Texas Annual Conference
United Methodist Church

Center for Connectional Resources
Group Health Benefits (GHB)

2024 Open Enrollment Information

Health. Wealth. Peace of Mind.

Active Clergy
&
TAC Fiscal Office Lay Employees

Please review carefully.

Texas Annual Conference
United Methodist Church
CENTER FOR
CONNECTIONAL RESOURCES
Rev. Robert Besser
Treasurer / Benefits Officer
rbesser@txcumc.org

October 17, 2023

Dear Active TAC Group Health Benefits Plan Participant,

Thank you for your unwavering commitment and faithful service to our Lord Jesus Christ through the Texas Annual Conference United Methodist Church.

Enclosed is your 2024 Annual Open Enrollment Packet for the Texas Annual Conference Group Health Benefits Plan. All **2024 Open Enrollment Materials** and documents are available online at **www.txcumc.org** > Connectional Resources > Benefits > 2024 Open Enrollment Materials, or by scanning the enclosed QR code shown on the GHB Open Enrollment Instructions in this packet.

We are pleased to announce an exciting new relationship with Apta Health! Effective 1/1/2024, UMR will replace Boon-Chapman as the third-party plan administrator (TPA) using the United Health Care (UHC) PPO network and care navigation services will be added on top of this through Apta Health. UHC is the nation's largest provider network, and Apta Health is the industry leader in care navigation and member services. Our partnership with Apta Health has been instituted to deliver a best-in-class experience for member services, provider services and care navigation.

The Apta Health Care Coordinators will be your personal "Healthcare Warrior" - a dedicated team of nurses, case managers, utilization management experts, health coaches, and disease management specialists that have backgrounds in hospitality and motivational customer service alongside their medical specialty. The dedicated team is there to support you (the member) in real-time with engagement and solutions.

Please review the enclosed *Overview of the TAC Group Health Plan for 2024*. Note there are **6** important updates for 2024:

1. The Group Health Benefits Church contribution rate will **increase** from 11.2% to 12.5% for 2024. This is part of a 4-year process (voted on in 2020) to eliminate the Group Health Benefits apportionment by 2024 and to collect all church and clergy GHB contributions solely through the church monthly GHB drafts for eligible employees who receive benefits.
2. Effective 1/1/2024, Marriage and Family Counseling is added as a covered benefit under both the Standard PPO and High Deductible PPO plans. This replaces the standalone Supplemental Counseling Benefit which is terming 12/31/23. There will be a $25 copay for all in-network mental health counseling visits (including marriage and family counseling) under the Standard PPO Plan.

3. Effective 1/1/2024, Hearing Aids is added as a covered benefit under both the Standard PPO and High Deductible PPO plans. This replaces the standalone Hearing Aid Out-of-Pocket Reimbursement Benefit which is terming 12/31/23.
4. Deductible and co-insurance amounts waived at Houston Methodist (and related facilities) will not be applied toward your deductible and out-of-pocket maximums should you visit other facilities subsequently.
5. Effective 1/1/2024, there will be billing rate adjustments for participants in our Group Health Benefit plan. Please see the details of rate changes included in this packet.
6. There will be **no increases** in the Humana Dental PPO and Humana Vision Plan premiums for 2024.

As a reminder, Active TAC GHB 2024 Open Enrollment is November 1 – 15, 2023.

Effective 1/1/2024, **everyone will receive new ID cards** in the mail. Please be on the lookout for those in *January*. A sample proof of the ID card is enclosed. If you need an electronic version of your ID card, please contact the Benefits Office, or be sure to create your Apta Health Member Portal in *January* for a faster digital way of viewing your new ID card.

As in past years, if you do not wish to make any changes to your benefit plans or dependent coverages for 2024, you *do not need* to submit a new Group Health enrollment form to the TAC Benefits Office during Open Enrollment – **we will continue your 2023 coverages in 2024.**

If you would like to make changes for next year, you must complete, sign and date a new GHB Enrollment and return it to the TAC Benefits Office between November 1 and 15, 2023. All changes will be effective January 1, 2024.

2024 Open Enrollment Webinar: There will be a Zoom 2024 Open Enrollment Webinar on **Wednesday, October 25, 2023, from 2:00 to 4:00 pm** to discuss benefit changes for 2024. Representatives from UMR and Apta Health will also do a presentation and will be available to answer any questions. Details and the link to the webinar have been emailed to GHB plan participants.

High Deductible PPO Plan Webinar: We are also hosting, separate from the 2024 Open Enrollment Webinar, ***a High Deductible PPO Health Plan Webinar*** on **Tuesday, October 31, 2023, from 2:00 to 3:00 pm**. This webinar will go in depth on the High Deductible PPO Health Plan giving participants the opportunity for Q&A. Details and the link to the webinar have been emailed to GHB plan participants.

Texas Annual Conference Family, we are grateful for the service you provide daily to our Lord Jesus Christ and to the United Methodist Church. It is our prayer that the benefits provided by the Texas Annual Conference will enable you to fulfill our mission to make disciples of Jesus Christ for the transformation of the world to the glory of God! Amen!

Robert Besser

5215 Main Street ┼ Houston, Texas 77002-9752 ┼ Office: 713-533-3720 ┼ Fax: 713-521-7516

Group Health Benefits
2024 Open Enrollment Instructions

(Please read carefully)

1. Your 2024 Open Enrollment Packet includes information about plan changes for 2024*. Please review it carefully.* Additional Open Enrollment documents including the TAC Group Health Benefits Enrollment Form are posted at **2024 Open Enrollment Materials**, by going to **www.txcumc.org** > Connectional Resources > Benefits > 2024 Open Enrollment Materials, or by scanning with your phone the QR code at the bottom of this page.

2. *You can easily review your current benefit plans in your Boon-Chapman Member Portal online.* Go to **https://www.boonchapman.com/member-login** to do so. On the *Member Portal* home page, click on "Benefits and Coverages" on the top menu bar and scroll down to Benefit Plans to access your current 2023 benefit plan elections for you and your enrolled dependents.

   You can also contact the TAC Benefits Office if you have any questions regarding your current plan enrollments.

3. Please review the benefits information provided in this packet. *If you do not wish to make any changes to your benefit plans or dependent coverages in 2024, you do not need to submit a new enrollment form during Open Enrollment.* We will continue your current 2023 benefit plans and dependent enrollments in 2024.

