

ENROLLMENT PROCEDURES
GROUP BENEFIT PROGRAM
General Synod, Associate Reformed Presbyterian Church



COVERAGE

The Group Benefit Program provides an insurance program for:

- (a) ARP Ministers serving ARP Churches or Agencies under the terms of a Call (Calls after January 1, 2006, must meet the requirement of the *Form of Government*, Chapter X.E.11) and
- (b) full-time (routinely works at least 30 hours per week) lay employees of ARP Churches and Agencies, provided, however, **Career Missionaries** assigned to a field outside the United States have separate medical and dental plans.

Coverage begins on the date you become eligible. **HOWEVER**, you will not be enrolled until you complete the necessary enrollment forms. If you fail to enroll within 31 days of becoming eligible, you will not be enrolled in the medical or dental programs **AND** coverage under the other areas of coverage may be in jeopardy:

- (a) Erskine employees and all non-Erskine **salaried** employees become eligible on the first day of work as a full-time employee.
- (b) Non-Erskine **hourly** employees become eligible on the 91st day of employment.

Area of Coverage	Employee	Dependent
Medical, including drug	Yes*	Yes**
Dental	Yes***	Yes**
Term Life Insurance	Yes****	Yes*****
Accidental Death	Yes****	No
Long Term Disability	Yes*****	No

- * Coverage may be waived if Employee has other “Creditable Coverage” at the time they become eligible. (See “Failure to Enroll”)
- ** Optional. Employee Coverage required. (See “Failure to Enroll”)
- *** Optional (See “Failure to Enroll”)
- **** Erskine Employees (\$10,000); Non-Erskine Hourly Employees (\$20,000); Non-Erskine Salaried Employees (\$50,000).
- ***** \$5,000 on Spouse, 2,500 on each Dependent over six months of age. Dependent children from 15 days to 6 months - \$ 200.
- ***** Coverage required for all Employees except Erskine Employees who are excluded.

For Ministers serving under the terms of a Call: Call provisions may require participation in the “Optional” coverage areas.

The medical program has a preexisting condition exclusion which is explained in the attached “Notice of Plan's Preexisting Condition Exclusion” (Form INS-2). A synopsis of coverage provided is attached. (FORM INS-2A)

ENROLLMENT

To enroll you must complete and return all forms (Dental is optional)

- For Dental - Kanawha HealthCare Solutions Group Dental Enrollment Form
- For Medical – BlueCross BlueShield Enrollment Form
- For Employee Term Life and Accidental Death & Dismemberment, Dependent Term Life, and Long Term Disability - The appropriate Life, AD&D, LTD Enrollment Form

General Synod Group Medical. Complete all sections of BlueCross BlueShield Membership Application, excluding Section 8. If you are declining coverage on yourself and/or dependents complete the “Waiver of Coverage” on the second page of the form. (See “Failure to Enroll”)

General Synod Group Dental. Complete all sections of Kanawha HealthCare Solutions, Inc. Enrollment form. If you are declining coverage on yourself and/or dependents complete the “Waiver of Coverage” on the second page of the form. (See “Failure to Enroll”)

General Synod Auxiliary Coverage. Complete sections A, B, and C of General Synod Auxiliary Coverage Enrollment Form. Have your Employer complete Section D.

Please call 864-232-8297, ext. 224 or ext. 222 if you have questions. **Return completed forms to:**

Group Insurance
Associate Reformed Presbyterian Center
One Cleveland Street, Suite 110
Greenville, SC 29601-3696

The General Synod

ASSOCIATE REFORMED PRESBYTERIAN CHURCH

Board of Benefits



Group Benefits Program Associate Reformed Presbyterian Church Notice of Plan's Preexisting Condition Exclusion

The medical care benefit program contains a preexisting condition exclusion that may limit your coverage. The preexisting condition exclusion is an exclusion of coverage for an injury, medical condition or illness for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months prior to the date you enroll in the plan or the first day of any period your employer requires of new employees before they become eligible for coverage (whichever came first). The following **are not** preexisting conditions:

- pregnancy;
- conditions found in a newborn child who is enrolled within 30 days from the date of birth;
- conditions found in a child who is adopted or placed for adoption before attaining age 18 and who is enrolled within 30 days of the date of adoption or placement for adoption; or
- conditions discovered as a result of genetic testing, but which have not manifested themselves in conditions requiring treatment.

Treatment for preexisting conditions will not be covered during the Preexisting Condition Exclusion Period. The Preexisting Condition Exclusion Period shall be:

- 12 months, if you, or you and your dependents, or your dependents enroll in this plan within 30 days of initially becoming eligible for coverage; or
- 12 months, if at the time you initially became eligible for coverage under this plan you declined coverage in writing because you had other health coverage, and you enroll in this plan within 30 days of losing eligibility for the other health coverage; or
- 18 months for all other individuals.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), this plan will subtract one day from the preexisting condition exclusion period for each day of creditable coverage that you had, so long as there was no period of 63 or more consecutive days during which you did not have creditable health coverage. Creditable coverage includes periods during which you were covered under:

a group health plan; group or individual health insurance coverage; Part A **or** Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; The Peace Corps Act; a State health benefits risk pool; a public health plan; health coverage for current and former members of the armed forces and their dependents; or health insurance for federal employees and their dependents.

