

Optional Consumer Driven Health Plan (CDHP) – United HealthCare beginning 1/1/2011

Pharmacy Plans -

Medco Health beginning 1/1/2005

United Behavioral Health (UBH) – Features an Employee Assistance Program (EAP) and Pastoral Consultation Line

Vision Service Provider (VSP) - Annual eye exam through network of providers

Wellness & Healthy Lifestyles Condition Management Programs –

WebMD Health Quotient – Risk assessment tool; Harris Health Trends; Health Management Corporation (HMC)

Flexible Spending Accounts - Ceridian beginning 1/1/2005.

HealthFlex includes flexible spending accounts under Section 125 of the Internal Revenue Code for active participants. You have available both a Medical Reimbursement Account (MRA) and a Dependent Care Assistance Account (DCA).

HOW YOUR HEALTH CARE INFORMATION IS ORGANIZED

This portion of your Employee Guide is divided into three sections:

Enrollment Information explains guidelines on enrolling for benefits and applies to the NGAC HealthFlex Plan.

Description of Benefits explains the major features of the NGAC HealthFlex.

General Information discusses situations that may affect your benefits. This segment applies to the NGAC HealthFlex Plan.

Take time to read through the material carefully and share it with your family. If you have any questions about your coverage, contact the NGAC Benefits Office.

ENROLLING FOR BENEFITS

Because hospitals and physicians frequently change their affiliations with networks and organizations, printed directories are often outdated. To ensure that the hospital or physician you are going to receive treatment from is a current network provider, contact United HealthCare directly **before** each visit or hospital stay (see the For More Information on the NGAC HealthFlex Plan section for more information on United HealthCare).

ELIGIBILITY and ENROLLMENT

- A. The following persons are eligible to be covered in the North Georgia Conference (“Conference”) insurance program:
 1. All full-time employees of the Annual Conference, its local churches and its related agencies and institutions, more specifically defined as:
 - Members of the Annual Conference under full-time Episcopal appointment to the local church or a unit of the Annual Conference.
 - Other clergy under full-time Episcopal appointment to the local church
 - Full-time lay employees of Conference agencies, institutions and local churches (requires coverage of $\frac{3}{4}$ of eligible lay employees.)
 2. Persons described in Section 1 above who are retired and who were covered by the Conference insurance program for five years immediately prior to the time of retirement.

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3. Persons described in Section 1 above who become disabled with CPP/BPP coverage. Limited long term eligibility for others on disability.
- B. Conference members taking honorable location or terminating their conference relationship for any other reason shall not be eligible to continue in the conference insurance program.

ACTIVE PARTICIPANT ELIGIBILITY and ENROLLMENT

The date the person first enters an eligible category is considered to be his/her eligibility date.

The plan sponsor (North Georgia Conference) must notify an eligible person of his/her eligibility and give to him/her a HealthFlex enrollment packet and form to complete and return to the plan sponsor. This notification must be done on a timely basis such that the person can complete and return the necessary forms to the plan sponsor for signature within 30 calendar days following his/her eligibility date. (The date is included in the 30-day count.) On the enrollment form, the participant indicates whether coverage is being accepted or declined on him/herself and/or other dependents. If coverage is being declined on an eligible person, the participant indicates whether that person has other group health coverage. "Other group health coverage" has the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Medicare does not qualify as "other group health coverage." The participant must complete and return the form to the plan sponsor such that the plan sponsor can audit and sign it within 30 calendar days following the participant's eligibility date.

The plan sponsor faxes (mails) the enrollment form to the plan administrator who maintains for administrative, communications and compliance purposes a record of all eligible participants and their dependents, and their decisions about coverage. The plan administrator should receive the enrollment forms as soon as possible since there are limitations on how far back in time coverage can be made effective.

If the 30-day plan sponsor signature requirement is not met, the plan administrator enrolls the participant in HealthFlex and assigns an election of "No Coverage" under the medical, medical reimbursement account and dependent care account plans. In this case, the participant is unable to make an election of coverage until the next annual election period and coverage would not begin until the following plan year. The exception to this is if he/she subsequently experiences a special enrollment event as defined under HIPAA.

An eligible participant who declines coverage under HealthFlex may apply for coverage under HealthFlex in conjunction with any annual election period and coverage will begin with the following plan year. The eligible participant is encouraged to complete an enrollment/change form and indicate acceptance of coverage, and provide it to the plan sponsor by September 1 prior to the annual election period. In this way the participant is assured of timely receipt of medical identification cards and other materials needed for accessing benefits. The latest an enrollment/change form will be accepted as part of annual election is November 30.

An eligible participant who declines coverage under HealthFlex may also apply

for coverage before annual election if he/she experiences a special enrollment event as defined under HIPAA.

If a participant who is in a retirement status resumes compensated employment within the connectional structure of the Church and is in an eligible category, he/she is treated as an active participant for HealthFlex benefit purposes.

DEFINITIONS and PROCEDURES

Active/Retiree/Dependent Eligibility and Enrollment

The definition of an eligible dependent under the medical plan is provided below. To actually be covered under HealthFlex, however, the eligible dependent spouse and/or child must be enrolled in the plan and the participant must indicate that coverage is desired on the eligible dependent. Even if the current coverage category of the participant allows for the inclusion of an additional person any eligible dependent, including a newborn child, must be enrolled through the enrollment/change form process. **IT IS THE PARTICIPANT'S RESPONSIBILITY TO NOTIFY HIS/HER PLAN SPONSOR WHEN A NEW DEPENDENT IS ACQUIRED.** A participant should notify his/her plan sponsor even if he/she is declining coverage on the newly acquired dependent.

A dependent's eligibility date is the date he/she first meets the definition of an eligible dependent. This means, with respect to a new hire or newly eligible participants' dependent, an existing dependent's eligibility date is the same as the participant's. A newly acquired dependent's eligibility date is the date he/she first meets the dependent definitions stated below. For example, a newborn child's eligibility date is his/her birth date. The eligibility date of a dependent regaining eligibility (i.e., returning to school full-time) is the effective date of the event causing the dependent to regain eligibility (i.e., first day of the semester).

If the participant wishes to cover the newly acquired dependent, the participant must notify the plan sponsor. The timing of this notification must be such that the plan sponsor can give (mail) the participant the enrollment/change form and other important information, and the participant can complete and return the necessary forms to the plan sponsor for signature within 30 calendar days following the newly acquired dependent's eligibility date. (The eligibility date is included in the 30-day count.)

The plan sponsor faxes (mails) the enrollment/change form to the plan administrator. If the 30-day plan sponsor signature requirement is not met, the plan administrator enrolls the dependent in HealthFlex and assigns to the dependent a status of "Not Covered" under the medical plan. The participant is unable to make an election of coverage for the dependent until the next annual election period and coverage will not begin until the following plan year. (The exception to this is if the participant or dependent experiences a special enrollment event as defined under HIPAA.)

The dependent is considered a late entrant for future enrollment purposes. The plan definition of an "eligible spouse" is the husband or wife of an eligible participant, married in accordance with the law of the jurisdiction in which the eligible participant legally resides. The plan definition of an "eligible dependent child" is:

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Any child of an eligible participant from birth through the last day of the month the child attains age 26.

