	50% of cost; min \$125 to max \$450

* The maximum amount you pay each year in out-of-pocket prescription costs is \$2,500. This does not apply to non-formulary drugs or surcharges.

If any discrepancy exists between this product sheet and the official Benefits Plan document, the official plan document governs. Call the Board of Pensions at 800-773-7752 (800-PRESPLAN), or access the website at Pensions.org, for a copy of this official document.