4. Your Open Enrollment Period is ***November 1 – 15, 2023****. If you want to make changes in your coverage, please complete in full the TAC Group Health Benefits Enrollment Form found on the Open Enrollment Documents, in the above link.* Indicate all plan elections and all dependents you wish to enroll. *Your dependent coverages can be different for each plan in which you enroll. Please print legibly to avoid errors or delays in your coverage. Sign and date your enrollment form no later than November 15, 2023.*

5. GHB Enrollment forms must be received in the TAC Benefits Office by November 15, 2023*. Please submit forms by fax or email rather than regular mail if possible:*

   Email: **mmorales@txcumc.org**
   Fax: 713-521-7516
   Mail: TAC Benefits Office, 5215 Main St., Houston, TX 77002
   Attn: **Marianela Morales**

6. *All changes in coverage you elect will be effective January 1, 2024.*

7. After Open Enrollment ends, you will not be able to change plans or add dependent coverage until the next Open Enrollment in November 2024 (unless you have a qualifying event such as marriage or the birth of a child).

Scan the following QR code to see all 2024 Open Enrollment Materials

Overview of the TAC Group Health Plan for 2024

All plan changes are effective 1/1/2024

We are pleased to announce an exciting new relationship with **UMR, UnitedHealthcare, and Apta Health for 2024!**

Effective 1/1/2024, UMR will replace Boon-Chapman as the third-party plan administrator (TPA) using the UnitedHealthcare (UHC) PPO network. UHC is the nation's largest provider network and Apta Health is the industry leader in care navigation and member services. Also adding a layer for Care Coordinators with Apta Health.

Our partnership with Apta Health has been instituted to deliver a best-in-class experience for member services, provider services and care navigation. **The Apta Health Care Coordinators** will be your personal **"Healthcare Warrior"** - a dedicated team of nurses, case managers, utilization management experts, health coaches, and disease management specialists that have backgrounds in hospitality and motivational customer service alongside their medical specialty. The dedicated team is there to support you, the member, in real-time with engagement and solutions.

Please see the Apta Health Welcome flyer in the packet for more information.

Medical Plans

Key Components:

Third Party Administrator (TPA): UMR
Network: UnitedHealthcare PPO (UHC)
Care Navigators: Apta Health
Pharmacy Benefit Manager: RxBenefits~Express Scripts
Specialty Medications: Accredo Specialty Pharmacy

Both Standard PPO and High Deductible PPO Plans utilize the same network and offer the same covered services. The difference is the cost-share (what you pay if you receive care) and the premiums you pay upfront. There are *no changes to deductibles or out-of-pocket maximum expense limits* for either the Standard PPO or High Deductible PPO Plans for 2024.

All deductibles and out-of-pocket maximum expense limits are effective January 1 each year.

Please see chart on the following page comparing what you would pay under each medical plan.

Visit **Standard PPO Plan / High Deductible PPO Plan** on our website for detailed information on each medical plan.

Plan Name	High Deductible PPO Plan	Standard PPO Plan
Eligible to open Health Savings Account (HSA)	Yes*	No
Individual Deductible	**$1,850 Combined Medical and Prescription deductible** (in-network) / **$5,550 Combined Medical and Prescription deductible** (out-of-network)	**$1,000 Medical deductible** (in-network) / **$3,000** (out-of-network)
Family Deductible	**$3,700 Family** (in-network) / **$11,100 Family** (out-of-network)	**$3,000 Family** (in-network) / **$9,000** (out-of-network)
Coinsurance (in-network)	20% coinsurance (in-network)	
Medical Out-of-Pocket Maximum (Includes medical deductibles, co-payments and co-insurance)	**$4,500 Individual In-Network $10,000 Family In-Network**	**$4,500 Individual In-Network $10,00 Family In-Network**
Can access Houston Methodist Hospital System in-network?	Yes	Yes
Eligible for Houston Methodist Hospital Write-Off of Deductibles and Co-Insurance?	No	Yes
Preventive care (in-network)	No charge, includes lab and X-rays performed outside doctor's office.	
Office Visit Co-Pay (in-network)	20% coinsurance after deductible	$25 Primary Care (PCP) $40 Specialist
Teladoc®	$49 fee per visit until deductible is met, then 20% co-insurance	$0 Co-Pay
All other covered expenses (in-network)	20% coinsurance after deductible	
Pharmacy Deductible	Combined medical/pharmacy deductible**	Pharmacy-only deductible: $50 Individual/$100 Family***
Pharmacy Retail Costs	20% coinsurance after deductible	
Pharmacy Out-of-Pocket Maximum	High deductible plan **combines medical and prescription** drug out-of-pocket expenses	$2,000 Individual $4,000 Family (applies only to prescription drug expenses)
Total Medical + Pharmacy Out-of-pocket	**$4,500 Individual In-Network $10,000 Family In-Network**	**$6,500 Individual In-Network $14,000 Family In-Network**
Out-of-Network	You pay 40% of maximum allowable charge after applicable deductible is met.	

*Enrolling in the High Deductible PPO Plan allows you to set up a **tax-advantaged Health Savings Account**.

Under the High Deductible PPO Plan, certain ***generic preventive* prescriptions for the treatment of ***asthma, high blood pressure, high cholesterol, and diabetes*** are available at no charge.

Under the Standard PPO Plan, certain ***generic prescriptions for the treatment of ***asthma, high blood pressure, high cholesterol, diabetes, and proton pump inhibitor***s are available at no charge.

Plan Benefit Changes

A. Marriage and Family Counseling

- Effective 1/1/2024, the standalone Supplemental Counseling Benefit will be discontinued, and these services will be **integrated into the health plan**. Cost sharing for all mental health counseling visits (including but not limited to marriage and family counseling) will be covered under the health plan as follows:
    - **Standard PPO Plan**
        - There will be a $25 copay for all in-network mental health counseling visits (including marriage and family counseling) under the Standard PPO Plan.
        - Out-of-network mental health counseling visits (including marriage and family counseling) will be subject to applicable Standard PPO Plan out-of network deductibles and co-insurance.
    - **High Deductible PPO Plan**
        - All mental health counseling visits (including marriage and family counseling) will be subject to in-network and out-of-network deductibles and coinsurance as applicable under the High Deductible PPO Plan.

  Other mental health (non-counseling) office visits as well as all other mental health benefits under both the Standard PPO and High Deductible PPO Plans will be subject to applicable Standard PPO and High Deductible PPO Plan cost sharing (copays, deductibles, and coinsurance).

- This coincides with the termination of the standalone Supplemental Counseling Benefit on 12/31/23.

B. Hearing Aids

- Effective 1/1/2024, the standalone hearing aid will be discontinued, and these services will be **integrated into the health plan** as follows:
    - Hearing aid(s) will be covered **once every three years** for each ear if required. Applicable Standard PPO and High Deductible PPO Plan in-network and out-of-network deductibles, coinsurance and maximum out-of-pocket expense limits will apply.

