

Clergy Group Health & Pension Benefits

Health and Pension benefits provided by the Texas Annual Conference are unprecedented within the Denomination. In addition, both the Group Health Benefits and Pension committees have reserves for unexpected events (market downturns or cost increases).

Group Health Benefits offers two PPO plans (a \$500 deductible and a high deductible plan). These options allow clergy to choose how they want to fund their health care expenses and whether they want to take advantage of tax laws to expand their coverage through a high deductible plan which allows participants to open a Health Savings Account (HSA). A voluntary dental and vision plan is also available.

Finally, the Conference's partnership with The Methodist Hospital provides a cost effective way for clergy to receive high quality medical care ([click here](#)) to view Methodist Hospital benefits and the ability to participate in the Wellness Program ([click here for more information](#)).

Prior to CRSP, the MPP program provided an excellent way for clergy to save for retirement. With the Texas Annual Conference's CAC among the highest in the denomination, clergy were able to accrue significant amounts for retirement. With CRSP, the Texas Annual Conference still provides additional benefits over and above those required by General Conference legislation. Additional benefits include;

1. **Contribution to UMPIP:** Local churches make an extra 1% contribution to the clergy person's UMPIP.
2. **Sustentation Fund:** Which provides Interim Ministry support for local congregations; Special assistance to Clergy and their families; Provision for short term sabbaticals; and it pays for a percentage of the health care cost for clergy appointed to Incapacity Leave.
3. **The Reserve Fund:** The Reserve Fund provides protection against changes in market performance, since the Annual Conference has financial liability for the defined benefit portion of the pension and any market losses.

The group health benefits are managed by a committee of the Texas Annual Conference which assumes fiscal responsibility for the operation of the plan ([click here](#) to view current committee members). The CRSP pension plan benefits are determined by General Conference and implemented by the General Board of Pensions. The Board of Pensions of the Texas Annual Conference ([click here](#) to view current committee members) has responsibility to oversee the plan and decide on past service rates. Both group health benefits and the pension plan are administered by the benefits office ([click here](#) to view a list of the current employees).

Click on the appropriate hyperlink below to view the benefits provided to clergy persons or to access the Clergy Compensation reporting system through Logical Pathways.

[Group Health Benefits](#) [Pension Benefits](#)
[Clergy Compensation Reporting System](#)

Any conflict between the descriptions provided on these pages and the plan documents, the plan document will control.

Clergy Group Health Benefits

Clergy health care expenses are paid for from 3 sources;

1. Personal contributions from the clergy.
2. Church (entity) contributions.
3. Apportionments (line item 181).

The personal contribution and church contributions are a percentage of salary and are collected by electronic funds transfer (EFT) monthly. All 3 revenue sources are used to pay eligible expenses under the plan. If at the end of the year it is determined that collections exceeded costs during the year, the excess is reported to Annual Conference and held in reserve for future use. The interest income earned on the group health benefit committee reserve is integrated into the financial forecast which is used to forecast the coming year's contribution amounts.

Clergy have a choice of 2 options regarding their health care.

1. A self insured traditional deductible PPO plan which has a \$500 medical deductible and a separate \$50 prescription drug deductible. [Click here](#) to review a summary of the benefits provided under this plan or [click here](#) to review the plan document where you can find specific answers to benefit questions.
2. A self insured high deductible PPO plan which for 2010 has a \$1,200 deductible for single and a \$2,400 deductible for family. The high deductible plan requires that both medical and prescription drug expenses be paid by the participant until the deductible is satisfied (ScriptCare does provide a discount card which gives the member a % discount off the cost of prescription drugs). [Click here](#) to review a summary of the benefits provided under this plan or [click here](#) to review the plan document where you can find specific answers to benefit questions.
3. The HMO option previously available will terminate as of June 1, 2010. [Click here](#) to review a summary of the benefits provided under this plan or [click here](#) to review the plan document where you can find specific answers to benefit questions.

Click on the appropriate link below for more information on the various plans and requirements of the plan.

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Rate Sheet for \$500 deductible PPO

| | |
|---|------------------|
| | Boon Chapman PPO |
| Traditional Plan | |
| Church Contribution (with housing) | 7.2% |
| | |
| Clergy Contribution (with housing) | |
| Up to \$44,999 | 6.86% |
| \$45,000 and up | 8.35% |
| | |
| High Deductible Plan | |
| Up to \$44,999 | 5.8% |
| \$45,000 and up | 6.68% |
| | |
| | |
| Medicare Primary for Incorporated Churches with less than 20 employees | Boon Chapman PPO |
| | |
| Clergy Contribution with Medicare primary | |
| Up to \$44,999 | |
| Clergy over 65 with under 65 spouse | 5.08% |
| Clergy & Spouse over 65 | 4.0% |
| | |
| \$45,000 and above | |
| Clergy over 65 with under 65 spouse | 5.87% |
| Clergy & Spouse over 65 | 3.93% |
| | |
| | |
| Monthly direct billing rates | Boon Chapman PPO |
| Active employee | |
| Employee | \$856.81 |
| Employee & Spouse | \$1,639.89 |
| Employee & Children | \$1,639.89 |
| Employee and Family | \$1,639.89 |
| | |

Clergy enrolled in the Group Health benefit plan are allowed to enroll all of their eligible dependents for the same personal contribution amount. However, the dependent must be listed with the Group Health Benefits office to be covered.

Rate Sheet for HMO

| | |
|---|---------------------------------|
| | UniCare HMO |
| Traditional Plan | |
| Church Contribution (with housing) | 7.2% |
| | |
| Clergy Contribution (with housing) | |
| Up to \$44,999 | 12.12% |
| \$45,000 and up | 14.77% |
| | |
| High Deductible Plan | |
| Up to \$44,999 | N/A |
| \$45,000 and up | N/A |
| | |
| Medicare Primary for Incorporated Churches with less than 20 employees | UniCare Private Fee For Service |
| | |
| Clergy Contribution with Medicare primary | |
| Up to \$44,999 | |
| Clergy over 65 with under 65 spouse | 5.08% |
| Clergy & Spouse over 65 | 4.0% |
| | |
| \$45,000 and above | |
| Clergy over 65 with under 65 spouse | 5.87% |
| Clergy & Spouse over 65 | 3.93% |
| | |
| Monthly direct billing rates | UniCare HMO |
| Active employee | |
| Employee | \$725.45 |
| Employee & Spouse | \$1614.09 |
| Employee & Children | \$1,107.38 |
| Employee and Family | \$2,106.21 |
| | |

Clergy enrolled in the Group Health Benefits plan are allowed to enroll all of their eligible dependents at no additional cost. However, in order for eligible dependents to be covered, the clergy *must complete an enrollment form* listing all eligible dependents desiring coverage with the Group Health Benefits Office.

Rate Sheet High Deductible Plan

| | Boon Chapman PPO |
|------------------------------------|------------------|
| Traditional Plan | |
| Church Contribution (with housing) | 7.2% |
| | |
| | |
| High Deductible Plan | |
| Up to \$44,999 | 5.8% |
| \$45,000 and up | 6.68% |
| | |

Clergy enrolled in the Group Health Benefits plan are allowed to enroll all of their eligible dependents at no additional cost. However, in order for eligible dependents to be covered, the clergy *must complete an enrollment form* listing all eligible dependents desiring coverage with the Group Health Benefits Office.

Rate Sheet for Comparison

| | | |
|---|---------------------------------|----------------------------|
| | UniCare HMO | Boon Chapman PPO |
| Traditional Plan | | |
| Church Contribution (with housing) | 7.2% | 7.2% |
| | | |
| Clergy Contribution (with housing) | | |
| Up to \$44,999 | 12.12% | 6.86% |
| \$45,000 and up | 14.77% | 8.35% |
| | | |
| High Deductible Plan | | |
| Up to \$44,999 | N/A | 5.8% |
| \$45,000 and up | N/A | 6.68% |
| | | |
| Medicare Primary for Incorporated Churches with less than 20 employees | UniCare Private Fee For Service | Boon Chapman PPO |
| | | |
| Clergy Contribution with Medicare primary | | |
| Up to \$44,999 | | |
| Clergy over 65 with under 65 spouse | 5.08% | 5.08% |
| Clergy & Spouse over 65 | 4.0% | 4.0% |
| | | |
| \$45,000 and above | | |
| Clergy over 65 with under 65 spouse | 5.87% | 5.87% |
| Clergy & Spouse over 65 | 3.93% | 3.93% |
| | | |
| Monthly direct billing rates | UniCare HMO | Boon Chapman PPO |
| Active employee | | |
| Employee | \$725.45 | \$856.81 |
| Employee & Spouse | \$1614.09 | \$1,639.89 |
| Employee & Children | \$1,107.38 | \$1,639.89 |
| Employee and Family | \$2,106.21 | \$1,639.89 |
| | | |
| Retirees | UniCare Private fee For Service | Boon Chapman PPO |
| 40 + Years of Service | | |
| Single & over 65 | \$168.30 | \$172.81 |
| Family | Based on age of dependents | Based on age of dependents |
| | | |
| Retiree 65 with Medicare Primary | | |
| Single | \$168.30 | \$172.81 |

| | | |
|---|------------------------------------|------------------|
| Retiree & spouse age 65 | | |
| Family | \$318.73 | \$288.02 |
| Retiree with under age 65 dependent or – Retiree under age 65 with dependent on Medicare (Under age 65 individual on Boon Chapman) | \$618.25 | \$635.21 |
| | | |
| Retiree under 65 | UniCare HMO | Boon Chapman PPO |
| Single | N/A | \$856.81 |
| Family | N/A | \$1,639.89 |
| | | |
| | UniCare Private Fee For Service | |
| Surviving Spouse over 65 | | |
| Single | \$168.30 | \$172.81 |
| Children not on Medicare | \$467.53 | \$484.50 |
| Surviving spouse under 65 | | |
| Single | N/A | \$430.68 |
| Children | N/A | \$484.50 |
| | | |
| Pre 92 Retirees with subsidy approved at 2007 Annual Conference | UniCare Private Fee For Service | Boon Chapman PPO |
| Retiree and spouse over 65 | | |
| Single | \$123.30 | \$127.81 |
| Retiree & Spouse | \$373.73 | \$243.02 |
| | | |
| Retiree with under age 65 dependent (Under age 65 dependent on Boon Chapman) | \$573.24 | \$590.21 |
| | | |
| Contingent Annuitants over 65 | | |
| Single | \$134.55 | \$139.06 |
| With under 65 dependent | \$433.78 | \$452.45 |
| | | |
| Contingent Annuitants under 65 | | |
| Single | N/A | \$396.93 |
| With dependents | N/A | \$450.75 |
| | | |
| Continuation of Coverage | UniCare HMO | Boon Chapman PPO |
| Single | \$741.70 | \$875.68 |
| Employee & Spouse | \$1,648.11 | \$1,674.42 |
| Employee & Children | \$1,131.27 | \$1,674.42 |
| Employee & Family | \$2,150.07 | \$1,674.42 |
| | | |
| Rates include EAP cost | | |

Texas Annual Conference Unicare HMO Plan Effective 1/1/10 Plan Terminates June 1, 2010

Once you determine that UniCare's HMO is the right plan for you, you will need to select a "primary care physician", (PCP). Choosing the right PCP is one of the most important decisions you can make. That is because your PCP is your personal physician who coordinates all your health care—from routine health assessments to hospitalizations. Whenever you want medical attention, call your PCP first. If you need a hospital stay or a specialist's attention, your PCP will make all the necessary referrals. You can request a PCP change at any time by calling customer service. The change will be effective on the first of the following month. In addition, if you are a female enrollee you may choose an OB-GYN as your "woman's principal health care provider" in addition to your PCP. Your PCP and OB-GYN must have a referral relationship.