Any unmarried child, without regard to the child's age, who is not self-supporting due to mental or physical impairment. The participant must give the plan administrator proof, when requested, that the child meets these conditions. A child who is not self-supporting must be mainly dependent upon the participant for care and support. This child must have become incapable of self-support either before reaching age 19 or while covered as a dependent under this plan or any other group health plan.

A "child" includes:

The natural child, legally adopted child, stepchild of a participant or spouse, or child for whom the participant or participant's spouse has obtained court ordered legal guardianship, who resides in the eligible participant's home. (A child is considered legally adopted on the earlier of the date of placement or the date that the legal adoption proceedings have been started.)

A natural child, legally adopted child or child for whom the participant has obtained court ordered legal guardianship, under age 19, who is not living with the participant, and for whom the employee is responsible by legal decree for the majority of financial support of the child, or specifically for the medical health care expenses of the child.

To be eligible, dependents must reside in the United States.

The following is not considered an eligible dependent child:

- a. A grandchild or foster child who has not been legally adopted by the participant nor has court ordered legal custody.
- b. A natural or legally adopted child, under age 19, who is living with a former spouse at another location, and for whom the participant is not responsible by legal decree for the majority of financial support of the child, or specifically for the medical health care expenses of the child.
- c. A natural, legally adopted or step-child of a spouse of an eligible participant who is not living with the participant or for whom another party is legally responsible for the majority of financial support of the child, or specifically for the medical health care expenses of the child.

A newborn child is covered for 30 calendar days after the child's birth, even if the participant does not accept coverage on the child.

Under the medical reimbursement and dependent care account plans, the definition of "dependent" is expanded to include the definition used by the IRS for federal income tax purposes. For example, this could include dependent parents or grandparents.

UMC COUPLES ELIGIBILITY

If both persons are eligible for HealthFlex benefits because of their clergy, deacon or lay employee status, they are considered a UMC couple. A couple will be covered as two single coverages, unless there are dependent children. In that case the family is covered by one family coverage. If the member of the UMC couple who is listed as the "participant" loses eligibility, the covered dependent spouse will become the covered participant and maintain the existing coverage for any covered dependents.

NON-SALARIED ACTIVE PARTICIPANT ELIGIBILITY

If appointed to family leave, maternity/paternity leave or incapacity leave, a covered individual may remain covered.

If appointed to sabbatical leave, voluntary leave of absence, or an involuntary leave of absence, a covered individual may remain covered for up to one year. Subsequent eligibility is dependent on the new appointment category being an eligible category.

RETIREE BENEFIT ELIGIBILITY and ENROLLMENT

In order to be eligible for retiree benefits under HealthFlex as a retiree or a retiree dependent, both plan sponsor eligibility requirements and HealthFlex eligibility requirements must be met. Participants need to obtain information on plan sponsor-specific eligibility requirements from their plan sponsor (North Georgia Conference).

Under HealthFlex eligibility requirements, an active participant is eligible for retiree medical coverage if he/she completes five consecutive years of coverage upon retirement under a group health plan maintained by a participating HealthFlex plan sponsor and retires from active salaried or not-salaried service with a participating HealthFlex plan sponsor.

Under HealthFlex eligibility requirements, a dependent spouse or child is eligible for retiree coverage if the retiring participant has satisfied HealthFlex retiree eligibility requirements.

Any eligible participant who is retiring must be notified by the plan sponsor of his/her eligibility for HealthFlex retiree benefits and be given a HealthFlex retiree enrollment packet and forms to complete and return to the plan sponsor. The recommended time for this material to be given to the retiring participant is three months prior to his/her retirement date.

On the enrollment form, the participant indicates whether coverage is being accepted or declined on him/herself and/or other dependents. If coverage is being declined, the participant indicates whether that person has other group health coverage. The participant also indicates the legal residence he/she will have as of the retirement date.

It is recommended that the retiring participant complete the enrollment/change form and pension withholding form and return them to the plan sponsor no later than two months prior to his/her retirement date.

The plan sponsor faxes (mails) the enrollment/change form to the plan administrator for processing. It is recommended that this be done no later than two months prior to the participant's retirement date. This enables the retiring participant to receive the necessary election materials on a timely basis. Because there are limitations on how far back in time coverage and election changes can be made, it is important for the plan administrator to receive the forms as soon as possible.

A covered retired participant and his/her covered spouse must be covered under the same benefit options, unless age restrictions apply. In the event the necessary elections and enrollment forms are not completed accordingly, the retiree spouse will lose coverage and all future coverage rights.

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If an eligible retiree or retiree dependent declines HealthFlex retiree coverage when first eligible for such coverage without having other group health coverage, all future coverage rights are lost with respect to that person.

If a covered retiree or retiree dependent subsequently declines retiree coverage, all future coverage rights are lost with respect to that person and, in the case of the retiree's declination, all dependents.

A NEW SPOUSE OR DEPENDENT ACQUIRED BY A RETIREE AFTER RETIREMENT IS NOT AN ELIGIBLE DEPENDENT UNDER HEALTHFLEX. The exception to this is a retiree gaining a new dependent child through court ordered legal guardianship, in which case the child is considered eligible.

Medical premium contributions of retirees are after-tax. The General Board of Pension and Health Benefits may deduct premiums from pension benefits payable under benefits administered. NGAC will bill this amount if the pension deduction is not chosen.

SURVIVING DEPENDENT ELIGIBILITY and ENROLLMENT

Survivors of active participants:

The covered dependent of a deceased active covered participant is eligible for medical coverage as a "surviving dependent." This means one of the coverage options at the time of death in order for survivor benefits to be available under HealthFlex.

The plan sponsor must notify all eligible covered surviving dependents of their eligibility for HealthFlex survivor benefits and give them important information about HealthFlex survivor benefits. This notification of survivors must be done on a timely basis.

If a survivor wishes to decline survivor benefits, the plan sponsor includes in the information packet an enrollment/change form for the survivor to complete and indicate declination of coverage. The plan sponsor signs and dates the form within 60 days following the participant's death and faxes/mails the form to the plan administrator. (The date of death is included in the 60-day count.) If a surviving dependent declines HealthFlex survivor coverage when first eligible for such coverage, all future rights to HealthFlex coverage are lost with respect to that dependent.

A covered surviving dependent spouse may continue under the active medical options until age 65 and then until death under the retiree medical options.

A covered surviving dependent child may continue under the active non-salaried medical until he/she no longer meets the plan definition of an eligible child.

If a covered surviving dependent subsequently declines HealthFlex coverage, all future coverage rights are lost.

A legally separated or divorced spouse of a deceased participant is not eligible for survivor benefits.

Premiums for survivor coverage are billed and collected by the plan sponsor.

Survivors of retirees:

The above also applies to the survivor of an eligible retiree. However, if the surviving dependent of an eligible retiree is not a covered dependent under HealthFlex but has other group health coverage, he/she may decline survivor coverage at the time of the retiree's death and retain future coverage rights.

Those rights can be exercised in conjunction with any annual election for coverage commencing at the beginning of the next HealthFlex plan year, so long as she/he maintains the other employer sponsored group health coverage through the last day of the HealthFlex plan year preceding the commencement of HealthFlex coverage.