  Covered benefits include:
    1. a hearing aid instrument, monaural or binaural, including ear mold(s).
    2. visit for fitting, counseling, and adjustments;
    3. the initial battery;
    4. cords;
    5. other ancillary equipment.
    6. surgically implanted hearing devices.

  The following are **not** covered:
    1. purchase of batteries or other ancillary equipment except those covered under the terms of the initial hearing aid purchase;
    2. charges for a hearing aid that exceed the specifications prescribed for correction of a hearing loss;

3. replacement parts for hearing aids, repair of a hearing aid after the covered warranty period, and replacement of a hearing aid more than once in any 36-month period

- This coincides with the termination of the standalone Hearing Aid Out-of-Pocket Reimbursement Benefit 12/31/23.

C. Houston Methodist Hospital Deductible & Coinsurance Write-off

- The Houston Methodist Hospital Deductible & Coinsurance Write-off (Non-collection Agreement) will continue in 2024; however, Deductible and co-insurance amounts waived at Houston Methodist (and related facilities) will not be applied toward your deductible and out-of-pocket maximums should you visit other facilities subsequently.

TAC Wellness Program

There are no changes to Wellness Program Benefits for 2024. Wellness Program Incentives remain as follows:

2024 Weight Loss Incentives	Amount
5% of weight at the Day of Wellness	$200
10% of weight at the Day of Wellness	$200
100% of weight to reach a BMI of 25.0 or less	$600
Total Weight Loss Incentives	$1,000
Pregnancy Weight Loss Incentive	$1,000
Annual Maintenance Incentive	$1,000

TAC Walking Program

There are no changes to Virgin Pulse Walking Program Benefits for 2024. Walking Program Incentives remain as follows:

Points Reached	Incentive Earned	Cumulative Total per Quarter
1,000	$5	$5
5,000	$15	$20
10,000	$25	$45
15,000	$30	$75

Wellness (Preventive Care) Benefits Covered at 100% for In-Network Providers only

As a reminder, effective January 1, 2021, wellness benefits under the Standard PPO and High Deductible PPO Plans are *covered at 100% for in-network (PPO) providers only*. Wellness benefits for out-of-network (non-PPO) providers will be subject to applicable deductibles and co-insurance.

For an informational flyer go to **www.txcumc.org** > Connectional Resources > Benefits > 2024 Open Enrollment Materials.

2024 Group Health Benefits Contribution Rates

Change in the 2024 *Church* Group Health Contribution Rate

The Church Group Health Benefits contribution rate will increase from 11.2% in 2023 to 12.5% of the clergy's Total Group Health Benefits Compensation as specified on the Clergy Comp Fillable Form for 2024.

This is the final step of a 4-year process (voted on in 2020) to eliminate the Group Health Benefits apportionment by 2024 and to collect all church and clergy GHB contributions solely through the church monthly GHB drafts.

Change in the 2024 *Clergy* Group Health Contribution Rates

Clergy Group Health contribution rates will change for 2024 for both the Standard PPO and the High Deductible PPO Plans as specified below. The following percentages are applied to the clergy's Total Group Health Benefits Compensation as specified on the Clergy Comp Fillable Form for 2024.

Effective 1/1/2024, clergy billing rates will be adjusted whereby a greater portion of actual expenses are covered via premium collections for dependent coverage in the plan. In addition, direct billing rates for laity, early retiree, surviving spouse, dependents of Medicare eligible participants and long-term disabled will be adjusted upwards accordingly.

Coverage Level	High Deductible Plan	Standard PPO Plan
Clergy Only	3.25%	6.75%
Clergy & Spouse	7.10%	13.30%
Clergy & Child(ren)	5.45%	10.35%
Clergy & Family	9.65%	15.65%

Change in the 2024 *Clergy Medical Leave* Group Health Contribution Rates

The TAC Sustentation Fund pays 60% of the direct billing rate for Group Health coverage for clergy appointed to Medical Leave. The clergy pays 40% as per the charts below. The monthly Group Health contributions for ***Clergy appointed to Medical Leave*** (***on Apta Health***) are as follows for 2024:

Coverage Level	High Deductible Plan	Standard PPO Plan
Clergy Only	$180.00	$260.00
Clergy & Spouse	$420.00	$600.00
Clergy & Child(ren)	$260.00	$380.00
Clergy & Family	$500.00	$720.00

The monthly Group Health contributions for ***Clergy appointed to Medical Leave*** (***Medicare primary, Apta Health secondary***) are as follows for 2024:

Coverage Level	High Deductible Plan	Standard PPO Plan
Clergy Only	$90.00	$130.00
Clergy & Spouse	$210.00	$300.00
Clergy & Child(ren)	$130.00	$190.00
Clergy & Family	$250.00	$360.00

Change in 2024 *TAC Fiscal Office Lay Employee* Group Health Contribution Rates

TAC Fiscal Office Lay Employee Group Health contribution rates will change for 2024 for both the Standard PPO and the High Deductible PPO Plans as specified below.

Coverage Level	High Deductible Plan	Standard PPO Plan
Employee Only	$ 0.00	$ 0.00
Employee & Spouse	$600.00	$850.00
Employee & Child(ren)	$200.00	$300.00
Employee & Family	$800.00	$1,150.00

Note: The above amounts exclude the employer-paid portion of the monthly contribution which is $650.00 for the Standard PPO Plan and $450.00 for the High Deductible Health Plan.

Optional Humana Dental/Vision Plans

The Texas Annual Conference Group Health Benefits Plan will continue to offer optional **Dental PPO** and **Vision** Coverage through **Humana in 2024**:

Following are the eligibility requirements to enroll in optional dental and or vision coverage:

1. Employee must be a participant of the Group Health Benefits Plan of the Texas Annual Conference. *Eligible dependents do not have to participate in the medical plan in order to participate in the TAC Dental PPO and/or Vision plans.*
2. Your salary-paying unit (e.g., your local church) will be drafted for your optional dental/vision coverage along with your medical contributions each month.

There are no increases in the Humana Dental PPO rates or Humana Vision Plan rates for 2024:

	Dental PPO	Vision 130
Employee Only	$29.29	$ 7.28
Employee & Spouse	$65.31	$14.53
Employee & Child(ren)	$62.61	$13.82
Employee & Family	$100.46	$21.73

There are no changes to the benefits for the Humana Dental PPO or Vision plans for 2024.

High Deductible PPO Plan and a Health Savings Account (HSA)

Enrollment in the High Deductible PPO Plan allows you to set up a tax-advantaged Health Savings Account (HSA) to help pay for eligible healthcare expenses today and down the road. Funds in the HSA account can be used to pay for your deductible and any eligible medical expense, even if the expense is not covered by the medical plan. Eligible dental and vision expenses may be reimbursed through an HSA account as well.