Please note that the HMO contracts with both the Kelsey-Seybold clinics and independent providers. If you choose a Kelsey-Seybold provider, then all your care will be accessed through the Kelsey-Seybold providers (PCP/Specialists). If you choose an independent PCP, all your care will be accessed with the independent providers.

If you need assistance or more information about PCP's, please call a customer service representative, Monday through Friday between the hours of 7:30am to 6:00pm CST at 1-**800-451-0608**. In addition, the list of PCP's is located on the UniCare website: www.unicare.com. Click on "Find a Doctor/Hospital" and follow the steps provided. There are over 5,000 PCP's and Specialists to choose from and over 50 hospitals in Houston and the surrounding counties.

If you or another covered plan member in your family needs care for a mental health or chemical dependency problem, you can seek treatment without going through your PCP and still be eligible for benefits. Call IRG at **1-800-438-7758**.

The Pharmacy benefits are handled through Wellpoint Pharmacy (retail) and PrecisionRX (mail order)--both companies are apart of the UniCare family of companies. If you have any questions regarding the benefits, the formulary list, please go to the UniCare website: www.unicare.com or call the following:

- Wellpoint Pharmacy: **1-888-214-4844**
- PrecisionRX: **1-866-274-6826**

UniCare provides the extras that help you get more from your health plan. Members can access valuable health-related articles and resources through the Healthy Living section of the www.unicare.com. Our HealthyExtensions program is designed to help you and your family take a personal path toward wellness.

Simply logon to the website and click on the “Health Living” section and then select “HealthyExtensions”. You will find an array of products, services and alternative health resources. Whether you order by telephone or online, be sure to let the vendor know that you are a UniCare member. Give your ID number from your UniCare ID or HealthyExtension member ID card so you get the maximum discounts on products and services

UniCare’s online service provides you and covered members access to most of the information you will need. By logging on to the website, www.unicare.com, the select “Member Services” you will find information and answers to many of the specific benefit questions. First time users will need to register their information. Once you are fully logged in, you will be able to view plan specific benefits, view explanation of benefits, select a new PCP, view HMO providers, check status of a claim , order ID cards and obtain information in the HealthyExtension program.

- [Click here to find a UniCare provider](#)
- [Click here to learn about the UniCare prescription drug formulary](#)

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| Basics | Your Doctor | | Each member should choose a primary care physician from the provider directory. That primary care physician is responsible for providing referrals for specialty care. Female members may access, in addition to her PCP, a network obstetrician/gynecologist to provide care within the scope of that specialty. To make these selections, call Customer Services. | | |
| | Annual Deductible (if applicable) | | None | | |
| | Out-of-Pocket Maximum | Individual | Aggregate copays for basic health care services will not exceed \$3,000 per calendar year. | | |
| | | Family | Aggregate copays for basic health care services will not exceed \$6,000 per calendar year. | | |
| | Lifetime Maximum | | Unlimited | | |
| Pre-existing Condition Limitations | | Does not apply | | | |
| Service | Coverage | Description of Coverage | Health Care Plan Covers | You Pay | |
| Physician Office Visits & Other Services | Doctor's Office Visits; including but not limited to physical exams; treatment of illness and injury; allergy tests/shots; diagnostic | Primary Care Physician (PCP), per visit | 100% after \$25 copay | \$25 copay | |
| | | Specialist, per visit | 100% after \$45 copay | \$45 copay | |

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|--|---|--|------------------------|-------------|
| | tests, imaging or X-rays | | | |
| | Well Child Care | From birth | 100% after \$45 copay | \$45 copay |
| | Well Child Immunizations | From birth through six (6) years of age | 100% | No copay |
| | Pediatric & Adult Immunizations | From age seven (7) | 100% after \$45 copay | \$45 copay |
| | Annual Self-Referred Well-Woman GYN Exam | PCP | 100% after \$45 copay | \$45 copay |
| | CAT, MRI, MRCT or MRMRA, PET scan or Nuclear Cardiac scan | Per procedure | 100% after \$150 copay | \$150 copay |
| Physician Inpatient Visits & Other Services | Physician Visits to a Member | Includes visits that take place in a hospital, emergency room, skilled nursing facility, visits in which surgery is performed and visits to the home | 100% | No copay |

FOR CUSTOMER SERVICE – Please call the toll-free number on your ID card

| Service | Coverage | Description of Coverage | Health Care Plan Covers | You Pay |
|--|---|---|--|-----------------------------|
| Hospital & Related Services | In-Patient Room & Board | Semi-Private or Intensive Care Unit | 100% after \$1,500 copay per admission | \$1,500 copay per admission |
| | Other Inpatient Services & Supplies | Normal daily services, x-ray services, laboratory and other diagnostic tests and drugs, medications, and anesthesia | 100% | No copay |
| | Emergency Room Services <i>(Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in serious jeopardy of the person's health, serious impairment to bodily functions, or serious dysfunction of any organ or part)</i> | Copay waived if admitted as an inpatient within 24 hours | 100% after \$150 copay | \$150 copay |
| | Urgent Care Services / After Hours Clinics | Per visit | 100% after \$70 copay | \$70 copay |
| Out-Patient Services & Supplies | Outpatient Surgery | Includes cardiac catheterizations | 100% after \$500 copay per admission | \$500 copay per admission |
| | Diagnostic Tests & X-rays | At a participating hospital or facility | 100% after \$75 copay | \$75 copay |
| | Radiation Therapy, Chemotherapy or Dialysis Services | Specialty Care; per visit | 100% after \$75 copay | \$75 copay |
| Pregnancy Related Services | Services & Supplies Related to Pregnancy | PCP; copay applies to initial visit only | 100% after \$25 copay | \$25 copay |
| | | Specialist; copay applies to initial visit only | 100% after \$45 copay | \$45 copay |

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|--|--|--|-------------------------|-------------------------|
| | Services Related to the Treatment of Infertility | After a diagnosis of Infertility has been made | 50% of Reasonable Costs | 50% of Reasonable Costs |
|--|--|--|-------------------------|-------------------------|

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| Service | Coverage | Description of Coverage | Health Care Plan Covers | You Pay |
|-----------------------|---|---|--|---------------------------------|
| Other Services | Physical Therapy, Occupational Therapy and Speech & Hearing Therapy | Specialty care; per visit or service rendered or received on an out-patient basis | 100% after \$75 copay | \$75 copay |
| | Emergency Ambulance Transportation | Transportation to or from the nearest hospital | 70% per service | 30% per service |
| | Skilled Nursing Facility Services | 60 days maximum per calendar year; copay waived if transferred from another inpatient setting | 100% after \$500 copay per admission | \$500 copay per admission |
| | Home Health Care | Specialty care per visit or service; includes skilled nursing visits, physical and occupational therapy, speech therapy | 100% of reasonable charges | No copay |
| | Hospice Care Services | \$10,000 lifetime maximum; includes bereavement counseling for family members | 100% per admission/period of service | No copay |
| | Durable Medical Equipment (DME) | \$2,500 calendar year maximum | 70% of reasonable charges | 30% copay of reasonable charges |
| | Prosthetic and Orthotic Devices | No annual maximum | 70% of reasonable charges | 30% copay of reasonable charges |
| | Wigs for Chemotherapy Patients | Up to a limit of \$500 | 100% | No copay |
| | TMJ / CMJ | Includes diagnostic and/or surgical treatment | 100% after \$2,000 copay per admission | \$2,000 copay per admission |

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| Service | Coverage | Description of Coverage | Health Care Plan Covers | You Pay |
|-------------------------------------|---|--|--|---|
| Mental Health Services | Inpatient Mental Illness | Coverage for semi-private accommodations , no day limits | 100% after \$1,500 copay per admission | \$1,500 copay per admission |
| | Outpatient Mental Illness | Unlimited visits for outpatient treatment, group and/or individual, per calendar year | 100% after \$25 PCP or \$45 specialist copay | \$25 PCP or \$45 specialist copay |
| | Intensive Outpatient Mental Health Services | Includes services in a Psychiatric Day Treatment Facility, Crisis Stabilization Unit or Residential Treatment Center for Children or Adolescents | 100% after \$500 copay per inpatient admission/defined outpatient treatment program (waived if a continuation of an inpatient episode) | \$500 copay per inpatient admission/defined outpatient treatment program (waived if a continuation of an inpatient episode) |
| Chemical Dependency Services | Inpatient Chemical Dependency | Coverage for semi-private accommodations , no day limits | 100% after \$1,500 copay per admission | \$1,500 copay per admission |
| | Outpatient Chemical Dependency | Includes diagnosis, medical treatment and referral services, no visit limits | 100% after \$25 PCP or \$45 specialist copay per service | \$25 PCP or \$45 specialist copay per service |

FOR CUSTOMER SERVICE – Please call the toll-free number on your ID card

The information provided is only an illustrative summary. Refer to your benefits plan booklet, the Group Service Agreement, (which is provided to you after enrollment) for details of your coverage. To be eligible for benefits, an employee and his/her dependents must reside, live or work within the UNICARE service area. Additional eligibility criteria may be required by the employer's benefits or human resources department(s). In the event information in this Summary of Benefits differs from information in the Group Service Agreement, the information in the Group Service Agreement will prevail.

Medical benefits are **NOT** payable under the UNICARE HMO plan for any of the following:

1. Any care, treatment, services or supplies received outside of the Service Area – except for emergency health care services or as otherwise provided for under this Group Services Agreement (GSA).
2. Services and supplies not provided, authorized or prescribed by or under the direction of a Member's Primary Care Physician, authorized specialist, or authorized by the Health Plan.
3. Hearing aids, eye glasses, eye refractions, refractive eye surgery or contact lenses, and the fitting thereof, except for the initial pair of eyeglasses or contact lenses up to a retail value of \$100 needed due to cataract surgery, unless coverage for these items is expressly provided by rider to or amendment of the GSA. This will not apply to the necessary diagnostic and follow-up care associated with hearing screenings for a Child from birth through age 24 months.
4. Services and supplies for dental care, oral surgery or treatment of the teeth or periodontium, overbite or malocclusion, oral injury resulting from biting or chewing. The Health Plan will not cover dental braces, dental implants, splints, bridges or any treatment related to the preparation or fitting of dentures, or oral care and supplies, or orthognathic surgery.
5. Injury or Illness arising out of employment when benefits are paid or payable or the Injury or Illness under any Workers Compensation or Occupational Disease Act or Law.
6. Custodial care or respite care.
7. Services such as a private room, television, telephone, barber or beauty service, guest service, and similar incidental services and supplies that are primarily for the convenience of the Member.
8. Prescription and non-prescription Drugs and medicines, unless expressly provided by the GSA and any attachments or riders.
9. Any drug, biological product, device, medical treatment, or procedure that is Experimental or Investigational.
10. Cosmetic surgery or procedures. This will not include reconstructive surgery as shown in the Schedule of Health Services. The presence of a psychological condition will not entitle a Member to coverage for plastic, cosmetic or reconstructive surgery.
11. Elective termination of pregnancy.
12. Infertility treatment and services other than those appearing in the Schedule of Health Services, Item 5, Pregnancy Related Services. Infertility treatments after voluntary sterilization of a Member are not covered. The cost of sperm and its collection are not covered by the Plan.
13. Services and supplies for or related to sex change services.
14. Services and supplies for or related to the reversal of elective sterilization.
15. Sexual therapy programs, or treatment for sexual offenders or perpetrators of sexual or physical violence, treatment of chronic or long-term mental health disorders involving psychological or abusive behavior, or psychosexual problems, including but not limited to child abuse and long-term sexual dysfunction.
16. Services and supplies that are: (a) for mental retardation or a learning or behavioral disability, when such services extend beyond the period necessary for evaluation and diagnosis of the condition; (b) for educational rehabilitation; (c) for marriage counseling, when such services extend beyond the period necessary for short-term evaluation or crisis intervention; or (d) for treatment required by an order of a court of competent jurisdiction, including orders of parole or probation or as an alternative to same or (e) for Intelligence Quotient (IQ) testing; or (f) not authorized by a Primary Care Physician.
17. Services and supplies for routine care and maintenance of the feet, other than medically necessary care associated with diabetes.
18. Enrollment in a health, athletic or similar club.
19. Treatment or surgical procedures intended for the treatment of obesity, morbid obesity or similar condition involving a Member's weight.
20. Hypnosis or Hypnotherapy.
21. Treatment for smoking or nicotine addiction.
22. Biofeedback, or other services, including acupuncture, massage therapy, music therapy, aqua therapy, aromatherapy, or any alternative therapy(ies).
23. Spinal manipulation for chronic neuromusculoskeletal conditions and any non-neuromusculoskeletal conditions.