If prior to the end of the HealthFlex plan year the surviving dependent loses other group health coverage and he/she wishes to exercise his/her coverage rights, it is the survivor's responsibility to notify the plan sponsor. The survivor should notify the plan sponsor on a timely basis such that the plan sponsor can give (mail) the survivor the enrollment/change form and other important information, and the survivor can complete and return the necessary forms to the plan sponsor for signature within 30 calendar days following the loss of that other group health coverage. (The first day of being without coverage is counted as the first of the 30 days.) If this 30-day requirement is not met, all future surviving dependent coverage rights are lost.

If a non-covered surviving dependent of a retiree declines HealthFlex survivor coverage when first eligible for such coverage without having other group health coverage, all future coverage rights are lost with respect to that dependent.

DIVORCED SPOUSE ELIGIBILITY and ENROLLMENT

Divorced spouse of an active participant:

The medical plan also considers as eligible the covered legally separated or divorced spouse of a covered participant, provided the participant is responsible by legal decree for the majority of financial support of the former spouse or specifically for the medical, or other health care expenses, of the spouse.

The participant must notify the plan sponsor when there is an eligible divorced spouse who meets the conditions above and for whom the participant wishes to obtain HealthFlex coverage. This notification must be done on a timely basis such that the plan sponsor can give/mail the divorced spouse an enrollment/change form and the "divorced spouse" can complete and return it to the plan sponsor within 30 days of the date of the legal decree. If this 30-day requirement is not met, all future divorced spouse rights under HealthFlex are lost.

On the enrollment/change form, the divorced spouse indicates whether coverage is being accepted or declined on him/herself. The divorced spouse also indicates his/her legal residence. The only coverage category available to a divorced spouse is "participant only." If coverage is declined, the divorced spouse loses all future rights for coverage under HealthFlex.

A covered divorced spouse may continue under the active medical option until age 65 and then until death under the retiree medical option. In no event, however, will HealthFlex eligibility extend beyond the period specified in the legal decree, the date of the participant's death or the period for which premiums are paid.

If a divorced spouse remarries, he/she remains eligible for HealthFlex benefits, unless otherwise provided for in the legal decree. HealthFlex will consider as ineligible any newly acquired dependent of a divorced spouse.

A divorced spouse of a deceased participant is not eligible for survivor benefits unless legal decree requires it.

If a covered divorced spouse subsequently declines coverage, all future coverage rights are lost.

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Premiums for divorced spouse coverage are billed and collected by the plan sponsor. Any contribution paid by the participant must be paid on an after-tax basis.

Divorced spouse of a retiree participant:

The above also applies to a legally separated or divorced spouse of an eligible retiree. However, if the divorced spouse is not a covered dependent under HealthFlex but has other group health coverage, he/she may decline divorced spouse coverage at the time of the legal separation or divorce and retain future coverage rights. Those rights can be exercised in conjunction with any annual election for coverage commencing at the beginning of the next HealthFlex plan year, so long as she/he maintains the other group health coverage through the last day of the HealthFlex plan year preceding the commencement of HealthFlex coverage.

If prior to the end of the HealthFlex plan year the divorced spouse loses other group health coverage and he/she wishes to exercise his/her coverage rights, it is the divorced spouse's responsibility to notify the plan sponsor. The divorced spouse should notify the plan sponsor on a timely basis such that the plan sponsor can give/mail the divorced spouse the enrollment/change form and other important information, and the divorced spouse can complete and return the necessary forms to the plan sponsor for signature within the 30 calendar days following the loss of the other group health coverage. (The first day of being without coverage is considered the first of the 30 days.) If this 30-day requirement is not met, all future divorced spouse coverage rights are lost.

If a divorced spouse declines HealthFlex coverage, all future coverage rights are lost.

If a covered divorced spouse of a retiree subsequently declines coverage, all future coverage rights are lost.

CONTINUANTS

Active participants and their dependents, surviving dependents, divorced spouses, retiree dependents:

When a covered participant and/or dependent loses eligibility under the medical plan, coverage is lost the first of the month coincident with or next following the month in which the event that causes the loss of eligibility occurs. This is the same date on which any changes in billing are effective.

The person losing eligibility may continue medical coverage for no more than nine months from the date coverage is lost. Continuation of coverage is not available with respect to medical/dependent care reimbursement accounts.

It is the responsibility of the participant to notify the plan sponsor when dependent eligibility is lost. It is the responsibility of the plan sponsor to notify the participant of his/her loss of eligibility.

Once the plan sponsor is aware of the loss of eligibility, the plan sponsor must give the participant or dependent an enrollment form for continuation purposes. This must be done within 60 calendar days following the date the person loses coverage. (The first day of being without coverage is the first of the 60 days.) It is important for the person to accept continuation coverage and return the form to the plan sponsor within those same 60 days. The plan sponsor signs and dates the form, authorizing the continuation of coverage. This must be done within the same

60-day period. The plan sponsor faxes or mails the form to the plan administrator. The plan administrator processes the enrollment form.

If the participant or dependent does not elect continuation coverage or if the plan sponsor does not audit and sign the enrollment/change form within the 60-day period, all continuation rights with respect to that person or persons are lost.

HealthFlex considers as ineligible any newly acquired dependent of a continuant.

Premiums for continuation coverage are billed and collected by the plan sponsors. Contributions are paid on an after-tax basis.

WHEN A PARTICIPANT'S MEMBERSHIP CONFERENCE CHANGES

In the event a participant's employment, membership or appointment changes from one HealthFlex plan sponsor to another, the participant is treated as a new hire for eligibility, enrollment and election purposes. For retiree eligibility and determination of continuous coverage purposes, however, the prior period of continuous coverage will carry over to the new plan sponsor.

In the event a participant's membership results in him/her joining a non-HealthFlex plan sponsor, the participant is considered to have lost eligibility under HealthFlex. Continuous coverage for retiree eligibility purposes is lost. The exception to this is in the case of a ¶346.1 appointment. If the participant returns to a HealthFlex plan sponsor and he/she has maintained continuous medical coverage while on the ¶346.1 appointment, he/she will be considered to have continuous coverage under HealthFlex.

ELECTION of OPTIONS, EFFECTIVE DATES of COVERAGE and BILLING

At the time of hire or on becoming a newly-eligible participant:

Within ten calendar days of the plan administrator receiving the participant's enrollment/change form, the participant receives a health administration system-generated election worksheet listing the alternative options available to him/her. The participant has 30 calendar days from the date the worksheet is generated to make his/her elections using the HealthFlex Web site, which includes accepting the plan sponsor's base options. Once elections are made no changes are permitted until the next annual election period, or unless a family status change or special enrollment event occurs.

A participant and his/her dependents must be covered under the same options, even if they live in different geographic areas. The exception to this is a retiree where the covered person who is age 65 or over may be covered under an option that is different from that of the covered person who is under age 65.

On becoming an active non-salaried participant:

If a participant goes on a disability leave of any type, a family medical leave or a maternity/paternity leave as defined in The Book of Discipline and determined by the plan sponsor, the following occurs:

The participant maintains his/her medical, medical reimbursement account and dependent care account benefits, as if he/she were an active salaried participant, for three calendar months from the end of the month in which that particular leave status began. Participant premium conversion and salary-reduction amounts due for that period must be paid in full on a pre-tax basis either before the leave or upon return from leave (if within the three month period), or may be paid by the participant on an after-tax basis during the leave. In the case of a participant receiving disability benefit

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payments under a plan administered by the General Board of Pensions and Health Benefits, the participant may request for his/her premium and salary reduction amounts to be paid out of his/her disability benefit (certain plan sponsors may require this on a mandatory basis). If the participant is receiving salary, premiums and salary reduction amounts may be deducted on a pre-tax basis.