Your HSA contributions accumulate in your account, earning interest, until you need them. The funds contributed to the account are not subject to federal income tax, thus reducing your taxable income, and interest you earn on your HSA balance is tax-free. Unused HSA funds roll over from year-to-year, allowing your balance to grow over time.

An HSA is opened like a typical bank account at your preferred bank or financial institution. Another option is to use the online HSA Bank. Go to **https://ioe.hsabank.com/home** for further information. HSA Bank provides you with a debit card to use when paying for qualified healthcare expenses. You can deposit one lump sum for the year (up to the IRS contribution limit) or make smaller deposits throughout the year. **Additional information can be found in the brochure in this packet.**

We are also hosting ***a High Deductible PPO Health Plan Webinar*** on **Tuesday, October 31, 2023, from 2:00 to 3:00 pm**. This webinar will go in depth on the High Deductible PPO Health Plan giving participants the opportunity for Q&A. Details and the link to the webinar have been emailed to GHB plan participants.

Note: You cannot be enrolled in Medicare or Tricare and make contributions to an HSA. Also, the Houston Methodist Hospital write-off of deductibles and co-insurance is not available to TAC High Deductible Health Plan participants due to HSA rules.

Scan the following QR code to see all 2024 Open Enrollment Materials

WHAT IS APTA HEALTH?

Dear Apta Health Member,

Congratulations! You are a member of an exciting new way of managing your healthcare. Your employer has chosen Apta Health to bring amazing benefits that are usually reserved for Fortune 500 Companies to its employees. The Apta Health program brings together some of the best healthcare vendors in the country and combines them into a single package to help you get the best care at the best prices.

Care Coordination is at the heart of our program. This unique approach to healthcare allows you access to a real, live person to talk to about your health concerns and is available **completely free of charge** whenever you need help. Think of your Care Coordinators as healthcare warriors that will fight for you to make sure you get the best care possible! They are based in Ohio, USA and available Monday through Friday, 8:30 AM to 10:00 PM Eastern Time. You can call them for anything from replacing a lost ID card, to help finding an in-network physician, to help with an upcoming medical procedure, and questions or issues with your medical bills. They are also available through your company's custom web portal, or through the Quantum Health App on the Apple App Store or Google Play. Your Care Coordinators are the best place to start whenever you have questions or need help.

Apta Health includes the standard components that you would expect from a healthcare program like a network of doctors and hospitals as well as prescription drug insurance. Your company may also choose additional components that further enhance your coverage. These additional components are included and explained in this benefit guide.

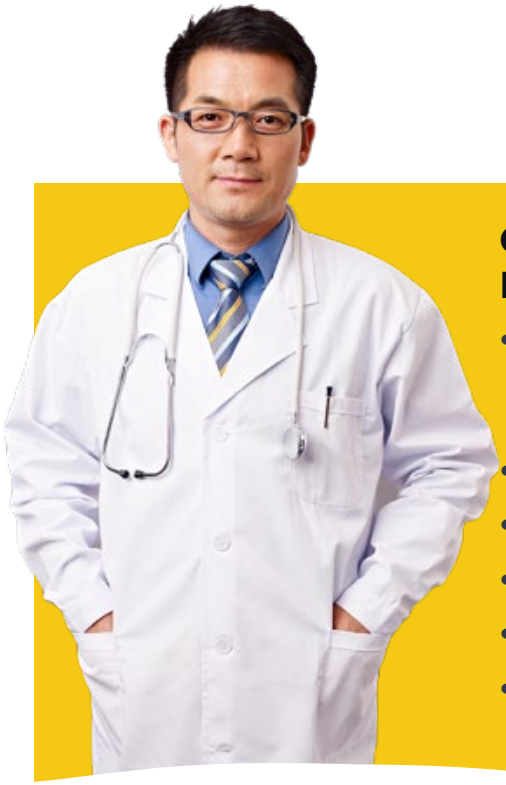
The great news is that your care coordinators are trained experts in all your benefits and will guide you through your benefit decisions. Your care coordinators will help you move along your healthcare journey and make the process as smooth as possible.

We hope you will enjoy your healthcare benefits and wish you a happy and healthy year!

Sincerely,

The Apta Health Team

REFERRAL PROCESS FOR A SPECIALIST



COORDINATE YOUR CARE THROUGH YOUR PRIMARY CARE PHYSICIAN (PCP)

- Obtain a referral from your PCP before seeing a specialist to save money on member out-of-pocket costs and get alerts for not fully covered benefits
- Helps avoid visits to the wrong specialist
- Helps avoid referrals to an out-of-network specialist
- Get in to see specialist faster
- All referrals obtained are valid for 12 months.
- The PCP must provide the referral to the Care Coordinators.

PRE-CERTIFICATION

Before you receive certain medical services or procedures, your health plan requires a doctor to confirm that these requested services are considered medically necessary under your plan. This verification process is called "pre-certification.“ Even if some services or therapies are performed in your doctor's office, you may still need a pre-certification. Pre-certification requests must be submitted by your physician directly to the Apta Care Coordinators.

SERVICES REQUIRING PRE-CERTIFICATION			
Inpatient Hospitalizations & Skilled Nursing Facility Admissions	Home Health Care and Services	Oncology Care & Services (chemotherapy, radiation therapy, etc.)	MRI’s, MRA’s and PET Scans
Hospice Care	Dialysis	Transplants – Organ and Bone Marrow	Durable Medical Equipment (DME) purchases over $1500 and all rentals
Out-Patient Surgeries (includes Colonoscopies)	Genetic Testing		
• A $500 penalty will be applied for all services rendered that do not have pre-certification completed.			

APTA CASH CAN HELP SAVE YOU MONEY!

DO YOU NEED SURGERY OR AN EXPENSIVE DIAGNOSTIC TEST?

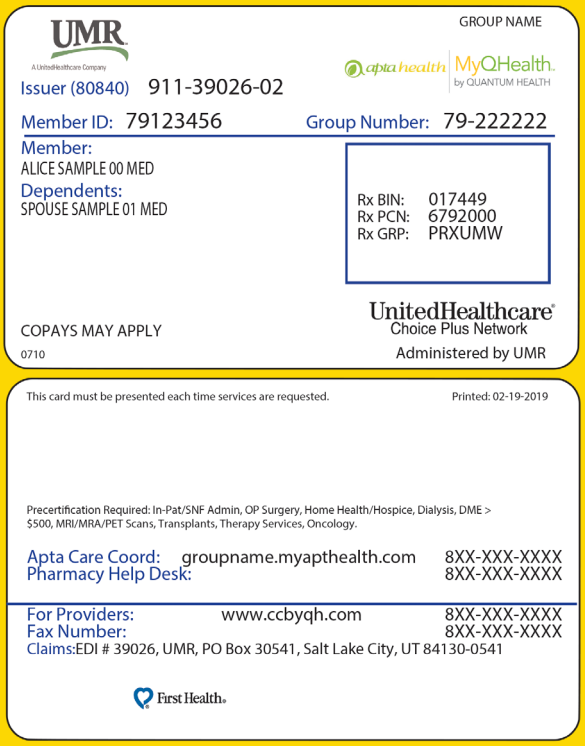
WHAT IS APTA CASH?
It's a healthcare concierge service that helps employees lower their out-of-pocket costs by choosing high-quality providers who offer affordable cash prices.