24. Care for health conditions that are required or directed by state or local authorities to be treated in a public facility.
25. Care or supplies which are furnished by a facility operated for or by the U.S. Government (or its agency) or by a Physician employed by that facility unless for Emergency Care when the Member must pay for those services, for non-service connected disabilities in a Veterans Administration Hospital, or incurred by a U.S. military retiree (covered by this GSA) and his or her covered Dependents, while confined in a military medical facility.
26. Care and services to the extent furnished or payable under a plan or program operated by the federal or state government or one of its agencies, or while the Member is active in the military. This exclusion will not apply to benefits received under the Medicaid program of the State of Texas.
27. Care and supplies for which no charge is made, or for which the Member would not have to pay if the Member did not have this coverage.
28. Health Services provided prior to the effective date or after the termination date of the Member's coverage under the GSA.
29. Miscellaneous non-covered services and supplies, including but are not limited to:
 - a. Ambulatory blood pressure monitor (unless Member is a diabetic);
 - b. Refractive eye surgery; immunotherapy for food allergy; and genetic testing.
 - c. Items of equipment not primarily used for a medical purpose such as exercise cycles or exercise equipment, air conditioners, humidifiers, personal comfort items, motorized transportation equipment or motorized wheelchairs, escalators or elevators, saunas or swimming pools, and items not authorized by a Participating Physician or Participating Provider.
 - d. Equipment and appliances considered dispensable or convenient for use in the home and not primarily used for a medical purpose, such as dressings or disposable OTC cervical collars, corrective shoes and shoe inserts (unless the Member is diabetic), air filtering units, aphakic lens, bandage lens, blood pressure cuffs/stethoscopes, corset/girdles, intercom systems, battery operated nebulizers, overbed tables, oxygen cylinder racks, pacemaker monitors, restraints/safety equipment, seat lift chairs and similar apparatus, shower bench, stools/chairs, support garments (such as Jobst stockings), toilet rails and seats, urinals/bed pans, vacuum devices for impotence, vacuum systems, vibration/massage units or chairs, or whirlpools.
30. Replacement or repair of Durable Medical Equipment damaged or disabled as a result of circumstances beyond the normal use and/or wear and tear of the equipment.
31. Any service rendered by a Close Relative or someone having the same legal residence as the patient, ("Close Relative" means a Member's spouse, or the brother, sister, parent or child of a Member or Member's Spouse).
32. Thermograms, temperature gradient studies.
33. Exercise for the eyes (orthoptics).
34. Non-emergency transportation.
35. Reduction mammoplasty.
36. Care provided by a Christian Science Practitioner.
37. All over the counter formulas or nutritional supplements to be used for enteral feeding, except for the treatment of PKU or other heritable diseases when this GSA includes a prescription drug rider.
38. Any services or costs related to a Member acting as an organ donor including the determination of the Member's suitability to provide an organ donation.
39. Drugs prescribed, directed or authorized by a Primary Care Physician to be consumed or administered in a physician's office, or while confined in a Participating Hospital or approved health care facility on an inpatient basis.
40. Health Services furnished due to war or an act of war (declared or undeclared).

This plan provides benefits for expenses for non-inpatient Prescription Drugs and Self-Administered Prescription Drugs when prescribed by a Physician or Provider as defined in the Group Service Agreement and obtained from a Participating Pharmacy. In Emergency situations, a 3-day supply of Medically Necessary Prescription Drugs prescribed by a non-participating Physician or provider is covered.

Member is responsible for paying the difference between the Participating Pharmacy's contract rates with UNICARE for the preferred formulary (brand) or non-preferred formulary (brand) and the generic drug cost when a generic equivalent (or similar) drug is available. In addition, Member is also responsible for paying the copayment applicable to the generic drug. This provision will apply whether the request for the preferred formulary (brand) or non-preferred formulary (brand) drug is made by the Member or the Physician.

BENEFITS

Prescription Drug Deductible: Not Applicable per Member per year

Participating Pharmacy Benefits and Copayments after Prescription Drug Deductible:

| | | |
|--|---|---|
| <p>GENERIC Prescription Drugs Initial or Refill prescriptions up to a 30-day supply</p> | <p>\$10 or the pharmacy's contract rate with the Health Plan, whichever is less</p> | |
| <p>BRAND Prescription Drugs Initial or Refill prescriptions up to a 30-day supply</p> | <p>Formulary \$30 (including supplies) or the pharmacy's contract rate with the Health Plan, whichever is less</p> | <p>Non-Formulary \$45 or the pharmacy's contract rate with the Health Plan, whichever is less</p> |
| <p>GENERIC OR BRAND Self-Administered Injectables and Compound Prescription Drugs</p> | <p>20% of Health Plan contracted rate up to a maximum amount of \$100 per covered Prescription with an annual Out-of-Pocket maximum of \$5,000 per Member</p> | |
| <p>INFERTILITY Oral Prescription Drugs</p> | <p>50% of Reasonable Costs or negotiated rate This amount will not apply towards any Member or Family out- of-pocket copayment maximum listed in the GSA or other Riders</p> | |
| | <p>Includes only oral Prescription Drugs for the treatment of infertility. There is no coverage for injectable fertility prescriptions. Does not include prescription drug therapy for infertility which involves non-FDA approved indications or non- standard dosages, lengths of treatment or cycles of therapy.</p> | |

FOR PHARMACY CUSTOMER SERVICE – Please call the toll-free number on your ID card

Mail Order Pharmacy Benefits and Copayments after Prescription Drug Deductible:

| | | |
|--|---|--|
| <p>GENERIC Prescription Drugs Initial or Refill prescriptions up to a 90-day supply</p> | <p>\$20 or the pharmacy's contract rate with the Health Plan, whichever is less</p> | |
| <p>BRAND Prescription Drugs Initial or Refill prescriptions up to a 90-day supply</p> | <p>Formulary \$60 (including supplies) or the pharmacy's contract rate with the Health Plan, whichever is less</p> | <p>Non-Formulary \$90 or the pharmacy's contract rate with the Health Plan, whichever is less</p> |
| <p>GENERIC OR BRAND Self-Administered Injectables and Compound Prescription Drugs</p> | <p>20% of Health Plan contracted rate up to a maximum amount of \$100 per covered Prescription with an annual Out-of-Pocket maximum of \$5,000 per Member</p> | |
| <p>INFERTILITY Oral Prescription Drugs</p> | <p>50% of Reasonable Costs or negotiated rate This amount will not apply towards any Member or Family out- of-pocket copayment maximum listed in the GSA or other Riders</p> | |
| | <p>Includes only oral Prescription Drugs for the treatment of infertility. There is no coverage for injectable fertility prescriptions. Does not include prescription drug therapy for infertility which involves non-FDA approved indications or non- standard dosages, lengths of treatment or cycles of therapy.</p> | |

HOW MAIL ORDER WORKS

The mail order feature allows covered employees and their dependents who regularly take one or more types of maintenance prescription medications to order a 90-day supply of a maintenance medication by enclosing a check for one mail-order copayment amount per prescription along with their order to the UniCare Mail Order Drug provider.

GENERICCHOICE PROGRAM

When your first GenericChoice prescription is filled, you will not pay a copayment. The GenericChoice program applies only to the drugs on the GenericChoice list and is not valid for current prescriptions or if the prescription is filled at an out-of-network pharmacy.

For more information regarding this program and for the complete list of GenericChoice drugs visit our website at www.unicare.com or call Pharmacy Customer Service at the phone number listed on your ID card.

The information provided is only an illustrative summary. Refer to your benefits plan booklet, the Group Service Agreement, (which is provided to you after enrollment) for details of your coverage. To be eligible for benefits, an employee and his/her dependents must reside, live or work within the UNICARE service area. Additional eligibility criteria may be required by the employer's benefits or human resources department(s). In the event information in this Summary of Benefits differs from information in the Group Service Agreement, the information in the Group Service Agreement will prevail.

EXCLUSIONS

1. Drugs or medicines that are not Prescription Drugs.
2. Prescription Drugs used for a condition, application, or indication other than those for which approval of the U.S. Food and Drug Administration (FDA) has been given.
3. Extemporaneous prepared combinations of chemicals or drugs in a non-FDA approved dosage form, whether or not such combinations contain Prescription Drugs.
4. Initial prescriptions or prescription refills in excess of standard Health Plan quantity and frequency limits unless approved by Health Plan.
5. Initial prescriptions and prescription refills dispensed more than twelve (12) months after the date of the Physician's original order.
6. Charges for the administration of a Prescription Drug unless for the administration of immunizations or vaccinations.
7. Any pharmaceutical goods or services covered as a benefit as described in the Group Service Agreement.
8. Immunization agents; allergy and biological sera; blood or blood plasma; Injectable medications other than covered Self-Administered Injectable Prescription Drugs.
9. Any drug, product or device that is Experimental or Investigational.
10. Appetite suppressants and sympathomimetic amines prescribed for weight reduction.
11. Nutritional or dietary supplements or formulas and Legend vitamins unless required to be covered by law.
12. Prescription Drugs for cosmetic conditions not covered by the Group Service Agreement.
13. Drugs not requiring a prescription (over-the-counter drugs and their Prescription equivalents, and other substances not requiring a Prescription even if ordered by a Physician via a Prescription, or vitamins, etc.). This will not apply to a Prescription drug whose over-the-counter availability changes during the course of a contract year. Prescription drug benefits will continue to be provided until the plan renewal date at the level specified herein.
14. Anabolic steroids.
15. Dental products.
16. Smoking cessation patches, gum and other such aids.
17. Prescription Drugs obtained from a Non-Participating Pharmacy.

The information provided is only an illustrative summary. Refer to your benefits plan booklet, the Group Service Agreement, (which is provided to you after enrollment) for details of your coverage. To be eligible for benefits, an employee and his/her dependents must reside, live or work within the UNICARE service area. Additional eligibility criteria may be required by the employer's benefits or human resources department(s). In the event information in this Summary of Benefits differs from information in the Group Service Agreement, the information in the Group Service Agreement will prevail.

Self-Funded \$500 Deductible PPO Plan

The Texas Annual Conference offers a self funded Preferred Provider Organization (PPO) as an option to help eligible clergy pay for their medical bills. The specifics of the program including eligibility criteria are described in the plan booklet.