DISABILITY and MEDICARE

If an active participant becomes entitled to Medicare due to a disability, the medical options available to the participant are the same as those offered retirees age 65 and over. Dependents of the participant remain in their current options.

If a covered dependent of an active participant becomes entitled to Medicare due to a disability, the medical options available to him/her are the same as for Medicare eligible retirees. If the retiree also happens to be eligible for Medicare, the dependent needs to make an election from available options.

UPON REGAINING ELIGIBILITY in the SAME PLAN YEAR

When a person regains eligibility during the same plan year in which he/she lost eligibility, there are certain rules that apply to the benefits available to him/her. This situation occurs when a person is rehired in the same plan year as his/her previous employment terminated with the same plan sponsor or when a person loses HealthFlex eligibility due to a status change and gains eligibility again in the same plan year due to another status change. An example of this is when a person goes into an ineligible leave status and returns to active service in the same plan year.

When the person returns, he/she indicates on the enrollment/change form whether he/she accepts or declines coverage. The process and 30-day plan sponsor signature requirement apply as for a newly eligible participant. If he/she accepts coverage, the plan administrator automatically places the participant in the same medical option he/she last had when eligible.

Generally, a medical reimbursement account or dependent care account will not be reinstated. The exception to this is if the participant had a medical reimbursement account and/or dependent care account and lost eligibility directly from an active salaried status. In this case, the original accounts will be reinstated.

ACTIVE CLERGY, SPOUSES and DEPENDENTS

Insurance shall be provided for enrolled clergy who are under Episcopal appointment (optional coverage is available for the spouses and dependents of those clergy), and who are:

- A. full-time clergy of local churches, or
- B. full-time clergy whose salaries are paid by the Conference.

DISABLED CLERGY, SPOUSES and DEPENDENTS

Insurance shall be continued, at Conference expense, on Conference members and full-time local pastors who become disabled according to the standards of the Comprehensive Protection Plan who were covered by the Conference insurance program at the time of their becoming disabled.

For a Conference member or a full-time local pastor who becomes disabled according to the above standards, insurance shall be continued, at Conference expense, on the spouse and dependents of such disabled clergy, provided such spouse and

dependents were covered by the Conference insurance program at the time the clergy became disabled.

Coverage shall terminate on the spouse of a disabled clergy when such spouse accepts employment where medical coverage is offered at no expense to such spouse.

RETIRED CLERGY, THEIR SPOUSES and DEPENDENTS

Retirement (§358 2008 *Discipline*):

1. Subject to the limitations set forth below, medical insurance may be continued, at shared Conference and individual expense, on retired clergy, their covered spouses and dependents, where such clergy were, at the time of their retirement, Conference members or full time local pastors retiring under mandatory retirement, voluntary retirement at age 65 or 40 years of service, or voluntary retirement at age 62 or 30 years of service and were covered by conference insurance for at least 5 years immediately prior to retirement.

2. Individual cost is based on date of participant retirement (or death prior to retirement), years of service, and actual coverage:

a. All service Pre-1982: No contribution is required from retirees whose service is all prior to 1/1/1982.

b. Service completed between 1/1/1983 and 12/31/2004 will pay on a graduated scale over the next 9 years:

<u>Dates</u>	<u>Conference pays</u>	<u>Participant pays</u>
From 1/1/05 to 12/31/08	90%	10%
From 1/1/09 to 12/31/12	85%	15%
From 1/1/13 Forward	80%	20%

c. Service completed after 1/1/2005 will pay on a graduated scale based on

<u>Years of service</u>	<u>Conference pays</u>	<u>Participant pays</u>
35+	80%	20%
30-34	70%	30%
25-29	60%	40%
20-24	40%	60%
15-19	30%	70%
10-14	20%	80%
0-9	0	100%

Beginning January 1, 2011 the charts above apply until Conference portion reaches \$5,000 annually for single coverage or Conference portion reaches \$10,000 annually for 2-party or family coverage. At that point participant must pay all increases. Eventually this will act as a Subsidy Cap of 5,000/10,000 from the Conference. As premiums rise, those who pay least will begin to see increases at the rate of premium inflation.

3. Years of service shall be as determined by the Conference Benefits Office in conjunction with the Board of Pension's records and standards. All full-time service to the denomination is recognized. In the case of Deacons in Full Connection, any years of service as a Diaconal Minister shall be included in the total number of service years.

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4. The Conference contribution to the Conference medical insurance program on retired clergy, their spouses and dependents that are 65 years of age and older shall be limited to the Medicare Supplement rate.

5. After July 31, 1986, Conference members, local pastors and their dependents will not be entitled to coverage under the Conference insurance program and Conference funding unless such member/pastor and dependents have been covered by the Conference insurance program for five (5) years immediately preceding retirement. Conference members/pastors and dependents not entitled to coverage with Conference funding because of the limitations provided above who would otherwise be entitled to such coverage, may apply for coverage under the Conference insurance program, subject to such restrictions and limitations as are from time to time established by the insurance carrier, and, if such members are accepted for coverage by the insurance carrier, pay the full cost of providing the coverage to the Conference in accordance with guidelines and procedures which are established by the Conference from time to time.

6. Retirees will be billed monthly or may authorize premiums to be withheld from their monthly pension check.

7. Clergy members retiring under voluntary retirement with 20 years' service who meet coverage eligibility noted in #5 above may have coverage in retirement, but no Conference subsidy will be provided.

SURVIVING SPOUSES and OTHER DEPENDENTS

Insurance may be continued, at shared Conference and individual expense, on spouses and dependents of deceased Conference members and deceased full-time local pastors provided such spouses and dependents were covered by the Conference insurance program at the time of the death of the member or pastor.

1. Conference funding for surviving spouse/dependents is according to the graduated scales above. The survivors' cost equals that which would apply to the deceased clergy person.

2. Conference funding shall terminate for a surviving spouse upon remarriage prior to age sixty or through acceptance of employment where medical coverage is offered at no expense to such spouse.

3. Surviving spouses and dependents of other deceased persons covered by the Conference insurance program may continue in the program provided they were insured under the Conference program at the time of such person's death and their premium is timely and regularly paid to the Conference in accordance with guidelines from time to time established by the Conference.

Amendments - These guidelines may be amended from time to time by the Conference in its discretion.

DUAL COVERAGE

You may not be covered under the health care program as both an employee and a dependent. If both you and your spouse are covered by a plan as employees, either one of you, but not both, can cover your children as dependents.