WHEN SHOULD I CONTACT APTA CASH?
Whenever one of your doctors or medical providers recommend a major diagnostic test or surgery that can be planned in advance, contact Apta Cash first at **855-378-0770.**

WHY SHOULD I CONTACT APTA CASH?
Your health plan has partnered with Apta Cash to help you and your employer save money. Your plan deductible and coinsurance will be waived when you use Apta Cash. If you are enrolled in a HDHP Plan, the minimum deductible may apply.

HOW DOES THE PROGRAM WORK?
When you contact Apta Cash, your coordinator will ask you questions to understand the procedure you need and help you choose a high-value provider. Next, they will attempt to negotiate a cash price for your procedure that is less than your medical plan's typical cost. When you, the provider, and the plan agree to the cash rate, Apta Cash will walk you through the steps to get the procedure scheduled, make sure any required pre-certification is completed, and prepare to pay the full cash price when you receive care.

Getting Started with Apta Health



HOW TO REQUEST ADDITIONAL ID CARDS

You and your eligible dependents will receive ID cards in the mail. You can request an additional ID card by logging into the website and clicking on either Download >, Print > or Mail > to choose your method of delivery.

HOW TO CHANGE YOUR PASSWORD

After logging in to the home page, you will see your name in green on the left-hand side. Below your name, you will see Settings. Select settings and click on your name. From here, you will see the option to change your password.

Your Healthcare Coordinators are standing by and ready to help!

https://TAC.myaptahealth.com

877-610-8817

(Monday - Friday, 8:30am - 10:00pm EST)

Know Your Benefits

The Importance of Preventive Care

According to the U.S. Centers for Disease Control and Prevention (CDC), 7 out of 10 Americans die each year from chronic diseases, many of which are preventable. When preventive care is used and illnesses and diseases are caught early enough, individuals can avoid or better control their health problems.

What Is Preventive Care?

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. Preventive care occurs before you feel sick or notice any symptoms and is designed to prevent or delay the onset of illness and disease. The CDC asserts that treatment for chronic diseases works best when they are detected early.

In its broadest definition, prevention includes a healthy lifestyle, exercise, diet and other similar efforts. Preventive care in a medical setting includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations. Regular health evaluations will help keep you healthy and prevent more serious problems later.

Why Use Preventive Care?

Preventive care is important because it helps you stay healthy and access prompt treatment when necessary, and it can also help reduce your overall medical expenses.

ALERA GROUP

- Stay healthier and get more effective treatment – Many types of screenings and tests can catch a disease before it starts; for example, diabetes screenings can tell you whether you're pre-diabetic, or whether you already have diabetes without being aware of it.

  Starting treatment or lifestyle changes before a disease starts or while it is still in its early stages will help you stay healthier or recover more quickly.

- Pay less for medical expenses – Preventive care saves you money in two ways.

  - First, preventive care helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

  - Second, many preventive services are now covered in full by insurance due to the Affordable Care Act (ACA), which means they are free for you if you have health insurance. The ACA requires certain preventive services to be covered with no cost-sharing—this means that for many preventive care services, you will not have to pay a deductible, copay, coinsurance or other out-of-pocket expenses.

The U.S. Department of Health and Human Services has provided lists of preventive services that must be covered by most health insurance plans. Lists are available for adults, women and children, as covered services depend on age and gender. Click here for the lists of covered preventive care services.

For adults, services such as blood pressure and cholesterol checks and screenings for depression are covered. Women may have folic acid supplements and anemia screenings covered if they are pregnant. Children's covered preventive services include autism screenings for children at ages 18 and 24 months and alcohol and drug use assessments for adolescents.

When preventive care services are combined with a lifestyle that is focused on wellness, significant savings can be realized. Ultimately, preventive care provides the benefit of saving lives and improving the quality of your health for years to come.

TAKE ACTION

Know Where to Go for Your Health Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs $1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Shortness of breath
- Uncontrollable bleeding
- Poisoning or suspected poisoning

Urgent Care

Urgent care centers handle nonemergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Sprains, ear infections and high fevers are conditions that can be treated in urgent care centers. Urgent care visits are less expensive than ER visits, but are typically more expensive than a visit to your primary care doctor.

Doctor's Office

For most nonemergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

What's Next?

Now that you're aware of the differences between these types of health care facilities, next time you're sick or hurt, you'll be prepared to make the right decision for your health and wallet.

Understanding Qualified High Deductible Health Plans (HDHP) and Health Savings Accounts (HSA)

What is a Qualified High Deductible Health Plan (HDHP)?

A high deductible health plan (HDHP) is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. The IRS determines the requirements of a qualifying HDHP.

You are responsible for paying your eligible medical and prescription expenses up to the deductible(s) stated in the HDHP plan. Your deductible is the amount you must pay toward your health care and prescription **before** benefits are paid by the HDHP plan. All eligible in-network preventive services are covered at 100% and do not accumulate toward the deductible.

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a tax-advantaged medical savings account that can be established and combined with a qualified high deductible health plan to help pay for healthcare expenses today and down the road. Your HSA contributions accumulate in your account, earning interest, until you need them. The funds contributed to the account are **not** subject to federal income tax or even state taxes in most cases. They reduce your taxable income. And interest you earn on your HSA balance is tax free.

How an HSA Works

An HSA is opened like a typical bank account. Money that is deposited to your HSA can be used to pay for qualified healthcare expenses. You can deposit one lump sum for the year (up to the IRS contribution limit), or make smaller deposits throughout the year. You can also make a one-time, tax-free transfer from your IRA to your HSA. Contributions can be deducted on your federal tax form for the year in which the contributions are made.