To administer the plan, the Group Health Benefits Committee has retained 2 provider networks ([PHCS](#) and [HealthSmart](#)) and a prescription drug manager ([ScriptCare](#)) to handle details and generate provider discounts for various services.

Boon Chapman (a third part administrator – TPA) processes the PPO medical claims except for the prescription drug program charges. If you have a question regarding when a bill was paid, how much was paid or whether they have received a provider's bill, you can contact them using their website at www.boonchapman.com or by calling 1-800-252-9653.

The Group Health Benefits Committee uses provider networks to obtain significant discounts on the cost of care provided to participants. For those located in the Houston and Tyler/Longview area, Private Healthcare Systems (PHCS) is used. Contact them at their website at www.multiplan.com or by calling (888) 719-7427 or visit. Outside of the Houston and Tyler/Longview area HealthSmart is used. Contact them at www.healthsmart.net or by calling (800) 687-0500. The Group Health Committee recommends that you check with your provider on every visit to make sure they are still part of the PPO network of providers.

The maximum level of benefits will be obtained by utilizing PPO providers, but the choice on which provider to use is entirely up to you.

Participants living within 50 miles of the Methodist Hospital Fannin facility have a \$1,000 inpatient co-pay if admitted to a hospital other than Methodist (or its 4 subsidiaries) for a non-emergency admission.

| | PPO | Non-PPO |
|---|--|----------------------|
| Lifetime Maximum | \$2,000,000 per member | |
| Calendar Year Deductible | | |
| Single | | \$500 |
| Family | | \$1,500 |
| Co-Insurance | 80% | 60% |
| Maximum out of Pocket (Not including the deductible) | | |
| Single | \$3,000 | \$30,000 |
| Family | Per Participant | Per Participant |
| Physician Office Visit Charge | \$20 co-pay for PCP and \$30 for Specialist/ then 100% | 60% after deductible |
| Other services at Physician | 80% after deductible | 60% after deductible |
| Inpatient hospital | 80% after deductible | 60% after deductible |
| Emergency room services | 80% after deductible | 60% after deductible |
| Wellness benefit (\$200 maximum benefit per year) then regular benefits | \$20 co-pay / 100% no deductible | 100%, no deductible |

| | | |
|--|---|---|
| Well child care (limited to children under the age of 3) | \$20 co-pay / 100% no deductible | 100%, no deductible |
| All other services | 80% after deductible | 60% after deductible |
| Mental Health - Serious | 80% after deductible | 60% after deductible |
| Chemical Dependency | 80% after deductible Limited to a lifetime maximum of 3 separate series of treatments; includes diagnosis, medical treatment and referral services | 60% after deductible Limited to a lifetime maximum of 3 separate series of treatments; includes diagnosis, medical treatment and referral services |

Prescription Drug Program

| Calendar year deductible | ScriptCare | Mail Order |
|--------------------------------------|----------------------------------|---|
| Single | | \$50 |
| Family | | \$100 |
| Generic | \$10 plus 20% of cost over \$50 | \$25 plus 20% of cost over \$125 |
| Preferred Brand on Formulary | \$55 plus 20% of cost over \$220 | \$137.50 plus 20% of cost over \$687.50 |
| Non- Preferred Brand (off formulary) | \$80 plus 20% of cost over \$350 | \$200 plus 20% of cost over \$1,000 |

Employee Assistance Plan (EAP)

| | | |
|--|--|-----|
| Mental Health counseling – EAP <u>No charge</u> Marriage & family concerns, legal & financial issues, anxiety, stress and bereavement. | Up to 6 face to face visits per incident or per year. Support is available 24/7 for short term problem resolution. | N/A |
| Work Life EAP <u>No charge</u> | Child care resources, Adoption support, Educational resources (financial aid programs) and Elder care assistance | N/A |

1. Maximum PPO benefits are obtained when the participant uses a PPO provider from the PPO to which they are assigned.

2. The Preferred Provider Organization (PPO) or network of providers for both plan options is Private HealthCare Systems (PHCS) for the Greater Houston and Tyler/Longview areas. To verify network providers contact PHCS at 888-719-7427 or visit their website at www.multiplan.com. All other areas will access the HealthSmart Preferred Care PPO. To verify network providers for HealthSmart call 800-687-0500 or visit their website www.healthsmart.net.

3. See plan document for further details of the program.

The prescription drug plan requires specialty pharmaceuticals be purchased through ScriptCare. The PPO also has a disease management and Wellness program providing incentives for participating in the respective programs.

FOR CUSTOMER SERVICE – Please call the toll-free number on your ID card

High Deductible Plan

High deductible plans are often referred to as consumer-directed health care arrangements (CDHC). The plan uses the same provider networks ([PHCS](#), [HealthSmart](#) and [ScriptCare](#)) as the \$500 deductible PPO and requires the use of participating providers to receive maximum benefits. While it is argued that the CDHC may not be the “silver bullet” to drastically reduce health care costs, the committee feels it has some advantages for Clergy and is making a plan available as an option.

In 2010 the high deductible plan has a \$1,200 single and \$2,400 family annual deductible which applies to medical and prescription drugs. In addition, you will be responsible for co-insurance until you have paid an additional \$3,000 single and \$6,000 family. Also, The Methodist hospital is unable to write off deductibles and co-insurance under this plan.

The advantage of participating in the high deductible plan is twofold. First, you receive a discount on your personal contribution. Second, you are able to open a Health Savings Account if you qualify. To review the **Health Savings Account Road Rules**, [click here](#) and download the plan booklet which explains eligibility requirements, funding requirements and answers many questions on this type of program.

Health Savings Accounts were developed to manage health care expenses without risking your health care coverage. The concept has two parts: (1) enrollment in a qualified High Deductible Health Plan and (2) opening a Health Savings Account.

The Health Savings Account is an account that you open with a financial institution which allows you to reimburse yourself for eligible medical expenses.

Following is a list of financial institutions that will open an HSA account for you. When selecting a bank to use (possibly your own bank can accommodate you), check the monthly fees and minimum balances.

- [HSA Bank](#)
- [First American Bank](#)
- [Or click here](#) to use the HSA selector tool to guide you through the process.

If you have a question regarding the maximum amount of money you can put in an HSA, [click here](#) to be taken to a calculator that can answer your question.

| | PPO | Non-PPO |
|--|-------------------------|----------------------|
| Lifetime Maximum | \$2,000,000 per member | |
| Calendar Year Deductible | | |
| Single | \$1,200 | |
| Family | \$2,400 | |
| Co-Insurance | 80% | 60% |
| Maximum out of Pocket (Not including the deductible) | | |
| Single | \$3,000 | \$30,000 |
| Family | \$10,500 | Per-Participant |
| Physician Office Visit Charge | 80% After deductible | 60% after deductible |
| Other services at Physician | 80% after deductible | 60% after deductible |

| | | |
|---|---|---|
| Inpatient hospital | 80% after deductible | 60% after deductible |
| Emergency room services | 80% after deductible | 60% after deductible |
| Wellness benefit (\$200 maximum benefit per year) | \$20 co-pay / 100% no deductible | 100%, no deductible |
| Well child care (limited to children under the age of 3) | \$20 co-pay / 100% no deductible | 100%, no deductible |
| Mental Health (Pre-Certification required) | 80% after deductible | 60% after deductible |
| Chemical Dependency | 80% after deductible Limited to a lifetime maximum of 3 separate series of treatments; includes diagnosis, medical treatment and referral services | 60% after deductible Limited to a lifetime maximum of 3 separate series of treatments; includes diagnosis, medical treatment and referral services |
| All other services | 80% after deductible | 60% after deductible |
| Prescription Drug Program | | |
| Calendar year deductible | ScriptCare | Mail Order |
| Single | N/A | |
| Family | N/A | |
| Generic | 100% co-pay (you pay all until deductible is satisfied), which can be applied to the medical deductible, then payable at 80%. | |
| Preferred Brand on Formulary | | |
| Non- Preferred Brand (off formulary) | | |
| Employee Assistance Plan (EAP) | | |
| Mental Health counseling – EAP No charge – Marriage & family concerns, legal & financial issues, anxiety, stress and bereavement. | Up to 6 face to face visits per incident or per year. Support is available 24/7 for short term problem resolution. | N/A |
| Work Life EAP No charge | Child care resources, Adoption support, Educational resources (financial aid programs) and Elder care assistance. | N/A |
| 1. Maximum PPO benefits are obtained when the participant uses a PPO provider from the PPO to which they are assigned. | | |
| 2. The Preferred Provider Organization (PPO) or network of providers for both plan options is Private HealthCare Systems (PHCS) for the Greater Houston and Tyler/Longview areas. To verify network providers contact PHCS at 888-719-7427 or visit their website at www.multiplan.com . All other areas will access the HealthSmart Preferred Care PPO. To verify network providers for HealthSmart call 800-687-0500 or visit their website www.healthsmart.net . | | |
| 3. See plan document for further details of the program. | | |

The PPO also has a disease management and Wellness program providing incentives for participating in the respective programs.

Clergy Retirement Plans

Depending on your length of service in the ministry, clergy can be eligible to receive various retirement benefits from programs sponsored at different times by the [General Board of Pensions](#).

Following are the contribution rates currently approved by the Texas Annual Conference for the CRSP Retirement Plan;

| | |
|---------------------------|------|
| Defined Benefit Plan | 8.5% |
| Defined Contribution Plan | 3% |
| CPP | 3% |
| UMPIP | 1% |
| Sustentation Fund | .5% |
| Reserve | 1% |

Determination of actual benefit balances can be made by using the Pension Projection Calculator provided by the General Board of Pensions by [clicking here](#). After 12/31/2006 contributions to MPP will cease and beginning in January, 2007 contributions will begin into the new Clergy Retirement Security Plan (CRSP). Your current MPP account will remain at the General Board of Pension until time of distribution.

As the nation's largest faith-based pension fund, the General Board demonstrates its stewardship with a solid financial track record coupled with a steadfast history of positive social and environmental returns. Through their shareholder advocacy efforts, they work with the world's largest corporations to address the pressing environmental, economic and social issues of our time. For more information on the General Board of Pensions Socially Responsible Investing [click here](#).

We take the long-term view with respect to investing for retirement, and offer outstanding retirement and savings plans to eligible clergy:

Click on the hyperlink in the left hand column to learn more about the specific program.

| | |
|---|--|
| Clergy Retirement Security Program (CRSP) | Provides both a defined benefit and a defined contribution plan to clergy of The United Methodist Church. Replaces MPP effective 1/1/2007. |
| Ministerial Pension Plan (MPP) | Serves more than 26,000 United Methodist clergy from 65 conferences. No further contributions will be made to this plan after 12/31/2006. |
| United Methodist Personal Investment Plan (UMPIP) | Provides retirement benefits and savings opportunities for clergy and lay employees of United Methodist churches, church-related organizations and general agencies. |
| Comprehensive Protection Plan – (CPP) | Provides a death and disability benefit for eligible United Methodist clergy. |

| | |
|-------------------|--|
| Sustentation Fund | A Texas Annual Conference benefit. |
| Reserve Fund | A Texas Annual Conference benefit. |
| Pre 1982 Service | Those persons who are already retired are not affected by CRSP, and those who are yet to receive a distribution who have years of service before 1982 will continue to receive those monies as well as any MPP account and CRSP account distributions for which they are eligible. |

[Click here](#) to access retirement planning tools.