Changing Benefit Coverage During the Year

EVENT	You, your spouse or your dependents lose COBRA coverage	You or your dependents lose non-NGAC coverage because of divorce or legal separation	You, your spouse or your dependents lose non-NGAC coverage because of a death	You, your spouse or your dependents lose non-NGAC coverage because of termination employment reduction in hours; employer contributions stop	You gain a dependent through: birth adoption placement for adoption	You become a guardian of a dependent through a court order	You get married	<p>WHO CAN SIGN UP?</p> <p>You, your spouse and your dependents</p> <p>You and your dependents</p> <p>You, your spouse and your dependents</p> <p>You, your spouse or your dependents</p> <p>You, your spouse, your new dependent and your new dependent's siblings</p> <p>Child under guardianship</p> <p>You, your spouse, your dependents and your spouse's children (employee stepchildren)</p>
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QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The plan provides coverage at any time to your child if it is required under the terms of a QMCSO. A QMCSO is any judgment, decree or order issued by a court of law or qualified state agency requiring you to provide support or health care coverage for your child. If the child is not in your custody, the plan will:

1. provide the custodial parent with information about health benefits under the plan;
2. permit the custodial parent to submit claims; and
3. pay claims directly to the custodial parent.

DROPPING COVERAGE for YOURSELF or a DEPENDENT

You can drop coverage only if one of the following status changes occurs and if dropping coverage is consistent with the change:

a change in your marital status (marriage, death of a spouse, divorce, legal separation or annulment);

a change in the number of your dependents because of birth, adoption, placement for adoption or death;

a change in the employment status of you, your spouse or your dependent (such as employment has started or ended, a strike or lockout takes place, there is a beginning or ending of unpaid leave of absence or there is a change in worksite); a dependent is no longer eligible for coverage due to age or student status; or you, your spouse or your dependents enroll for Medicare or Medicaid.

You must notify the NGAC Benefits Office within 31 days of a status change if you wish to drop your coverage. If you fail to provide notice to the NGAC Benefits Office within 30 days, your premium payments will not be refunded.

PRE-EXISTING MEDICAL CONDITIONS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affects coverage for any pre-existing conditions that you or your dependents may have. It is important for you to know that HealthFlex limits coverage for certain pre-existing conditions if you are enrolled in the PPO or OOA options. Federal law allows HealthFlex to limit benefits under the PPO and OOA options for pre-existing conditions for up to 12 months. The pre-existing condition cannot apply to pregnancy. A newborn child who is enrolled for coverage under HealthFlex within 30 days after the date of birth cannot be subject to pre-existing condition limitations. In addition, a child who is adopted or placed for adoption before reaching age 18, and who is enrolled for coverage under HealthFlex within 30 days after adoption or placement, cannot be subject to pre-existing condition limitations. (A newborn or adopted child would be subject to pre-existing limitations if the child later changes health care plans and has a break in coverage of 63 days or more between plans.)

If you or your covered dependent(s) have received medical advice, diagnosis, care or treatment for an injury or sickness before beginning coverage under HealthFlex, that injury or sickness may be considered a pre-existing condition. Under federal law, medical advice, diagnosis, care or treatment received in the six months before coverage begins may be considered a pre-existing condition. Genetic information that does not result in a specific diagnosis cannot be considered a pre-existing condition.

Application of the pre-existing condition limitation means that full coverage for the condition will be postponed until the earliest of the following dates:

six months after the last date in which care or treatment was performed for the pre-existing condition while you or your dependent(s) are covered under HealthFlex, or after you or your dependent(s) have been covered under HealthFlex for 12 consecutive months (applicable if you or your dependents are a new or special enrollee or a late entrant to the plan).

CREDITABLE COVERAGE

If you or your dependents are subject to the pre-existing condition limit, you may shorten or eliminate the exclusion period by providing proof of prior health care coverage before enrolling in this program. You and your covered dependents will receive credit for prior health care coverage as long as you or your dependents did not have a break in coverage of 63 days or more. This credit will reduce the 12-month exclusion period by a length of time equal to the period you or your dependents had other health coverage. Examples of other health coverage include another group health plan, COBRA, an HMO, an individual health insurance policy, Medicare or Medicaid. If a pre-existing condition limit applies to you or your covered dependents, you will be notified in writing about what your appeal rights are and how long you or your dependents will have to wait until the pre-existing condition will be covered under this health care program

Proof of Creditable Coverage:

If you choose to provide proof of prior coverage, you will need to present UHC with a copy of a certificate from your or your dependents' prior plan. The certificate should be mailed to UHC at:

United HealthCare Insurance Company
450 Columbus Boulevard
Hartford, CT 06115-0450
UHC Fax (801) 567-5498

Alternatively, you may fax it to NGAC at 678 533-1380 to be forwarded to the General Board of Pension & Health Benefits.

Most group health plans will automatically provide you with this certificate. If you or your dependents are unable to obtain a certificate of prior coverage, your local Benefits Administrator will attempt to assist you. In some cases, when a certificate cannot be obtained, alternative methods of proof will be accepted (such as a paycheck stub with a deduction for medical coverage).

DESCRIPTION OF BENEFITS

This section explains the major features of the NGAC HealthFlex Plan.

The following terms have special meaning under the NGAC HealthFlex Plan. Other definitions appear in the appropriate sections.

United Health Care

A special feature of the NGAC HealthFlex Plan is the preferred provider organization (PPO). Our PPO network of hospitals and physicians is offered through United Health Care (UHC), specifically their Choice Plus product.

Claims Administrator

Claims administrator refers to the entity that reviews and determines whether to pay claims on behalf of the plan. The medical, prescription drug, and vision plans have separate claims administrators (see How to File Claims).

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Co-payment

The co-payment is a set dollar amount you pay for certain services. You will be required to pay this amount each time you obtain services or supplies for which a co-payment is required.

Covered Expenses

Covered expenses are charges for services and supplies that are eligible under the plan and are considered to be reasonable and customary as well as medically necessary by the claims administrator.

Custodial Care

Custodial care is care provided to a patient that can be safely provided by a person without medical skills; is designed mainly to help the patient with daily living activities such as: walking, bathing, exercising, dressing and eating with a spoon, tube or gastrostomy, homemaking, oral hygiene, ordinary skin and nail care, taking medication is related to watching or protecting an individual.

Educational Care

Educational care refers to teaching or care provided in an institution designed to address the special needs of patients who cannot attend a teaching facility for the general public because of a mental or physical incapacity.

Emergency

An emergency is a serious accident or sudden illness that causes symptoms that are severe and could result in a long-term medical problem, severe disability or loss of life.

Experimental or Investigational Treatment

A drug, device, medical treatment or procedure is considered experimental or investigational if:

the drug or device cannot be lawfully marketed without the required approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is provided;

the drug, device, medical treatment or procedure, or the patient informed consent document used with the drug, device, medical treatment or procedure, was reviewed and approved by the treatment facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval;

reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety or efficacy compared to a standard means of treatment or diagnosis; or

reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy compared to a standard means of treatment or diagnosis.

Reliable evidence refers to published reports and articles in authoritative medical and scientific literature only; the written protocols used by the treating facility or the protocol of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treatment facility or by another facility studying substantially the same drug, device, medical treatment or procedure, that states it is experimental, investigational or for research purposes.

Hospice- A hospice is a facility or part of an institution that primarily provides care for terminally ill persons with life expectancies of six months or less; is accredited by the National Hospice Organization; and fulfills any licensing requirements of the state or locality in which it operates.