You have the right to demonstrate the amount of creditable coverage you have, including any waiting periods that were applied before you became eligible for coverage. For any period after July 1, 1997, you may ask a plan sponsor, health insurer, or HMO to provide

you with a “certification form” documenting the periods during which you had health benefit coverage. If you do not have a “Certificate of Creditable Coverage” to submit with your enrollment, please contact your prior provider and request that documentation be sent to our Third Party Administrator:

BlueCross BlueShield of South Carolina
P. O. Box 6000
Greenville, SC 29606

If you submit a “Certificate of Creditable Coverage” BCBS will notify you of the number of days credited and the number of days, if any, that the preexisting condition exclusion will apply.

BCBS will inform you of procedures to follow if you do not agree with the calculation of your creditable coverage. If any response to your inquiry is not satisfactory, you may request an appeal by writing to the address shown above within 60 days of receiving notification. Please give specific reasons for your appeal.

If you are have trouble obtaining documentation of your prior creditable coverage, please call Ed Hogan at 864-232-8297, Ext. 224 for assistance.



Ed Hogan, Secretary
Board of Benefits

GROUP BENEFIT PROGRAM
General Synod, Associate Reformed Presbyterian Church
FAILURE TO ENROLL



If you or your dependents fail to enroll within 31 days after becoming eligible, future participation will be limited as follows:

- (A) **Dental Insurance:** Unless there is a qualifying event as described under Medical Insurance, late enrollment and/or adding of dependents will be limited to December for coverage to become effective January 1. During the first year, coverage will be limited to Preventive Coverage.
- (B) **Medical Insurance:** Unless the Plan authorizes an OPEN ENROLLMENT due to unusual circumstances, eligible non-participants are not allowed entry into the Plan except for SPECIAL ENROLLMENT PERIODS:
- (a) **Individuals losing other coverage.** An Employee or Dependent who is eligible but not enrolled may enroll in the SPECIAL ENROLLMENT PERIOD if each of the following conditions is met:
- (1) The Employee or Dependent had other “Creditable Coverage” at the time they became eligible and had stated in writing at the time coverage was offered that other creditable health coverage was the reason for declining enrollment in the medical plan;
 - (2) The coverage was terminated as a result of loss of eligibility for the coverage; and
 - (3) The Employee requests enrollment in the General Synod Plan not later than 31 days after the termination of coverage.
- (b) **Individuals with a new dependent.**
- (1) If an eligible employee did not enroll at the time of enrollment and later adds a new dependent through marriage, birth, adoption or placement for adoption, then the employee and all eligible dependents may be enrolled. The request for enrollment must be no later than 31 days after the date the new dependent became eligible as a dependent.
 - (2) Dependents that have not been enrolled may be enrolled if
 - a. The Employee is a participant under this Plan; and
 1. A person becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption; or
 2. The Dependent or Dependents lost coverage as a result of loss of eligibility under another group plan; and
 - b. The Employee requests enrollment in this Plan not later than 31 days after the date of eligibility.

If the Employee or Dependent loses the other coverage because of the individual’s failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

Please call 864-232-8297, ext. 224 or ext. 222 if you have questions.

GENERAL SYNOD, ASSOCIATE REFORMED
PRESBYTERIAN CHURCH
HEALTH BENEFITS PLAN

WOMEN'S HEALTH AND CANCER RIGHTS ACT

On October 21, 1998 Congress passed a bill called the Women's Health and Cancer Rights Act. This new law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Protheses, and
- Physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:

- Interfere with a woman's rights under the plan to avoid these requirements, or
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

If you have any questions about the current plan coverage, please contact your Human Resources Department.

GROUP BENEFITS PROGRAM HIGHLIGHTS

January 1, 2007

MEDICAL BENEFITS

BlueCross BlueShield of South Carolina, Third Party Administrator

Plan Lifetime Maximums

Medical (includes in-network mental and nervous)	\$ 2,000,000
Home Health Care	\$ 10,000
Hospice Care	\$ 10,000
Infertility Treatment	\$ 10,000
Inpatient Mental Disorders Treatment/Biofeedback	67 Days
Substance Abuse Treatment/Marriage Counseling/Biofeedback	\$ 50,000

Plan Annual Maximums

Mental Disorders Treatment/Biofeedback	52
Visits	
Substance Abuse Treatment/Marriage Counseling/Biofeedback	\$ 2,000
Skilled Nursing Facility	100 Days
Private Duty Nursing	50 Visits
Wellness Benefit	\$ 300

Plan Deductibles

	Plan A	Plan B
Individual Calendar Year Deductible	\$ 750	\$ 1,250
Family Calendar Year Deductible	\$ 1,500	\$ 2,500

The Individual Calendar Year Deductible is waived for Maternity related charges and for Marriage and Family Counseling.