[The Clergy Retirement Security Plan](#) (CRSP), which became effective January 1, 2007, is a General Board of Pensions program and has three core benefits; the first three in the list below. The Texas Annual Conference has added three additional parts to the pension apportionment which goes to the local church; they are items 4 through 6 in the list below. They have been explained in the district tours made by the Conference Board of Pensions and are defined below for your benefit.

1. **Defined Benefit:** This portion of the clergy pension is based on an amount contributed by the local church, its payment to retired clergy is based on a formula provided by the GBOPHB, and will provide a fixed amount to the retired clergy which is guaranteed to them regardless of market performance.
2. **Defined Contribution:** This portion of CRSP is a defined amount, contributed by the local church into an account for the clergy, and the total amount will be made available to the clergy person upon retirement. The proceeds of this portion will be dependant upon market performance.
3. **Comprehensive Protection Plan:** This portion of CRSP was also a part of MPP and provides protection in the event of disability.
4. **Contribution to UMPIP:** The new CRSP pension plan, which began January 1, 2007, does not provide the level of retirement support that was previously supplied by MPP. In an effort to make it more equitable to previous pension protection the Annual Conference makes a 1% contribution to the clergy person's UMPIP.
5. **Sustentation Fund:** The Sustentation Fund provides benefits for clergy and local congregations. It replaced the former Covenant Fund, and now provides benefits for all eligible clergy. These include support for clergy sabbaticals, interim pastors, group health benefits for clergy on incapacity leave, and emergency support for clergy, as determined by the Cabinet.
6. **The Reserve Fund:** The most dramatic change that comes to the Annual Conference in the new CRSP pension plan is that all financial liability for the defined benefit portion of the pension has now become the responsibility of the Texas Annual Conference. The pension plans are based on market earnings. The Reserve Fund is to provide protection against changes in market performance.

[Click here](#) for Frequently Asked Questions regarding Pensions.

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Pension – Frequently Asked Questions

Are the General Board's pension plans adequately funded?

Yes. The General Board administers two types of plans: Defined Contribution (DC) and Defined Benefit (DB). DC plans include the [Ministerial Pension Plan](#) (MPP) and the [United Methodist Personal Investment Plan](#) (UMPIP). DB plans include the pre-1982 plan and MPP annuities (monthly benefit payments received by retired clergy). After 2007, the General Board is introducing the [Clergy Retirement Security Program](#) (CRSP) and the [Retirement Security Program](#) (RSP), which have both DB and DC components. All DC plans are fully funded. Participants should realize, however, that the value of their accounts will fluctuate up and down with the performance of the investment markets. DB plans provide participants with a specified monthly payment. Accordingly, funded status is affected by the performance of the investment markets. The General Board is confident that the current funded status of the DB plans is sufficient to fulfill its obligations to its participants. Ultimately, the annual conferences are responsible for ensuring that these plans have been fully funded.

For a more comprehensive answer to this question, see the article on the main Web site under SRI and Fund Performance titled [Q&A Regarding Recent Media Stories about Pensions and Pension Plan Funding](#).

How can I be assured that the assets supporting my retirement plans administered by the General Board are secure?

The General Board of Pension and Health Benefits is a not-for-profit administrative agency of The United Methodist Church, responsible for the general supervision and administration of the retirement, health and welfare benefit plans, programs and funds for more than 66,000 clergy and lay employees of the Church.

All of the assets invested in the funds are owned by the clergy and lay. The General Board serves only as the trustee of the investment programs. The General Board is a fiduciary and is therefore required to meet stringent standards for administering, monitoring and reporting on participant balances. In addition, the General Board is responsible for the daily monitoring and oversight of both the custodian Bank and the investment managers. Daily reporting is available to us through the Bank's online reporting system.

Periodically, I receive an account statement that shows my account value is less than the balance that appeared on my last account statement. Why does this happen?

Your account balance will change along with the daily fluctuations in the financial markets. Because markets sometimes lose value, the funds in your account may also lose value and lead to lower ending balances from one account period to the next. The General Board Investments Staff is focused on achieving sustained positive long-term investment results for participants.

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If markets are declining in value, why won't the General Board sell investments that are

declining in value and purchase investments that are increasing in value?

Because past performance is not a predictor of future results, the General Board does not believe that selling investments or terminating fund managers based on short-term negative performance is a prudent strategy. For example, after the tragedy of September 11th when U.S. stocks saw dramatic price declines, the General Board actually increased its holdings of U.S. equities. This strategy was rewarded when the markets rebounded and stock prices rose as investors regained confidence in the months following that event.

Why did the General Board discontinue the Diversified Investment Fund (DIF) in April of 2004 and invest my employer contributions in market-based funds?

The main impact of this change was to transfer participants' assets from a plan that protected participant balances from market fluctuations (DIF) directly into the market-based and daily-priced Multiple Asset Fund (MAF). The investment philosophy for investing MAF assets was the same as the investment philosophy and approach used for DIF. Accordingly, the General Board made no change to the underlying assets held by the General Board as a result of this transition. However, with the elimination of the reserve, the General Board transferred to participants the risk of daily fluctuation in the prices of the underlying securities. Hence, since April 2004, participants have seen their account balances increase and decrease based on the changes in the financial markets.

Why did the General Board shift the risk of market fluctuations to participants?

There were two reasons for shifting market risk from the annual conferences and other UMC-affiliated employers to participants. First, employers contributing to defined contributions plans are unwilling to accept the risk associated with a severe downturn in financial markets. As designed, there was a possibility that employers would have to make additional contributions if assets were insufficient to fulfill promises to participants. Second, the General Board could have structured a fund that substantially mitigates the risk of additional employer payments. However, the policies required to mitigate this risk would severely impact the long-term growth potential for participant account balances. The General Board would be required to retain a substantial portion of the earnings from the invested assets in order to provide a "reserve" against a severe market decline. When it discontinued DIF, the General Board fully distributed excess earnings to participants in the form of a final special distribution.

Who makes the investment decisions for the General Board's funds?

The General Board engages the services of investment managers to select investments for the General Board's plan assets. The staff of the General Board selects investment managers and carefully monitors their activities to ensure adherence to established guidelines. Staff continuously measures and analyzes investment returns compared to corresponding performance benchmarks. The General Board generally invests with a long-term investment horizon and seeks to establish lasting partnerships with its fund managers. Many of our relationships exceed ten years. A complete list of the General Board's [investment managers](#) is maintained on this Web site.

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Section 125

Section 125 Premium Only Plan (POP)

Section 125 of the Internal Revenue Code provides opportunities for employees to purchase and pay for health care on a tax advantaged basis. What we mean by a tax advantaged basis, is that personal contributions can be deducted from gross pay which is reported on the employee's W-2 form.

However, to take advantage of this provision there are specific conditions that must be satisfied by both the employee and the employer. Among these are;

1. Adoption of a section 125 plan by the churches Administrative Council.
2. Distribution of a summary plan description describing the benefits of the plan to eligible employees at the church.
3. Completion of a salary reduction form prior to the start of the year. Signed clergy compensation forms passed by charge conference are acceptable for this requirement.

While there are a number of strategies that can be included under a **Section 125** plan, the Texas Annual Conference makes available the necessary information so that churches can implement a **Premium Only Plan (POP)**. Under a premium only plan the employee agrees to have their personal contribution taken on a pretax basis.

The effect, is to reduce compensation which in turn reduces the employee's taxable income. Since the employee's W-2 income is reduced, both federal and social security taxes (FICA) are impacted by the reduction. The actual amount of tax savings will depend on the employee's taxable income after their personal contribution is removed from gross wages.

The Texas Annual Conference encourages all churches to implement a **Premium Only Plan** so that the cost of the employee's health care can be minimized through the tax savings. To obtain a **Premium Only Plan** kit which includes, a plan document, a summary plan description, adoption forms which allow each of the documents to be customized for the particular Church, a salary reduction form and a complete set of instructions, contact Mrs. Lydia Lopez Group Health Benefits and Pension Plan Administrator. Phone number 713-521-9383.

Methodist Hospital

Methodist Hospital is an integral part of the Texas Annual Conference. They are pledged to providing high quality cost effective health care that delivers the best value to the people served through its health care facilities in a spiritual environment of caring combined with internationally recognized teaching and research.

To support The Texas Annual Conference the Methodist Hospital has agreed to not collect deductibles and coinsurance from eligible participants of the Group Health Benefits program. See below for **Methodist Hospital Contract Terms**.

Please note, the hospital bill and doctor bill are separate. While the Hospital has agreed to not collect deductibles and coinsurance, the doctor will still collect deductibles and co-insurance.

To assist participants from outside of the Houston area who want to avail themselves of the high quality and cost effective services at Methodist Hospital, the Director of The Center for Clergy Excellence has arrangements with local hotels. Families can stay close to the Hospital and take advantage of all Houston has to offer (use the light rail to get around) while the patient gets the highest quality of care.

The Methodist Hospital is world renowned for their quality of care and internationally recognized research. The Group Health Benefits Committee recommends that all Group Health Benefits participants consider using Methodist Hospital (or their satellites – Willowbrook, Sugarland and San Jacinto) whenever possible. In addition to having your deductible and co-insurance written off, the quality of care is among the highest in the country. When it comes to your health, always seek out the highest quality of care.

To visit The Methodist Hospital website, [click here](#).

Methodist Hospital Contract Terms

History: For years The Methodist Hospital has not collected deductibles and co-pays from clergy at their Fannin facility. As announced at Annual Conference, changes to this practice are required to comply with the law. Following is an explanation of the new program.

Facilities covered : Prior to July 1, 2004, only the Fannin facility was included. As of July 1, 2004 San Jacinto, Sugarland and Willowbrook are now included in addition to the Fannin facility.

Who is eligible? Participants of both the PPO and HMO are included. The categories are; Clergy, dependents of clergy (including surviving spouses) and laity (including enrolled dependents) enrolled in the Conference's Group Health Plan who are NOT eligible for Medicare are eligible. ***Individuals who serve on The Methodist Hospital board are NOT eligible.***

What about those on Medicare? Under current law the Hospital cannot waive Medicare deductibles.

What are the benefits? The Hospital agrees to NOT collect deductibles and co-insurance that may be required under the Group Health Benefit plan for both inpatient and outpatient services billed by the hospital. In addition, Clergy will continue to be eligible for private room upgrades on a space available basis.

What services are not included? Any services or supplies listed in the exclusions section of the PPO plan document of the HMO policy are not included. For example, cosmetic surgery, experimental procedures, etc.

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Medicare Primary for Incorporated Churches

For churches that are incorporated and employ fewer than 20 employees, clergy who are enrolled in Part A and part B of Medicare can select Medicare as their primary coverage even if they are working full time.

Qualifications

- Clergy must be 65 or over 65.
- Fewer than 20 employees.
- Church is Incorporated.
- Must be a Medicare Part B participant.
- Must be in the PPO.

Benefits:

- Entitles you to a substantial *reduction* of your personal contribution. ([click here to see rate schedule](#))
- The Group Health Benefits *reduces* your personal contribution by the amount of the Medicare Part B premium.

For information call
Mrs. Lydia Fay Lopez at 713.521.9383 or email at Fay1@methodists.net.

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Disease Management

The Group Health Benefits Committee is pleased to announce a NEW PROGRAM that is designed to provide participants with necessary information and resources to assist in managing chronic conditions, such as:

- Asthma,
- Coronary Artery Disease,
- Congestive Heart Failure,
- Diabetes and High Blood Pressure.

The program is FREE OF CHARGE to eligible participants in the PPO program

TAKE CHARGE OF YOUR HEALTH! Following is a brief explanation of this program being provided through Boon Chapman. If you have any questions, please contact Boon Chapman (PRIME Dx) at 800 477-4625.