Hospital

A hospital is:

an institution licensed as a hospital, which maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of physicians; provides 24-hour service by registered graduate nurses

an institution which specializes in the treatment of mental illness, alcohol or drug abuse or other related illnesses; provides residential treatment programs; is licensed in accordance with the laws of the appropriate legally authorized agency; an institution which qualifies as a hospital, a psychiatric hospital or tuberculosis hospital, and is a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission of the Accreditation of Hospitals; or a freestanding surgical facility.

a hospital is not a facility that is used primarily for nursing home, convalescent or extended care; rest care; care for the aged; educational care or behavioral modification services for children with behavioral or social problems, mental retardation or autism; career advice or job training; or residence, play or exercise.

Maintenance Care

Any care provided after a determination that further treatment will not result in any meaningful improvement in the patient's condition or where the patient has reached the level of maximum functional improvement is considered maintenance care.

Medically Necessary

Medically necessary refers to services or supplies that are necessary for the diagnosis, care or treatment of an injury, illness, disease or pregnancy. The service or supply must be effective, appropriate and essential based on recognized standards of the health care specialty involved.

All services or supplies (except for wellness benefits) must be medically necessary to be covered under the plan. However, a determination of medical necessity does not guarantee coverage under the plan. Hospital stays will be determined to be medically necessary when the covered medical services you or your dependents receive require a hospital inpatient setting. If the physician's office, the outpatient department of a hospital or some other setting can provide appropriate services without adversely affecting your or your dependent's condition, a hospital stay will not be considered medically necessary.

Services and supplies that are not medically necessary include:

hospital stays consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, such as a physician's office or hospital outpatient department;

hospital stays primarily for diagnostic studies (diagnostic testing, laboratory, pathological services and diagnostic tests) that could have been provided safely and adequately in some other setting, such as a physician's office or hospital outpatient department;

continued inpatient hospital care when the patient's medical symptoms and condition no longer require a continued hospital stay;

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hospital stay or admission to a skilled nursing facility, nursing home or other facility for the primary purpose of providing custodial care, convalescent care, rest care or domiciliary care to the patient or for the convenience of the patient or physician;

hospital stay or admission to a skilled nursing facility for the convenience of the patient or physician or because care in the home is not available or is unsuitable; or

the use of skilled or private nurses or other caregivers to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient or his or her family.

Physician

Physician refers to a legally qualified practitioner of the healing arts, other than you, your spouse or your dependent, acting within the scope of his or her license. Recognized practitioners are a medical doctor (M.D.), osteopath (D.O.), chiropractor (D.C.), psychologist (Ph.D.), dentist (D.D.S.), optometrist (O.D.), and a licensed clinical social worker (L.C.S.W.) with a master's degree in social work who is licensed to provide therapy services by the state in which he or she practices.

Reasonable and Customary Charges

Reasonable and customary charges apply to out-of-network and out-of-area providers and prescription drug benefits.

Reasonable and customary charges are charges that are the same as, or compare fairly with, charges made for comparable services or supplies to individuals with similar medical conditions in the same geographic area. Charges made by providers in specific geographic areas and the level of service provided are reviewed periodically. Based on this review, the claims administrator determines the maximum covered charge he or she will accept as reasonable and customary. If your expenses exceed reasonable and customary charges, you will have to pay the excess amount. That amount will not be applied toward your deductible or out-of-pocket limit. However, you can be reimbursed for these excess amounts if you fund a Health Care Spending Account. (For more information, see the reimbursement account section.)

Review Program

The NGAC HealthFlex Plan includes a review program that is run by UHC. The program, staffed by specially trained nurses and physicians, is designed to ensure that you and your dependents avoid unnecessary or excessively long hospital stays.

Skilled Nursing Facility

A skilled nursing facility is a legally operated institution or part of an institution that: is licensed by the state in which it operates; is primarily engaged in providing skilled nursing services and medical care for sick and injured individuals on an inpatient basis or providing physical rehabilitation on an inpatient basis; maintains all facilities necessary for medical treatment on the premises; provides such services, for compensation, under the supervision of physicians; and provides nursing services.

A skilled nursing facility does not include any institution or part of an institution that is used primarily for educational care, custodial care or maintenance care.

NGAC HEALTHFLEX PLAN PREFERRED PROVIDER ORGANIZATION (PPO)

A special feature of the NGAC HealthFlex Plan is the preferred provider arrangement. A PPO is a network of hospitals and physicians that offer their services at lower negotiated rates. If you use network hospitals and physicians, the plan will reimburse you at a higher rate than if you receive services from non-network providers. Using PPO providers can

result in substantial savings because your deductible, coinsurance and out-of-pocket limit will be lower. Our PPO network of hospitals and physicians is offered through UHC, Choice Plus Plan. For up-to-date information on UHC's network of hospitals and physicians, contact UHC directly before each visit.

IN-AREA and OUT-of-AREA CLASSIFICATIONS

Your ability to access PPO hospitals and physicians from your home address determines whether you will be classified as in-area or out-of-area. This classification is based on your home zip code as of January 1st of each plan year. If you are classified as in-area, you have reasonable access to a wide range of PPO providers. You still have the option to receive care outside the network; however, you will have to pay more of the expenses for out-of-network services and supplies than for in-network services. If you have limited access to PPO hospitals and physicians, then you are classified as out-of-area. Under this classification, you can go to any doctor you choose; there are no provider network restrictions and the plan will generally pay 80% of the reasonable and customary expenses. You will be notified by the NGAC if you are considered to be out-of-area. If you move during the year, your classification may change. Please contact the NGAC Benefits Office with your new address as soon as possible.

FOR MORE INFORMATION

For more information about the NGAC HealthFlex Plan, you may contact UHC directly. You can also access UHC through the Internet at www.uhc.com for general and PPO provider information. More detailed information about your coverage and claims can be accessed by signing in on www.myuhc.com. Because hospitals and physicians frequently change their affiliations with networks and organizations, printed directories become quickly outdated. To ensure that the hospital or physician you are going to receive treatment from is a current network provider, contact UHC directly before each visit or hospital stay.

REVIEW PROGRAM

Unnecessary hospital stays and stays that last longer than necessary cause health care costs to increase. Sometimes, individuals are hospitalized for procedures that can be performed safely, effectively and more comfortably in an alternative setting, such as a hospital's outpatient department or a physician's office. The NGAC HealthFlex Plan includes a review program that is run by UHC, a leading provider of health care utilization review services. The program, staffed by specially trained nurses and physicians, is designed to ensure that you and your dependents avoid unnecessary or excessively long hospital stays.

Although the decision to seek medical treatment and health care services is always up to you and your physician, the plan will cover only services that are considered medically necessary as determined by UHC, regardless of your physician's recommendation. If a proposed treatment or stay is not reviewed when required, there may be severe limits on benefits, as explained on the following pages.

CALL for ADVANCE APPROVAL

Contact UHC for any inpatient hospital stays. If you do not contact UHC for approval when required, benefits will be reviewed afterwards to determine medical necessity. You will be responsible for all expenses (any supplies, services or hospital days) that are determined not to be medically necessary. Inpatient stay in an out of

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network hospital by person covered by PPO network, will result in additional \$200 deductible.

The following explains how the process works:

Situation: You or your covered dependents are scheduled to be admitted to the hospital for a non-emergency stay (including care for mental health or substance abuse treatment).