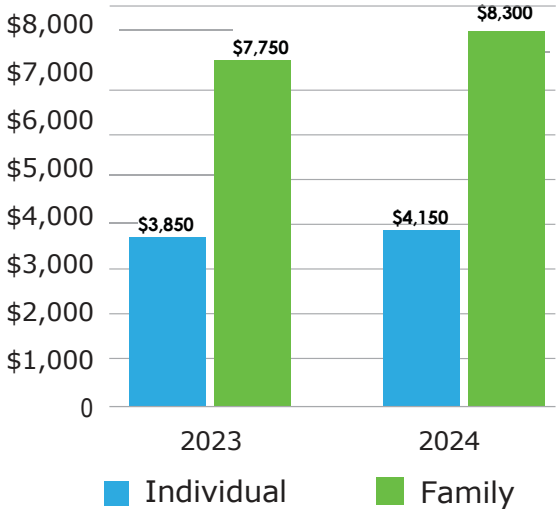
Funds in the HSA account can be **used to pay for your health plan deductible** and any "eligible medical expense," even if the expense is not covered by the medical plan.

Dental and vision expenses are also eligible to be reimbursed under an HSA account. See **IRS Publication 502 "Medical and Dental Expenses"** for a listing of eligible HSA expenses.

Your HSA is yours to keep – you own the account from the day you open it. There is no "use it or lose it". Any balance in your HSA rolls over from year to year whether you change jobs, retire, or choose a different health care plan.

HSA Contributions

There are limits, set by law and adjusted annually, for how much you can contribute to an HSA in a calendar year. For 2023 and 2024, those annual limits are as follows:



If you are age 55 or older, you can make "catch up" contributions, meaning you can deposit an additional $1,000 every year into your HSA. If your spouse is also 55 or older and enrolled in an HDHP, he or she may establish a separate HSA and make a "catch up" contribution to that account.

HSA Eligibility Requirements

Per IRS guidelines, you are allowed to open and fund an HSA if:

- You are covered under an HSA-qualified high deductible health plan (HDHP).
- You or your spouse are NOT covered by a non-HSA plan (i.e. PPO).
- You are not enrolled in Medicare*, TRICARE or TRICARE for Life.
- You can't be claimed as a dependent on someone else's tax return.
- You have not received Veterans Affairs (VA) benefits within the past 3 months.
- You or your spouse do not contribute to a Healthcare FSA.

*Enrollment in Medicare Part A may be retroactive by up to 6 months when you begin taking social security retirement after your Social Security Normal Retirement Age (SSNRA). This may affect your HSA eligibility.

Other restrictions and exceptions may also apply. For more information, visit **www.irs.gov/publications/p969/**.

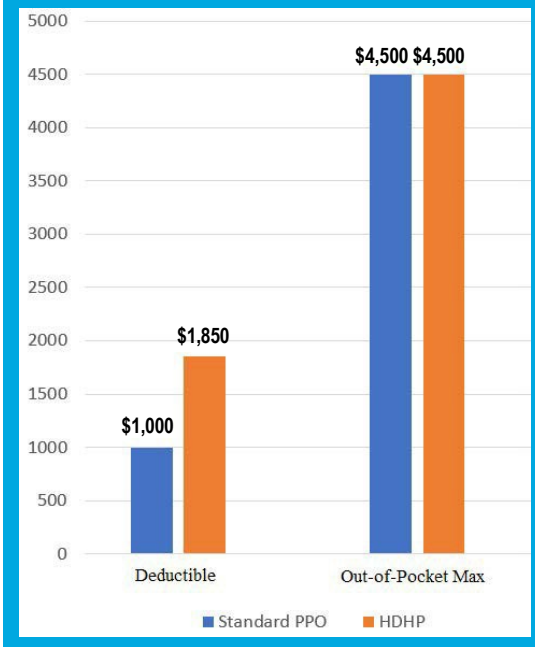
The official plan documents, summary plan descriptions, insurance contracts and company policies legally govern the administration of the plans. If there is any difference between the information presented here and the information in the official documents/ contracts, decisions will be based on the official documents/contracts.

How to set up an HSA: Contact your preferred bank or financial institution or HSA bank at: https://ioe.hsabank.com/home

Important Things to Know About Your HSA

- You will never lose any contributions you make to your HSA. You own this bank account.
- You are reimbursed for eligible expenses tax-free.
- If you do not use the HSA funds for an eligible health expense, your purchase will be subject to tax, plus a 20% penalty if you are younger than age 65.
- To avoid taxes on your contributions, you must file Form 8889 with your 1040 Form.
- The TAC HDHP's deductible is higher than the Standard PPO but the premiums are lower.
- The TAC HDHP and Standard PPO Out-of-Pocket Maximums are equal.

Deductible and Out-of-Pocket Maximum Comparison between TAC Standard PPO and HDHP



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://TAC.myaptahealth.com or call the Apta Care Coordinators at 1-877-610-8817. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call the Apta Care Coordinators at 1-877-610-8817 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,000 person / $3,000 family; for out-of-network providers $3,000 person / $9,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50 person / $100 family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $4,500 person / $10,000 family; for out-of-network providers $50,000 person / Unlimited family. Prescription drug coverage out-of-pocket limit of $2,000 person / $4,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Preauthorization penalty amounts, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://www.umr.com/oss/cms/umr/choice_plus_excl.html or call 1-	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance

Important Questions	Answers	Why This Matters:
	800-826-9781 for a list of network providers in the Choice Plus Network.	billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral, but referrals are encouraged.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay / office visit	40% coinsurance	Copay applies per visit regardless of what services are rendered. Deductible does not apply for participating network providers.
	Specialist visit	$40 copay / visit (with or without referral)	40% coinsurance	Referrals are encouraged for a specialist visit.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for PET Scans, MRI's and MRA's. Failure to obtain preauthorization will result in a $500 penalty.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail: 20% ($10 min copay) Mail Order: 20% ($25 min copay)	Not Covered	Copay applies per prescription. Covers up to a 90-day supply (retail and mail order prescriptions). No charge for ACA mandated preventive drugs and smoking deterrents. Specialty drugs are limited to a 30-day supply (retail and mail-order). Specialty drugs must be obtained directly from the specialty
	Preferred brand drugs	Retail: 20% ($55 min copay) Mail Order: 20% ($137.50 min copay)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	Retail: 20% ($80 min copay) Mail Order: 20% ($200 min copay)	Not Covered	pharmacy program.
	Specialty drugs (Tier 4)	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	The deductible applies. Preauthorization required unless performed in an office setting. Failure to obtain preauthorization will result in a $500 penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Urgent care	20% coinsurance	40% coinsurance	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay / office visit	40% coinsurance	Copay applies per visit regardless of what services are rendered and the deductible does not apply.
	Inpatient services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
If you are pregnant	Office visits	No Charge (deductible waived) for preventive services. Other services $25 copay / visit	40% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section). Failure to obtain preauthorization will result in a $500 penalty. Baby does not count toward the mother's expense; therefore the family deductible amount may apply. Cost-sharing does not apply to preventive services from a
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	services			participating provider. Depending on the type of services, a coinsurance and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Deductible applies. Limited to 120 visits per plan year. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Rehabilitation services	$25 copay / visit	40% coinsurance	Includes physical, speech & occupational therapy. Includes Chiropractor visits limited to 35 visits per year.
	Habilitation services	$25 copay / visit	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Deductible applies. Limited to 60 days per plan year. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization required for any item in excess of $1,500. Failure to obtain preauthorization will result in a $500 penalty.
	Hospice services	20% coinsurance	40% coinsurance	Deductible applies. Bereavement counseling is covered if received within 6 months of death. Preauthorization is required. Failure to obtain preauthorization will result in a $500 penalty.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	Not Covered	Not covered	None
	Children's dental check-up	No Charge	Not covered	Coverage limited to one exam/year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (adult & child)
- Glasses (adult & child)
- Infertility Treatment
- Long Term Care
- Massage Therapy
- Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)
- Private Duty Nursing (except for home health care & hospice)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Bariatric Surgery
- Hearing Aids
- Routine eye care (Adult & Child)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Humans Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa
Additionally, a consumer assistance program can help you file your appeal. Contact the
Texas Consumer Health Assistance Program, Texas Department of Insurance at (855) 839-2427 (855-TEX-CHAP).