Plan Out-of-Pocket Maximums

Preferred Provider		
Individual	\$ 3,000	\$ 5,000
Family	\$ 6,000	\$ 10,000
Preferred Provider and/or Non-Preferred Provider		
Individual	\$ 6,000	\$ 10,000
Family	\$12,000	\$ 20,000

Primary Care Office Visit

Co-payment	\$ 15	\$ 20
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Specialist Care Office Visit

Co-payment	\$ 30	\$ 35
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The co-payments do not accrue to the deductible or the Out-of-Pocket Maximum.
No co-payment is required for wellness benefits.

Emergency Room Care

\$100 Co-pay for Each Emergency Room Visit to be waived if admitted as a patient. The Co-pay does not apply to the annual deductible

Preferred Provider	80% after Co-pay
Non-Preferred Provider	80% after Co-pay

Hospital, ICU, Urgent Care, Skilled Nursing

(Average Semiprivate Room Rate; ICU Rate)

Preferred Provider	80% after CY Ded
Non-Preferred Provider	60% after CY Ded

Physician Services

Preferred Provider	80% after CY Ded
Non-Preferred Provider	60% after CY Ded

Hospice Care, Home Health Care (Deductible Waived) 100%

Mental Disorders Treatment/Biofeedback

Inpatient	
Preferred Provider	80% after CY Ded
Non-Preferred Provider	60% after CY Ded
Outpatient	50% after CY Ded

Substance Abuse Treatment/Biofeedback

Inpatient	
Preferred Provider	80% after CY Ded
Non-Preferred Provider	60% after CY Ded

Outpatient	50% after CY Ded
Marriage and Family Counseling	
Outpatient	50% No Deductible
Prescription Drugs No Deductible	
At Participating Pharmacy (Limited to Greater of 34 day supply or 100-unit dose and limited to two refills on Maintenance Drugs. If mail order is not used after two refills, the participant must pay full retail cost.)	
Generic.....	\$10.00 Co-Pay
Preferred	\$20.00 Co-Pay
Non-Preferred	\$35.00 Co-Pay
Mail Order (Limited to Greater of 90-day supply or a 270-unit dose)	
Generic.....	\$20.00 Co-Pay
Preferred and Non-Preferred	\$40.00 Co-Pay

Smoking Cessation

Voluntary Enrollment Program. Plan will pay for cost of participation.

Other Eligible Expenses

Preferred Provider	80% after CY Ded
Non-Preferred Provider.....	60% after CY Ded

Weight Reduction

Voluntary Enrollment Program. Plan will pay for cost of participation.

Wellness Benefit

Preferred Provider (Deductible and Co-payment Waived)	100% To Maximum of \$300
Non-Preferred Provider.....	No Benefit

Benefit Provisions:

- Participants must use preferred providers (Unless Participant has been coded as Out-of Area).
- The benefit must be for preventive purposes and cannot be used in connection with the treatment of illness or injury. Except for the usual periodic exams of a child in the first year of life and immunization, the benefits are limited to one such occurrence during any calendar year.
- The benefit provides for
 - Usual periodic exams of a child by a Physician during the first year of life, including immunizations, tests and laboratory services normally performed in connection with such exams, and routine circumcision.
 - Immunizations
 - Annual physical exams including mammogram or prostate exam.

DENTAL BENEFITS

Kanawha HealthCare Solutions, Third Party Administrator

Annual Deductible (Common to Basic and Major)	\$ 50
Family Deductible (Common to Basic and Major).....	\$ 150
Lifetime Maximum for Orthodontic	\$ 1,500
Preventive Services (Oral exam, cleaning, spacer, fluoride, 2 Cleanings Per Year - Normal and Reasonable Charges)	100%
Basic Services.....	80% after CY Ded
Major Services (Crowns, gold inlays, bridges, dentures)	50% after CY Ded
Orthodontics	50%
Maximum Benefit Per Calendar Year for Preventive, Basic, and Major Services	\$ 1,500

TERM LIFE INSURANCE and ACCIDENTAL DEATH

Erskine Employees	\$	10,000
Non-Erskine Salaried Employees	\$	50,000
Non-Erskine Hourly Employees	\$	20,000
Dependents age 15 days to 6 months of age	\$	200
Dependents age 6 months and older (No Accidental Death)		
Spouse	\$	5,000
Dependent Children age 6 months and older	\$	2,500

LONG TERM DISABILITY INSURANCE
(Erskine Employees Excluded)

Waiting Period After Onset of Disability		90 days
Benefit for Total Disability, Coordinated with Social Security		60% of Earnings
Maximum Monthly Benefit	\$	5,000