When to contact UHC: Before admission (for mental health treatment, contact UBH).

Situation: You or your covered dependents need emergency inpatient care (including patient care for mental health or substance abuse treatment).

When to contact UHC: Within 48 hours of admission. If you or a dependent is hospitalized when coverage under this plan begins, a UHC coordinator will determine whether the hospital stay and treatment are medically necessary.

Information UHC Will Need

When you call UHC, be prepared to provide the following information: your name, birth date, Social Security number, home phone number, address, and employer name (North Georgia Annual Conference/General Board of Pension & Health Benefits coverage), the treating physician's name and phone number; the treatment facility's name and phone number; the reason for the hospital stay; the proposed treatment or surgery; the date of proposed treatment or surgery; and any other relevant information.

If you call for your dependent, UHC will need your name and Social Security number as well as the dependent's name, date of birth, Social Security number, phone number and address (if different than yours). UHC will then contact the physician for additional information. Once UHC has gathered all necessary information, it will review the admission and determine medical necessity under the terms of the plan. You and the physician will then be notified of the decision and the number of inpatient days that will be certified. A hospital stay will not be considered medically necessary if UHC determines that appropriate care could be provided in another setting without endangering the patient's condition. If the UHC coordinator does not certify the medical necessity of all or part of a requested hospital stay, the case will be referred to a physician consultant who will call the treating physician immediately. In most cases, this physician-to-physician review will resolve any question about certifying the hospital stay. The plan will not pay benefits for any hospital confinement considered not medically necessary.

CASE COORDINATION

Focusing on education, accelerating access to care, and providing early identification and monitoring of chronic conditions, United Healthcare uses interventions on those cases that have significant, unmet health care needs and that are highly likely to increase utilization. In addition, all of the activities are integrated to achieve a seamless, efficient system of care. These activities include: Health Education & Reminder Programs, Admission Counseling, Inpatient Care Advocacy, Welcome Home! (readmission prevention), and IMPACT (complex illness support).

Healthy Pregnancy Program

United Healthcare offers personal support through all stages of pregnancy and delivery. To enroll, call 1 800-411-7984. You can access information about the Health Pregnancy Program at www.healthy-pregnancy.com.

Optum Nurseline

Visit www.myuhc.com and click on Health Topics & Tools tab on the toolbar at the top, next select Ask a Professional and click on Live Nurse Chats to have a one-to-one discussion on a variety of general health topics with a registered nurse. Or call 1 800 901-1939 to speak with a registered nurse or access information on many health and well-being issues via the Health Information Library (audio tape library).

WELLNESS BENEFITS

The NGAC HealthFlex Plan provides important preventive coverage for you and your eligible family members. The plan encourages wellness exams and screenings for the prevention and early detection of disease. Whether you obtain services in-network, out-of-network or out-of-area, wellness benefits are paid at 100% with no deductible (after office visit co-pay), provided however, that Out-of-Network benefits are subject to a \$100 annual maximum.

WELL CHILD CARE

To help promote a healthy childhood, the plan covers routine screenings, immunizations and tests from birth through age 16 at 100%, limited to 1 visit per calendar for children over age 2. Out of network coverage is limited to \$100 per benefit period for all wellness services.

Medical care needed for illness or injury between routine wellness exams may be covered under the plan as a physician's office visit (subject to the co-payment, deductible and coinsurance amount).

ADULT WELLNESS

The plan offers continuing wellness benefits for adolescents (beginning at age 16) and adults. The benefits include: one office visit after \$30 co-payment for primary care physician or \$50 co-payment for specialist physician, mammogram, pap test, digital rectal exam and PSA, colorectal cancer screening, routine blood work, and other age appropriate routine diagnostics and immunizations up to \$500 annual limit. In network screening colonoscopy \$100 co-pay, covered once every 3 years for participants age 45+. Out of network coverage is limited to \$100 per benefit period for all wellness services.

VISION COVERAGE

The NGAC plan includes one complete annual eye exam for each covered member of the family through Vision Service Provider (VSP) at a \$10.00 co-payment. To find a VSP provider in your area and to access your VSP benefits go to www.vsp.com.

HOW the HEALTHFLEX PLAN WORKS

While the HealthFlex Plan covers many medical services and supplies, you will be responsible for paying a portion of those expenses such as the co-payment, deductible and coinsurance, as explained below.

A. Co-payment

The co-payment is a set dollar amount you pay for certain services. You will be required to pay the established amount each time you obtain services or supplies for which a co-payment is required.

B. Annual Deductible

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The deductible is the portion of your covered expenses you pay each calendar year before the plan pays benefits. The amount of your deductible depends on the level of coverage you have (employee, employee plus one or family) and whether you use in-network or out-of-network providers. Covered expenses applied to your in-network deductible also count toward your out-of-network deductible and vice versa.

C. Deductible for Family Coverage (In-Network)

Each covered family member may contribute only up to \$750 toward the \$1500 family deductible. (If there are three in the family, the deductible may be satisfied by two of the family members reaching their \$750 limits, or any combination of the three individual family member deductibles that satisfy the \$1,500 limit.) A single family member may not count any amount in excess of his or her deductible limit towards satisfying the family limit.

D. Deductible for Family Coverage (Out-of-Network)

Each covered family member may contribute only up to \$1,500 toward the \$3,000 family deductible. A single family member may not count any amount in excess of his or her deductible limit for purposes of satisfying the family limit, but any combination of family members' deductibles may be combined (up to the individual deductibles) to satisfy the family deductible limit.

E. Maternity Deductible

Only one calendar year deductible will be required for the mother and newborn for all expenses resulting from a hospital stay during delivery. However, a separate calendar year deductible will apply for expenses incurred by the newborn after the mother is discharged from the hospital (see Changing Benefit Coverage During the Year for information on enrolling newborns during the year).

F. Carryover Deductible

There are no carryover deductibles in the HealthFlex Plan. Charges incurred in October, November or December that are applied to the current annual deductible will not count toward the calendar year deductible for the following year.

G. Coinsurance

Once you meet the deductible, where applicable, the plan will pay a percentage of covered expenses for you and your dependents. You pay the remaining portion. This portion is known as your coinsurance and the amount depends on whether you are classified as in-area or out-of-area and whether you use in-network or out-of-network providers.

H. Out-of-Pocket Limit

As added financial protection for you, the NGAC HealthFlex Plan places a limit on the amount of money you will have to pay out of your own pocket for medical care each year. Once you reach this out-of-pocket limit, the plan will pay 100% of **covered** medical expenses for the rest of the year. The out-of-pocket limit does not carry over to the following year.

The following expenses do **not** count toward the annual out-of-pocket limit and are not paid at 100% once the limit is reached:

1. expenses/penalties incurred for not using the review program;
2. charges above reasonable and customary (for out-of-network and out-of-area);

3. prescription drug co-payments;
4. vision care co-payments;
5. expenses not covered by the plan; or
6. expenses considered not medically necessary.

I. Lifetime Maximum Benefits

The NGAC HealthFlex Plan provides a lifetime benefit of \$2,000,000 for you and your dependents for most covered services and supplies. However, there is a separate lifetime maximum benefit for the combined inpatient and outpatient treatment of substance abuse for each covered individual. For substance abuse, the lifetime limit is 60 days of inpatient treatment and 60 outpatient visits.