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-826-9781.

* For more information about limitations and exceptions, see the plan or policy document at https://TAC.myaptahealth.com

Chinese (中文): 如果需要中文的帮助，请拨打这个号码800-826-9781.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-826-9781.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$320
Coinsurance	$2,264
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,644**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$876
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,096**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$160
Coinsurance	$328
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,488**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers 1,850 person / $3,700 family; for out-of-network providers $5,550 person / $11,100 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be satisfied, whether paid by a single individual or all family members, before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and children's eye exams are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $4,500 person / $10,000 family; for out-of-network providers $50,000 person / Unlimited family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, the overall family out-of-pocket limit must be satisfied, whether paid by a single individual or all family members, before this plan begins to pay.
What is not included in the out-of-pocket limit?	Premiums, Preauthorization penalty amounts, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://www.umr.com/oss/cms/umr/choice_plus_excl.html or call 1-800-826-9781 for a list of network providers in the Choice Plus network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral, but referrals are encouraged.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Deductible applies. Includes Chiropractor visits limited to 35 visits per year.
	Specialist visit	20% coinsurance	40% coinsurance	Deductible applies. Referrals are encouraged for a specialist visit.
	Preventive care/screening/ immunization	No charge	40% coinsurance	Deductible does not apply to participating providers. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for PET Scans, MRI's and MRA's. Failure to obtain preauthorization will result in a $500 penalty.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail & Mail Order: 20% coinsurance	Not Covered	The deductible applies per prescription. Covers up to a 90-day supply (retail and mail order prescriptions). No charge for ACA mandated preventive drugs and smoking deterrents. Specialty drugs are limited to a 30-day supply. Specialty drugs must be obtained directly from the specialty pharmacy program.
	Preferred brand drugs	Retail & Mail Order: 20% coinsurance	Not Covered	
	Non-preferred brand drugs	Retail & Mail Order: 20% coinsurance	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	The deductible applies. Preauthorization required unless performed in an office setting. Failure to obtain preauthorization will result in
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				a $500 penalty.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Urgent care	20% coinsurance	40% coinsurance	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Deductible applies.
	Inpatient services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
If you are pregnant	Office visits	No Charge for preventive services. Other services 20% coinsurance.	40% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section). Failure to obtain preauthorization will result in a $500 penalty. Baby does not count toward the mother's expense; therefore the family deductible amount may apply. Cost-sharing does not apply to preventive services from a participating provider. Depending on the type of services, a coinsurance and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Deductible applies. Limited to 120 visits per plan year. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Rehabilitation services	20% coinsurance	40% coinsurance	Deductible applies. Includes physical, speech

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				& occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	Deductible applies.
	Skilled nursing care	20% coinsurance	40% coinsurance	Deductible applies. Limited to 60 days per plan year. Preauthorization required. Failure to obtain preauthorization will result in a $500 penalty.
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization required for any item in excess of $1,500. Failure to obtain preauthorization will result in a $500 penalty.
	Hospice services	20% coinsurance	40% coinsurance	Deductible applies. Bereavement counseling is covered if received within 6 months of death. Preauthorization is required. Failure to obtain preauthorization will result in a $500 penalty.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	Not Covered	Not covered	None
	Children's dental check-up	No Charge	Not covered	Coverage limited to one exam/year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (adult & child)
- Glasses (adult & child)
- Infertility Treatment
- Long Term Care
- Massage Therapy
- Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)
- Private Duty Nursing (except for home health care & hospice)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Bariatric Surgery
- Hearing Aids
- Routine eye care (Adult & Child)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those

* For more information about limitations and exceptions, see the plan or policy document at https://TAC.myaptahealth.com

agencies is: the Department of Health and Humans Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa
Additionally, a consumer assistance program can help you file your appeal. Contact the
Texas Consumer Health Assistance Program, Texas Department of Insurance at (855) 839-2427 (855-TEX-CHAP).

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-826-9781.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码800-826-9781.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-826-9781.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,850
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,850
Copayments	$0
Coinsurance	$2,158
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,068**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,850
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,850
Copayments	$0
Coinsurance	$750
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,850
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,850
Copayments	$0
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,040**

The plan would be responsible for the other costs of these EXAMPLE covered services.

TO: Employees Eligible for Group Health Benefits under the Texas Annual Conference, The United Methodist Church Group Health Plans

DATE: January 1, 2024

SUBJECT: Required Annual Notices for Group Health Plans

*****Important Information – Action May Be Required*****

To make sure that you have all the information you need to make informed decisions for you and your family, the law requires Texas Annual Conference, The United Methodist Church to provide you with notice of certain legal rights that you may have and legal obligations that apply to the Texas Annual Conference, The United Methodist Church. These rights and obligations are described in more detail in the enclosed notices.

Contents

You should review these notices closely and keep them with other materials that you receive about benefits available under the Plan. If you have any questions about any of the legal rights and obligations described below or the Plan, you should write or call:

Marianela Morales, Senior Group Health Benefits Specialist / HIPAA Privacy Officer / Wellness Program Coordinator

5215 Main **St.** | Houston, Texas 77002
(713) 533-3723 | mmorales@txcumc.org

The following notices are not intended to be a description of the benefits offered under the Plan. For more information about specific benefits, refer to the Summary Plan Descriptions for the Plan, which are available by visiting **www.txcumc.org/benefits.**

*If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see **page 7** for more details.*

Women's Health and Cancer Rights Act (WHCRA) Notice

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

- Standard PPO Plan, 80/60, $1,000
- High-Deductible PPO Plan, 80/60, $1,850

If you would like more information on WHCRA benefits, contact your plan administrator:

Marianela Morales
Senior Group Health Benefits Specialist / HIPAA Privacy Officer / Wellness Program Coordinator
(713) 533-3723
mmorales@txcumc.org

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact your plan administrator for more information.