Overview: Disease management has the twin goals of cost savings and improved participant health. Our program utilizes claims data, pharmacy data and assessment information to identify participants with certain medical conditions in order to provide some level of care management/or intervention to each participant with a diagnosis of asthma, Coronary Artery Disease, Congestive Heart failure, Diabetes or High Blood Pressure.

The program is founded on clinical practice guidelines from nationally recognized sources such as the American Diabetes Association. Case management and pharmacy services are integrated into this program which is designed to function as an adjunct to clinical care provided by providers. This program has the following objectives:

1. Provide consistency in long-term management approaches to participants with these conditions.
2. Help participants achieve optimal levels of wellness through:
 - a) Improving the participant's understanding of his/her disease.
 - b) Increasing provider awareness and participation with recommended treatment modalities.
 - c) Initiating early collaborative Health Plan and physician conversations when specific indicators are not met.
 - d) Promoting increased compliance with treatment protocols.
 - e) Monitoring participant condition, including consideration of other health conditions and life-style issues.
3. Reduce emergency room/inpatient admissions.

The Group Health Benefits Committee hopes this benefit will help improve group health participant health.

[Click here](#) to review incentives available under the Disease Management program.

Disease Management Incentives

Eligibility: Those identified as qualifying for the disease management program (based on prior medical claims, prescription drug utilization and/or risk factors identified in the Wellness program).

Incentives are based on the severity of the condition.

Overview :

\$50 incentive is provided for those who participate in baseline assessment

\$25 incentive for each milestone completed

Assessment is performed by a Registered Nurse.

Baseline assessment – Comprehensive medical and psycho-social evaluation. This could take an estimated 30 minutes to 1 hour

Milestones Assessments:

High intensity assessment- will occur every 3 months

Moderate intensity assessment- will occur every 6 months

Low intensity assessment- will occur every 12 months

Milestone incentives continue as long as the participant qualifies to receive them.

Adoption of Children

What is the Adoption Assistance Program?

The Adoption Assistance Program is a new program under which Group Health Benefits will reimburse eligible clergy for certain expenses incurred in the adoption of a child. Under the Internal Revenue Code (sec. 137), some or all of the amount reimbursed may be excluded from income depending on the income level of the employee.

Who can participate in the program?

If you normally work at least 20 hours per week, and a participant of the Group Health benefits plan you are an "Eligible Employee" and may be a "Participant" in the Program. You may not participate if you are: (a) a contract employee (except those grandfathered into the plan at Annual Conference 2008) or independent temp; (b) employed on a temporary basis (as defined by any employment policies of the Employer and including but not limited to a co-op student or an intern); or (c) a leased employee.

What benefits are provided?

Pursuant to the guidelines of the Program, Group Health Benefits will reimburse a Participant's "Qualified Adoption Expenses." Qualified Adoption Expenses are the reasonable and necessary adoption fees, court costs, attorney fees, traveling expenses (including amounts spent for meals and lodging) while away from home, and other expenses – which are directly related to, and the principal purpose of which is for, the legal adoption of an Eligible Child by the Participant; and which are not incurred (i) in violation of state or federal law, or (ii) in carrying out any surrogate parenting arrangement, (iii) for the adoption of your spouse's child; and which have not already been paid using funds received from any federal, state or local program.

What does the term "Eligible Child" mean?

The term "Eligible Child" means any individual who - has not attained age 18, or is physically or mentally incapable of caring for himself or herself.

If my spouse's child is under 18, will I be reimbursed for expenses?

No. Expenses incurred for the adoption of a spouse's child are not Qualified Adoption Expenses under IRS rules.

Does it matter when I incurred the Qualified Adoption Expense?

Yes. You may only be reimbursed for expenses incurred after the Effective Date of this Program (January 1, 2001), and while an Eligible Employee.

How much will I be reimbursed?

Group Health Benefits will reimburse you for the cost of Qualified Adoption Expenses, up to \$2,300, for any one adoption effort, regardless of the number of Eligible Children considered for adoption and regardless of whether one or both adopting parents are Participants in the Adoption Assistance Program. For example, if you pay \$3,000 of qualifying adoption expenses in an unsuccessful effort to adopt a child, and then pay an additional \$4,000 for the successful adoption of a second child, the entire \$7,000 will be treated as expenses for one adoption effort and you will be reimbursed up to the allowable \$2,300 maximum under this program.

What if I adopt more than one Eligible Child in separate adoptions?

You will be entitled to reimbursement up to \$2,300 for each such adoption.

Can I also claim a credit on my tax returns for adoption expenses?

You may claim both a credit (under Code Section 23) and an exclusion (under Code Section 137 and this Program) for Qualified Adoption Expenses, but may not claim both a credit and an exclusion for the same expense. Note that both credits and exclusions are subject to Income guidelines as discussed below. Because each person's tax situation will be different (and tax laws may change), you should obtain a copy of IRS Publication 968, "Tax Benefits For Adoption" and consult a tax advisor regarding your own situation.

How do I seek reimbursement for Qualified Adoption Expenses?

You must complete a Reimbursement Form describing the Qualified Adoption Expenses for which you seek reimbursement. Submit the completed Reimbursement Form, together with copies of receipts to:

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Ms. Lydia Fay Lopez
Group Health Benefits Office
5215 Main St
Houston, Texas 77002

Tel. 713-521-9383

Is there a time limit for requesting reimbursement?

Yes, you must submit for reimbursement no later than 90 days after the adoption becomes final, or after the final expense is incurred in the case of an adoption that is not completed. Reimbursement Forms are available from the Group Health Benefits office. Reimbursement Forms, with copies of receipts attached, should be returned to:

Ms. Lydia Fay Lopez
Group Health Benefits Office
5215 Main St
Houston, Texas 77002
Tel. 713-521-9383

Are foreign adoptions treated differently from domestic adoptions?

Group Health Benefits will treat foreign and domestic adoptions the same. In the case of a foreign adoption, however, any amounts reimbursed by Group Health Benefits before the taxable year in which the adoption becomes final are not excludable from your gross income until the taxable year in which the adoption becomes final, and are not ever excludable if the foreign adoption does not become final. (A foreign adoption is the adoption of an eligible child who is not a citizen or resident of the United States at the time the adoption commenced.)

Will I have to pay income taxes on reimbursements?

Amounts received may be excluded from income subject to certain income limits. Because each person's tax situation will be different, you should consult a tax advisor as to your own tax situation. As a general rule, the income limit is based on modified adjusted gross income (modified AGI) (which adds certain items of income back into your adjusted gross income). You will receive a 1099 for all adoption expenses reimbursed by Group Health Benefits.

What about social security taxes?

Any amounts reimbursed by Group Health Benefits are fully subject to social security, Medicare and federal unemployment taxes, regardless of whether the amount reimbursed is excluded from income.

Will amounts reimbursed be subject to withholding like other income?

No. Group Health Benefits is not required to withhold income tax on any reimbursement payments made under this program. This means that your regular withholding may not be enough to cover the tax on amounts reimbursed.

What happens if my employment is terminated?

If your employment terminates for any reason (including retirement, death, resignation or discharge) or you no longer work 20 hours per week, you will no longer be eligible to participate in the Program, except to the extent that you have a right to reimbursement of Qualified Adoption Expenses incurred while you were an Eligible Employee, provided that you had applied for reimbursement while an Eligible Employee.

What happens if I switch from a full-time to part-time schedule?

If you switch to a schedule that is less than 20 hours per week, you will no longer be eligible to participate in this program (except to the extent that you may be entitled to reimbursement of expenses if you submitted a Reimbursement Form while you were an Eligible Employee).

How do I dispute a denial of benefits with regards to this program?

Contact the Group Health Benefits office.

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Boon Chapman EOB Key



P.O. Box 9201
Austin, TX 78766-9201

Address Service Requested

Employee Name
Address
City, State Zip

Questions? Contact Customer Service at
(800) 252-9653

Claim No.: 02-456897
Group Name: Sample Company, Inc.
Group#: 111
Employee: Jane Doe
Patient: Jane Doe
Patient Account: C8953452
Provider: Memorial Hospital
SSN: 123-45-6789
Prepared On: 05/09/2003

Patient Responsibility 9

| | |
|--------------------------------|-------|
| Amount Not Covered | .00 |
| Co-Pay Amount | 15.00 |
| Deductible: | .00 |
| Co-Insurance | 4.93 |
| Patient's Total Responsibility | 19.91 |
| Other Insurance Payment: | .00 |

EXPLANATION OF BENEFITS

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 10 | 11 | | |
|---|------------|------------|---------------|-------------|------------|--------------|----------------|-------------------|---------------|---------|----------------|
| Treatment dates | Serv. Code | Proc. Code | Charge Amount | Not Covered | Reas. Code | PPO Discount | Covered Amount | Deductible Amount | Co-Pay Amount | Paid At | Payment Amount |
| 04/04-04/04/2001 | 358 | 99214 | 120.72 | .00 | PP TI | 20.12 | 100.60 | .00 | 15.00 | 100% | 85.60 |
| 04/04-04/04/2001 | 334 | 90782 | 20.00 | .00 | PP | 14.04 | 5.96 | .00 | .00 | 90% | 5.36 |
| 04/04-04/04/2001 | 334 | J1040 | 28.80 | .00 | PP | 16.91 | 11.89 | .00 | .00 | 90% | 10.70 |
| 04/04-04/04/2001 | 334 | J1095 | 23.70 | .00 | PP | 17.92 | 5.78 | .00 | .00 | 90% | 5.20 |
| 04/04-04/04/2001 | 349 | 36415 | 15.00 | .00 | PP | 2.25 | 12.75 | .00 | .00 | 90% | 11.48 |
| 04/04-04/04/2001 | 349 | 99000 | 15.00 | .00 | PP | 2.25 | 12.75 | .00 | .00 | 90% | 11.48 |
| TOTALS | | | 223.22 | .00 | | 73.49 | 149.73 | .00 | 15.00 | | 129.82 |
| Other Insurance Credits or Adjustments | | | | | | | | | | | |
| Total Payment Amount | | | | | | | | | | | 129.82 |

Accumulators 12

Payment To 13

Check No.

Amount

150.00 of Patient Deductible met

167900

129.82

.00

Service Code 2A

358 OFFICE VISIT
334 INJECTIONS
349 OFFICE VISIT LABORATORY

Reason Code 6A

PP HAS-PREMIER PPO DISCOUNT
TI CO-PAYMENT AMOUNT NOT A COVERED EXPEN

Messages 14

Footnote: a) An internal rule, guideline, protocol or similar criterion was relied upon in making this determination, a copy of which will be provided free of charge upon request. If the determination was based upon a medical judgment, an explanation of the scientific or clinical judgment for this determination, applying terms of the plan to the claimant's medical circumstances, will be provided free of charge upon request. Footnote: b) Please contact Boon-Chapman Customer Service at 800-252-9653 if you are unable to find this provision in the Summary Plan Description (Plan Booklet).