Newborns' and Mother's Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Wellness Program Notice

Reasonable Alternative Standard

Note: Refer to TAC's Specific Wellness Program Notice Rev. 10-11-2023 for details.

Wellness Program
TAC WELLNESS PROGRAM NOTICE

The Texas Annual Conference (TAC) Wellness Program is a voluntary Wellness Program available to all employees and spouses enrolled in the TAC Group Health Benefit Plan. The program is administered according to federal rules permitting employer-sponsored Wellness Programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Taxable cash incentives may be available for employees and spouses who participate in certain health-related activities such as losing weight **and** maintaining a Body Mass Index (BMI) of 25**.0** or less**.**

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting **Marianela Morales**, **Senior Group Health Benefits Specialist / HIPAA Privacy Officer / Wellness Program Coordinator, at (713) 533-3723 or at mmorales@txcumc.org.**

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the Wellness Program and the Texas Annual Conference may use aggregate information it collects to design a program based on identified health risks in the workplace, the TAC Wellness Program as administered by the Center for Connectional Resources will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellness Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the Center for Connectional Resources and the Disease Management Program nurses at **Apta Health** in order to provide you with services under the Wellness Program.

In addition, all medical information obtained through the Wellness Program will be maintained separate from your personnel records in the Center for Connectional Resources or **Apta Health** offices, and no information you provide as part of the Wellness Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Wellness Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact **Marianela Morales, Senior Group Health Benefits Specialist / HIPAA Privacy Officer / Wellness Program Coordinator, at (713) 533-3723 or at mmorales@txcumc.org.**

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is intended to inform you of the privacy practices followed by the Texas Annual Conference, The United Methodist Church Health Plan and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 01/01/2024.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Texas Annual Conference, The United Methodist Church requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Texas Annual Conference, The United Methodist Church for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.
Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities. We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Marianela Morales
Senior Group Health Benefits Specialist / HIPAA Privacy Officer / Wellness Program Coordinator
(713) 533-3723
mmorales@txcumc.org

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Notice of HIPAA Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact:

Marianela Morales
Senior Group Health Benefits Specialist / HIPAA Privacy Officer / Wellness Program Coordinator
(713) 533-3723
mmorales@txcumc.org

CREDITABLE COVERAGE – Standard PPO Plan, 80/60, $1,000, High-Deductible PPO Plan, 80/60, $1,850

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Texas Annual Conference, The United Methodist Church and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Texas Annual Conference, The United Methodist Church has determined that the prescription drug coverage offered by the Texas Annual Conference, The United Methodist Church is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Texas Annual Conference, The United Methodist Church coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Texas Annual Conference, The United Methodist Church coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current Texas Annual Conference, The United Methodist

Church coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Texas Annual Conference, The United Methodist Church changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year you are eligible from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. *If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).*

Date:	January 1, 2024
Name of Entity/Sender:	Texas Annual Conference, The United Methodist Church
Contact - Position/Office:	**Marianela Morales,** Senior Group Health Benefits Specialist / HIPAA Privacy Officer / Wellness Program Coordinator
Address:	5215 Main St. Houston, Texas 77002
Phone Number:	(713) 533-3723

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

List begins on next page.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program Website: www.dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: www.myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: www.healthfirstcolorado.com HFC Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus CHP + Customer Service: 1-800-359-1991 / State Relay 711 Health Insurance Buy-In Program (HIBI): www.mycohibi.com HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: www.myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	Website: www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp Phone: 1-877-357-3268
GEORGIA – Medicaid	**MAINE – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: www.mymaineconnection.gov Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
INDIANA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Healthy Indiana Plan for low-income adults ages 19-64 Website: www.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Website: www.in.gov/medicaid Phone: 1-800-457-4584	Website: www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
IOWA – Medicaid and CHIP (Hawki)	**MINNESOTA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: https://dhs.iowa.gov/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: www.mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS – Medicaid	**MISSOURI – Medicaid**
Website: www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY – Medicaid	**MONTANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/pages/kihipp.aspx Phone: 1-855-459-6328 Email: kihipp.program@ky.gov KCHIP Website: https://kidshealth.ky.gov/pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov

LOUISIANA – Medicaid	NEBRASKA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid	**SOUTH CAROLINA - Medicaid**
Medicaid Website: www.dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: www.dhhs.nh.gov/programs-services/medicaid/ health-insurance-premium-program Phone: 603-271-5218 HIPP toll free number: 1-800-852-3345, ext 5218	Website: www.dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	**TEXAS – Medicaid**
Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609-631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: www.hhs.texas.gov/services/financial/ health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH – Medicaid and CHIP**
Website: www.health.ny.gov/health_care/medicaid Phone: 1-800-541-2831	Medicaid Website: www.medicaid.utah.gov CHIP Website: www.health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	**VERMONT– Medicaid**
Website: www.medicaid.ncdhhs.gov Phone: 919-855-4100	Website: www.dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: www.coverva.org/en/famis-select or www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
OKLAHOMA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: www.insureoklahoma.org Phone: 1-888-365-3742	Website: www.hca.wa.gov Phone: 1-800-562-3022
OREGON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: www.healthcare.oregon.gov/pages/index.aspx Phone: 1-800-699-9075	Website: www.dhhr.wv.gov/bms or www.mywvhipp.com Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)	Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND – Medicaid and CHIP	**WYOMING – Medicaid**
Website: www.eohhs.ri.gov Phone: 1-855-697-4347 Direct RIte Share Line: 401-462-0311	Website: https://health.wyo.gov/healthcarefin/medicaid/ programs-and-eligibility Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (Expires 1/31/2026)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

As of August 2022, the following 18 states had enacted comprehensive Balance Billing Protections: California, Colorado, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, Michigan, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon Texas, Virginia, Washington.

As of August 2022, the following 15 states had enacted limited Balance-Billing Protections: Arizona, Delaware, Indiana, Iowa, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Pennsylvania, Rhode Island, Vermont, West Virginia.

Generally, those state passed protections apply to fully insured medical plans governed by the specific state and not self-funded medical plans. Check the state insurance commissioner website for details on specific state laws.

If your state is not listed, check your state commissioner's website as states may adopt a surprising billing mandate at any time.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there

may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the US Dept. of Health & Human Services at 1-877-696-6775 or your State Insurance Commissioner.