Claims Appeals – You have a right to appeal this determination. If you disagree with this determination, you must submit proof that the claim for benefits is covered and payable under the Plan's provisions, including (a) all facts and theories supporting your claim, (b) a statement of the reasons for disagreement with the handling of the claim, and (c) any material/information that indicates that the claims does not fall within the referenced Plan provision. If you do so, it may be that some or all of this claim will be payable under the Plan. This Plan allows for appeal of an adverse benefit determination. Each appeal provides full and fair review of an adverse determination in compliance with the Employee Retirement Income Security Act of 1974 ("ERISA") and the regulations issued there under. Claimant will be provided free of charge with a complete description of the Plan's review procedures and the applicable time limits by calling Boon-Chapman Customer Service at 800-252-9653, briefly, with 180 days following receipt of this notice, the claimant may file an appeal which must be in writing and mailed to Boon-Chapman, P.O. Box 9201, Austin, Texas 78766. If the claimant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal no later than 30 days after receipt of the appeal. You are entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to your claim benefits. If you receive an adverse benefit determination following the final appeal, you have the right to bring civil action under section 502(a) of ERISA.

EXPLANATION OF BENEFITS KEY

1. Date services were rendered.
2. Boon-Chapman code for the type of service provided. Box 2-A lists the definition of these codes.
3. Total charges submitted to Boon-Chapman.
4. Any amounts excluded by the plan. There will always be a denied reason code in Box 6 for any amounts not covered. This amount will also be included in Box 9.
5. Boon-Chapman code identifying the reason for any amounts shown in Box 4 or 6. An explanation of this code appears in Box 6-A.
6. Amounts in this column are preferred provider discounts and will be written off by the provider. There will always be a reason code in Box 6 to identify this amount as a discount. This amount will not be included in Box 9.
7. This is the amount of the claim that will be considered for benefits. It is calculated by subtracting any not covered amounts and discounts from the total charge.
8. Amounts applied toward the calendar year deductible. This amount will be included in Box 9.
9. This is the amount the patient will need to pay the provider. It includes amounts shown in Box 4 and 8 as well as the patient's co-insurance amount (i.e. if the Plan pays 80% of eligible charges, the patient responsibility will include the 20% that should be paid by the patient).
10. This is the percentage paid by the Plan for this type of service.
11. Amount of payment issued.
12. Indicates year to date amounts applied to the individual and family calendar year deductibles.
13. Indicates who was paid the amount shown in Box 11.
14. Any special information the claims analyst would like the employee or provider to know.

Enrollment Information

To update your PPO or HMO information, click on the Boon Chapman Hyperlink below.

www.boonchapman.com

Once at the Boon Chapman page, click on login services.

Then enter your group number and social security number.

If you have questions please contact:

Melonie Joseph - GHB Eligibility / GHB and Pensions Customer Service

5215 Main St.

Houston, TX 77002

Phone: 713-533-3758

Fax: 713-521-7516

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Medical EFT Form

The United Methodist Church
of
The Texas Annual Conference – Group Health Benefits

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

Church Name: _____

Address: _____

City: _____ ST. _____ ZIP _____

GCFA Church #: _____ District: _____

I (we) hereby authorize The Texas Annual Conference of the UMC; (hereafter called the Conference), to initiate debit entries to my (our) Checking account indicated below and the depository named below, hereinafter called FINANCIAL INSTITUTION, to debit the same to such account for **Group Health Benefits** payments. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provision of U.S. law.

Financial Institution Name: _____

Transit/Routing/ABA#: _____ ACCOUNT# _____

Type of Account: _____ Checking _____ Savings _____

Start Month: **January 2009** Day of the month: **25th**.

This authority is to remain in full force and effect until Conference has received **written notification** from me (or either of us) of its termination in such time and in such manner as to afford Conference and Financial Institution a reasonable opportunity to act on it.

Signature: _____

Date: _____

PLEASE ATTACH A COPY OF A VOIDED CHECK TO THIS FORM

Mail completed form to:

Group Health Benefits
5215 Main Street
Houston, Texas 77002

Life Insurance

The **Group Health Benefits Committee** provides life insurance to active Clergy, laity and retirees (Surviving Spouses are not eligible) who are enrolled in the program. Following is an overview of the benefits. Refer to your policy for specific details which is the controlling document.

Schedule of Benefits Under Age 65

| | |
|-----------------|----------|
| Life | \$10,000 |
| AD&D | \$10,000 |

Benefits will reduce according to the following schedule:

Attained Age Reduced Benefits Amount

| | |
|---------------------|---------|
| 65-69 | \$6,500 |
| 70-74 | \$5,500 |
| 75-79 | \$3,000 |
| 80 and Older | \$2,000 |

To obtain a copy of your life insurance policy, contact the Group Health benefits office.

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6 Month Extension of Coverage

A member may elect to continue coverage with the Group for an additional six (6) months. To be eligible for such state law continuation coverage, the Member must have been continuously covered for at least three (3) months. Information regarding the availability of this state law continuation coverage will be provided to eligible Members or continuation coverage for certain Dependents upon termination of their coverage.

Continuation of group coverage for a Member under is subject to the following eligibility provisions:

a. Continuation of group coverage must be requested in writing within thirty-one (31) days following the later of (i) the date the group coverage would otherwise terminate; or (ii) the date the Member is given notice of the right of continuation by the Group;

b. A Member electing continuation must pay to the Group on a monthly basis, in advance, the amount of contribution required by the Group, plus two percent (2%) of the Group rate for continued coverage, on the due date of each payment;

c. The Member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis, in advance, must be given to the Group within thirty-one (31) days following the later of (i) the date the coverage would otherwise terminate; or (ii) the date the Member is given notice of the right of continuation by the Group;

d. Continuation may not terminate until the earliest of (i) six (6) months after the date the election is made; or (ii) the date on which failure to make timely payments would terminate coverage; or (iii) the date on which the covered person is covered for similar services and benefits by another Hospital, surgical, medical, or major medical expense insurance policy or Hospital or medical service subscriber contract or medical practice or other prepayment plan or any other plan or programs; or (iv) the date the Group coverage terminates in its entirety;

e. Not less than thirty (30) days before the end of the six (6) months after the date the Member elects continuance, the Health Plan shall notify the Member that he or she may be eligible for coverage under the Texas Health Insurance Risk Pool as provided under Article 3.77, Texas Insurance Code, and the Health Plan shall provide to the Member the address and toll-free telephone number for making application to this pool.

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Benefits Office Staff

To contact the benefits office call 713-521-9383 (or 1-800-606-0350) and ask for Melonie. Melonie will then route your call to the appropriate area.

Mrs. Lydia Fay Lopez
Benefits Administrator / HIPAA – Privacy Officer

Mr. Allen Bass
Pensions – Eligibility Assistant
General Board of Pensions Active Clergy reporting

Ms. Melonie Joseph
Group Health Benefits – Eligibility Assistant
Group Health Benefits – Pensions Customer service

Ms. Monica Obregon
Group Health Benefits – Account Receivable Assistant
General Board of Pensions Retirees & Surviving Spouse reporting

Ms. Patty Oliver
Pensions – Accounts Receivable
Group Health Benefits & Pensions Financial Assistant

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Frequently Asked Questions - HMO

Choosing a Primary Care Physician (PCP).

After you have chosen UniCare HMO as your health insurance, you must select a Primary Care Physician (PCP) who will provide the majority of your health care services. A PCP is a doctor practicing in general medicine, internal medicine, family practice or pediatrics. Your PCP serves as your personal doctor and manages all of your health care needs. You should call your PCP when you need medical advice, when you are sick and when you need preventative care such as immunizations.

It is important that you make sure your PCP has a referral relationship with your preferred specialists and hospitals (for example, The Methodist Hospital). Your PCP may be part of a group of health professionals – such as Kelsey Seybold – who work together to provide a full range of health care services. Or your PCP may be an independent provider.

To be eligible for benefits, see your PCP whenever you need care. All of your care must be provided by or referred by your PCP, except for covered women's health services, mental health and substance abuse services and emergencies. You will be responsible for payment of all other services provided without a referral from your PCP.

After your effective date, it's important to schedule an initial appointment with your PCP. This well person visit provides an opportunity to establish a medical relationship with your PCP and provide a medical history. Your medical history is a key part of your future health care.

Can I change my PCP once I have selected one?

Yes. Just call customer service at the phone number listed on your ID card. (1-800-451-0608)

How can I find a UniCare HMO provider?

Use the UniCare Provider Finder by [clicking here](#) and follow the instructions on your screen.

What are my Benefits?

Read your plan booklet (a copy is available on this website from the Group Health page of this document). If you cannot find your answer in the plan booklet and you are still confused, call customer service.

Remember, Monday mornings are the busiest day for phone calls. Following is a **list of vendors and phone numbers.**

| | |
|-----------------------|----------------|
| Unicare | 1-800-451-0608 |
| WellPoint Pharmacy | 1-888-218-4844 |
| Precision RX Benefits | 1-800-293-2202 |

How do I handle a claim problem?

Call the vendor that handles the benefit in question. If you still disagree and can find a reference for a different payment amount in your plan booklet, send a written appeal to the vendor along

with a copy of the page of the booklet. Pages 28 – 29 of the Group Service Agreement has specific instructions on how to file an appeal with your HMO.

You should receive a written response in 3 weeks or less. If you are appealing a claim decision, you must send these in writing as described in the **Claim Procedures** section of the **Plan Booklet**.

COMPLAINT PROCEDURES

To register a complaint with the Health Plan, the complainant may either telephone the Customer Service Department at 1-800-451-0608, or may write to the Health Plan at:

UNICARE Health Plans of Texas, Inc.
Attn: Quality Management Department
P.O. Box 271709
Houston, Texas 77277

I have a question about my paycheck deduction

Call your District Office which is responsible in assisting you with your **Compensation Report**. The percentage that applied to your salary is approved by Annual Conference and is listed on the rate sheet.

What if I have an emergency, do I have to see my PCP first?

No. If a sickness or injury is life threatening or severe and immediate medical attention is required, go directly to the nearest emergency facility or call 911.

What constitutes an emergency?

Emergencies can vary widely. In general, they are considered conditions with acute (or sharp) symptoms of sufficient severity – including severe pain – that a prudent layperson could reasonably expect to result in serious impairment to his or her bodily functions, or serious dysfunction of any bodily organs or body parts in the absence of medical attention.

What about urgent care and after hours care?

There maybe times when you need urgent care for problems such as ear infections, bladder infections and sprained ankles. Sometimes you will need this care during your PCPs office hours, but sometimes it's in the evening or on the weekend or holiday when the office is closed.

Network physicians make covered services available to members 24 hours a day, 7 days a week, either in person, through on-call or temporary coverage. Network physicians will have a colleague physician and an answering service available when the office is closed.

If you are in a network service area and need urgent care, always call your PCP first at the phone number on your ID card – anytime you need non-emergency care, whether its during or after office hours.

What if I need mental health or substance abuse services?

If you or another covered plan member in your family needs care for a mental health or substance abuse problem, you can seek treatment without going through your PCP and still be

eligible for benefits. You must call the toll free number printed on your ID card for these services.

What if I need a specialist?

If you need care or services that your PCP cannot provide directly, he or she may refer you to another network provider. Your PCP must complete a referral form, sign it and give you a copy to give to the specialist or fax it directly to the network specialist. Specialists do not need a certification number once they have a copy of the referral from the PCP. A referral is valid for one year from the date of the signature by the PCP.

Can I request a Specialist as a PCP?

Members with chronic conditions, complex diagnoses and/or special needs may request a network specialist, (non-primary care physician) as the PCP, in appropriate cases. These specialties include Cardiology, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Nephrology, Pulmonary Medicine and Rheumatology.

For more information contact the Utilization review Department at (713)479-4275 or toll free at (800) 510-4569.

What about women's health services?

A female member may see a network OB/GYN for any obstetrical or gynecological problem, pregnancy or well woman exam without a referral from a PCP. If your PCP is with Kelsey Seybold, then you must select a Kelsey Seybold OB/GYN from Kelsey Seybold to be eligible for benefits. Likewise, if you have an independent PCP not associated with Kelsey Seybold, you must select an independent OB/GYN.

What about coverage for mammograms?

After age 40, a female member does not need a referral from her PCP or OB/GYN for a screening mammogram performed at a network facility. But just like any other outpatient service, she needs an order from her physician for the mammogram. For more information about when a screening may be appropriate, talk to your PCP or OB/GYN. An OB/GYN may not be selected as a PCP. All female members have direct access to network providers for women's covered services.

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Frequently Asked Questions – PPO

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The questions in this section are broken down into the following categories. Click on the category to review the questions in that section.

[General PPO questions](#) (including high deductible plan)

[Utilization review questions](#)

[ScriptCare Questions](#) (including high deductible plan)

General PPO Questions

Who is my insurance carrier?

The PPO plans for The Texas Annual Conference are self-funded plans, which means there is not a traditional insurance carrier associated with the plan. The Conference funds the claims. When a provider asks you who is your insurance carrier. Let them know that PHCS or HealthSmart (as indicated on your ID card) is the PPO and Boon-Chapman is the claim administrator. Your ID card identifies where they should mail the claims.

Who is Boon-Chapman?

Boon-Chapman is a “Third Party Administrator”. Your medical claims are paid in our office in Austin, Texas. You can call our customer service department regarding the status of your medical claims or to get information about your benefit plan. The number to call with these questions is (800) 252-9653. When the recording begins, press “3”, you will then be prompted to enter the group number, which is “928”. At any time you may dial “0” for the operator.

What is a PPO?

A PPO is a Preferred Provider Organization, which is a list of providers that accept discounted rates for your benefit plan.

How do I find a PPO provider?

Please contact the PPO that is listed on your ID card by phone or their website to get information regarding PPO providers in your area. PHCS is the PPO (www.multiplan.com) for participants in the Greater Houston area. HealthSmart Preferred Care is the PPO (www.healthsmart.net) for employees in all other areas. To receive the best benefit you must use a PPO doctor, hospital, or other facility.

Who is PrimeDx and when do I need to contact them?

PrimeDx is the Utilization Management company. They would need to be called to pre-certify or get authorization for inpatient hospital stays and certain outpatient services, as well as when pregnant or possibly becoming a transplant candidate. Either the participant or the provider must call PrimeDx prior to receiving certain services. There is a penalty applied to the claim when services are not pre-certified. The penalty will be the patient's responsibility so it would be in your best interest to make sure that the provider has called PrimeDx to have the necessary

services approved. Please refer to your Plan Booklet for further information about pre-certification requirements. The number to call for pre-certification or pre-authorization is (800) 477-4625.

How do I file a medical claim?

Every time you go to the doctor or hospital, present your ID Card. In most cases, your doctor will file the claim for you. If you pay for services up front and need to be reimbursed from the Plan, please complete a Claim Form and send to Boon-Chapman with your receipt(s). Claims should be mailed to the address on your ID card.

What is a deductible and coinsurance?

Annual Deductible is the amount that the participant pays first before the plan's co-insurance begins to pay. Co-insurance is the percentage amounts paid by the plan and the percentage shared by the participant. There is a calendar year out-of-pocket maximum set by the plan. This means the participant's coinsurance will reach a specific amount and the plan will begin paying claims at 100%. Please see Plan Document for further details.

What are my Benefits?

Read your plan booklet (a copy is available on this website in the Documents section). If you cannot find your answer in the plan booklet and you are still confused, call customer service.

Remember, Monday mornings are the busiest day for phone calls. Following is a **list of vendors and phone numbers**.

| | |
|------------------|----------------|
| Boon Chapman | 1-800-252-9633 |
| Script Care | 1-800-880-9988 |
| Generic Pharmacy | 1-800-713-1230 |

How do I handle a claim problem?

Call the vendor that handles the benefit in question. If you still disagree and can find a reference for a different payment amount in your plan booklet, send a written appeal to the vendor along with a copy of the page of the booklet.

You should receive a written response in 3 weeks or less. If you are appealing a claim decision, you must send these in writing as described in the **Claim Procedures** section of the **Plan Booklet**.

The address is:

Boon-Chapman Benefit Administrators
Attention: Appeals
P.O. Box 9201
Austin, TX. 78766

If you still disagree with the vendor's payment after you receive the response to your written appeal. You can send an appeal letter to Ms. Lydia Lopez, Health and Pension Benefits Administrator, 5215 Main Street, Houston, Texas, 77002.

I have a question about my paycheck deduction

Call your District Office which is responsible in assisting you with your **Compensation Report**. The percentage that applied to your salary is approved by Annual Conference and is listed on the rate sheet.

Methodist Hospital sent me a bill for the deductible amount

Call the **Methodist Hospital** directly and talk to the billing department. Explain that you are Clergy (or laity) covered under the Texas Annual Conference, Group Health Plan and the hospital will implement the benefits agreed upon and not collect deductibles and co-insurance.

How do I find a physician at Methodist Hospital?

There are several ways to identify physicians who practice at **Methodist Hospital**:

- 1) Ask friends and other participants for a recommendation
- 2) Go to the [PHCS web site](#) and do a search on Methodist Hospital
- 3) Call the Methodist Hospital customer services **1-832-667-5900**
- 4) Call Charles Millikan at Methodist Hospital (713-441-3429)

Can Methodist Hospital provide the services I need?

Call either **Boon Chapman**. They will be able to answer your question.

How do I read my Boon Chapman EOB?

[Click here](#) to review an EOB explanation.

I enrolled in the High Deductible Plan, how do my benefits work?

You must meet your deductible before the Plan pays benefits, which means you pay for all services in full until the deductible has been satisfied. Present your ID Card every time you visit the doctor, hospital, or pharmacy so that you can take advantage of network discounts. Once you satisfy the deductible, the Plan pays 80% for most in-network services. Please refer to the High Deductible Plan Document for benefit details.

I am enrolled in the high deductible plan, will Methodist Hospital still waive the deductible and co-insurance for me?

No. The high deductible plan requires that you pay the deductible amount out of your own pocket. That is why there are significant tax advantages associated with the high deductible plan. For example, opening an HSA and being able to deduct your HSA contribution.

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Utilization review questions

What does preauthorization means?

Preauthorization or precertification is the process utilized to confirm if a proposed service or procedure or admission is medically necessary. Preauthorization or precertification pertains to medical necessity only, and is not a guarantee of payment. The patient's eligibility and benefits need to be verified by the patient, member and/or provider through Boon Chapman's Provider and Member Customer Service.

Who reviews the preauthorization or precertification?

PRIME Dx handles all reviews of preauthorization or precertification.

How do I contact PRIME Dx?

You may call PRIME Dx at (800) 477-4625, Monday thru Friday, 8:00 AM-5:30 PM. Voicemail is available after business hours, and messages are returned the following business day. Fax number is (800)213-5108

Who is responsible for initiating the preauthorization?

The member or patient is responsible for initiating any preauthorization. The physician who orders or schedules the admission is responsible for providing the clinical information.

What services require preauthorization?

The following services require preauthorization:

*Inpatient admission
Skilled Nursing Facility admission
Outpatient Procedures- Arthroscopy, Blepharoplasty, Cardiac Catherization/Surgery, Carpal Tunnel Surgery, Septoplasty
Diagnostic Tests- Computerized Tomography (CAT scan), Magnetic Resonance Imaging (MRI)
Durable Medical Equipment
Home Health Care
Hospice Care
Maternity
Substance Abuse Treatment or Services
Physical Therapy
Occupational Therapy
Speech Therapy
Transplant*

Is there a penalty if a member or provider fails to obtain preauthorization?

Yes. Please refer to your plan Schedule of Benefits to find out the reduction of any covered expenses because of failure to obtain preauthorization.

What happens if a preauthorization request is not approved?

PRIME Dx notifies the requesting provider and/or member/patient when a preauthorization service is not approved, which is called a denial. The requesting provider and/or member has

the right to appeal the denial. A denial letter is generated and sent to the requesting provider and member, and the appeal process is outlined in the denial letter.

What is case management?

PRIME Dx will assign a Registered Nurse case manager when a patient's condition requires complex, specialty or long term care. The case manager will attempt to coordinate healthcare services through direct interaction with the patient, family, or physician's office, in an effort to achieve quality, and the most appropriate medical care in a cost effective manner.

Your case manager will send you a letter that provides you with information about case management services, as well as her contact information.

How do I contact my case manager?

You may call your assigned case manager at (800) 477-4625.

Does case management change my benefits?

No. Case management is a voluntary program, and available to the patients at no cost to the member.

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ScriptCare Questions

Who is ScriptCare?

ScriptCare is a Prescription Benefit Manager (PBM) which contracts with pharmaceutical companies to obtain lower prices on prescription drugs. Those lower prices are then passed on to the Conference in the form of savings and lower costs.

When does the prescription drug annual deductible start and how much is it?

The annual deductible starts May of every year and is \$50 per person.

What pharmacies are in my prescription network?

Script Care's network includes over 60,000 pharmacies including all major chains. A full pharmacy listing can be found at www.scriptcare.com

What drugs are included on my Formulary and Specialty program?

A complete Formulary and Specialty listing can be found on Script Care's website at www.scriptcare.com

How do I find out how much a specific drug will cost me?

A copay calculator is available on Script Care's website at www.scriptcare.com

What is Script Care's Customer Service phone number and hours of operation?

Script Care Customer Service phone number is 1-800-880-9988, or you can email your questions to customerservice@scriptcare.com. Customer service is open 24 hours a day, 7 days a week.

What is the ScriptCare Specialty Pharmacy Program?

The ScriptCare Specialty Pharmacy Program focuses on the delivery and management of pharmaceutical products that are generally, but not exclusively, biotechnological in nature, and on coordinating care for members required to take these medications.

The Program's drug list includes core treatment therapies for disease states such as:

- Growth Hormone
- Multiple Sclerosis
- Hepatitis
- Hemophilia
- Cancer
- Pulmonary Disorders
- Infertility
- Rheumatoid Arthritis
- Other Various Disease States

How do I get setup in the Script Care Specialty Pharmacy Program ?

You can contact a Specialty nurse at 1-866-443-1991 and they will get you setup in the Specialty Program. Specialty nurses are available Monday through Friday from 8:00am – 5:00pm.

I enrolled in the high deductible plan, will ScriptCare still pay for my drugs after the co-pay?

No. Under the high deductible plan you must satisfy the deductible before you receive any medical or prescription benefits (the only exception are some wellness benefits). ScriptCare will send you a discount card if you are enrolled in the high deductible plan, but you will need to pay your prescriptions and submit them to Boon Chapman for payment.

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Numbers to Remember

Boon Chapman – Group #928

| Website | Customer service |
|--|------------------|
| www.boonchapman.com | 800-252-9653 |
| www.multiplan.com | 888-719-7427 |
| www.healthsmart.net | 800-687-0500 |

ScriptCare – Group H1718 (PPO Participants only)

| Website | Customer service |
|--|------------------|
| www.scriptcare.com | 800-880-9988 |

UniCare HMO – Group #144217

| Website | Customer Service |
|--|------------------|
| www.unicare.com | 1-800-451-0608 |

Wellpoint Pharmacies (HMO Prescription program)

| Website | Customer service |
|--|------------------|
| www.wellpoint.com | 1-800-218-4844 |

Precision Rx (HMO Mail Order)

| | |
|------------------|----------------|
| Customer Service | 1-800-293-2202 |
|------------------|----------------|

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