Summary of Deductibles, Out-of-Pocket Limits and Maximum Benefits:

	If you Live In-Area	
<u>Annual deductible</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Employee	\$750	\$1,500
Employee plus one	\$1,500	\$3,000
Family	\$1,500	\$3,000
	If you Live Out-of-Area	
Employee	\$750	
Employee plus one	\$1,500	
Family	\$1,500	
<u>Annual Out-of-Pocket Limit</u>		
Employee	The coinsurance you pay on the first \$3,500 of covered expenses. This amount includes the \$750 deductible.	
Employee plus one	The coinsurance you pay on the first \$7,000 of covered expenses. This amount includes the \$1,500 deductible.	
Family	The coinsurance you pay on the first \$7,000 of covered expenses. This amount includes the \$1,500 deductible.	

HOSPITAL – COVERED SERVICES and SUPPLIES

Certification for Hospital Stays

If you or your dependent is faced with a planned, non-emergency hospital admission, you must call United Healthcare before the admission to be sure that the treatment and stay are medically necessary and, therefore, covered under the plan. The plan will not pay any benefits if a stay or treatment is not medically necessary.

In Case of an Emergency

If you or your dependent is admitted to the hospital in an emergency situation, United Healthcare must be notified within 48 hours of the admission. UHC will then review the admission to determine medical necessity. An emergency admission occurs when a serious accident or sudden illness causes symptoms that are severe and could result in a long-term medical problem, severe disability or loss of life.

Covered Expenses

Covered hospital expenses include hospital room and board (semi-private room); general nursing care; intensive care unit; and nursery care of a newborn child. For more information, see Alternatives to a Hospital Stay.

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Maternity Benefits

Our plan, in compliance with federal law, provides that hospital stays will be covered for at least 48 hours following a normal vaginal delivery, or at least 96 hours following a cesarean section; the attending physician does not need to obtain authorization from the plan to provide the mother and newborn with this length of hospital stay; and shorter hospital stays are permitted if the attending health care provider, in consultation with the mother, determines that this is the best course of action. Maternity benefits include: initial visit to determine pregnancy; all subsequent prenatal visits; hospital admission and delivery; birthing centers; and a postnatal visit.

PHYSICIAN – COVERED SERVICES and SUPPLIES

Covered Expenses

Covered expenses include physicians' fees for: inpatient and outpatient medical care, including treatment or diagnostic services; surgical operations and assisting at surgery when required for medical reasons; and anesthesiology, radiology and pathology (if you are in-area and receive care or services from an in-network hospital, benefits will be paid at 80% even if the doctor is not part of the network; if you are out-of-area, benefits will be paid at 80%).

Second Surgical Opinions

Surgery is a serious matter and may not always be the preferred treatment. For this reason, the plan will pay 100% of the cost, with no deductible, for a second surgical opinion (a \$50 co-payment will apply if service is provided in a physician's office). A second surgical opinion is an additional evaluation by a board-certified physician to help you decide whether an operation is necessary or whether another course of treatment is available.

ALTERNATIVE THERAPY

Chiropractic care is treatment given by a Doctor of Chiropractic. As with other medical care, only chiropractic services that are medically necessary will be covered. Chiropractic care is medically necessary if: the care is part of a documented, prescribed and complete treatment plan established by the health care practitioner; and the care is based on an established plan that is deemed to be appropriate for the diagnosed condition. Other therapies covered are massage therapy and naprapathy.

The therapies are covered at 50% (chiropractic non participating provider at 50% after deductible) with a combined annual maximum of \$1000.

BREAST RECONSTRUCTION FOLLOWING MASTECTOMY

The following treatment and supplies are covered for you and your dependents if required as a result of a mastectomy: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Coverage for breast reconstruction and related services will be subject to co-payments, deductibles and coinsurance amounts (if applicable).

OTHER COVERED MEDICAL SERVICES and SUPPLIES

Other medically necessary services and supplies not previously described are covered after the calendar year deductible (except for in-network office visits that are covered at 100% with no deductible after a \$30 co-payment). The amount of coinsurance paid will be determined based on your classification: in-network, out-of-network or out-of-area. Covered services include:

- physician visits;
 - diagnostic testing and laboratory exams;
 - radium and radioactive isotope therapy;
 - chemotherapy;
 - dialysis;
 - durable medical equipment;
 - home infusion/IV;
 - outpatient physiotherapy by a legally qualified physiotherapist;
 - anesthetics, oxygen, other gases and their administration;
 - blood transfusions, including the cost of blood and plasma to the extent such charges are not reduced by blood donations;
 - artificial limbs, eyes and other prostheses including replacement when required because of pathological change, but not including charges for repair or maintenance;
 - trusses, braces, crutches, casts, splints and surgical dressings;
 - infertility;
 - diaphragms and IUDs, and related physician services for fitting, insertion or removal;
 - organ transplants; voluntary donation of organs to plan participants to the extent not covered by the donor's plan;
 - rental of a wheelchair, hospital-type bed, iron lung and other mechanical therapeutic equipment or the purchase of such equipment at the option of UHC;
 - rehabilitative therapy by a licensed physical, occupational or speech therapist on an outpatient basis;
 - local emergency ambulance service to or from a hospital by a licensed ambulance service;
 - treatment of anorexia and bulimia; and certain treatments of morbid obesity and obesity with underlying medical conditions.
- hearing exam and evaluation 100% after \$50 co-payment.

Hearing aid (excluding repair & replacement) 50% up to \$500 per ear

MENTAL HEALTH and SUBSTANCE ABUSE TREATMENT

For Mental Health and Chemical Dependency benefits, you should contact United Behavioral Health (UBH) at 1-800-788-5614 before receiving inpatient or outpatient treatment. Non-network benefits limited to usual, customary and reasonable. The following benefits are provided:

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	Network Benefit	Non-Network Benefit
Employee Assistance Program	Precertified visits 100% coverage; Outpatient 100% after \$15 co-pay	Benefit is not available when using a non-UBH provider
Individual Deductibles	No deductible	\$200 per admission
Non-notification deductible inpatient and intermediate care outpatient	\$200 per admission; benefits are paid at 70%	\$500 per admission
Office visit co-payments	\$15 per visit	Not applicable
Percentage payable of covered expenses after deductibles and/or co-payments are satisfied:		
Mental Health:	100%	70% (reduced to 35% per visit if UBH not notified)
Office Visit	90%	70% with notification
Inpatient care	90%	70% with notification
Intermediate care	100%	70% up to \$40 per visit with notification
Chemical Dependency:		
Office Visit	90% with pre-certification	70% up to \$400/day with notification
Inpatient Care	90% with pre-certification	70% up to \$200/day with notification
Intermediate Care		
Calendar year maximum amounts:	Network & Non-Network combined:	
Inpatient mental health chemical dependency	Severe unlimited; non severe 45 days	
Outpatient mental health chemical dependency	30 days Severe unlimited; non severe 50 visits 30 visits	
Calendar year out-of-pocket maximum	\$1,000 (excluding co-payments and deductibles)	Not applicable
Lifetime maximum amounts:	No lifetime maximum	No lifetime maximum
Mental Health	Inpatient–60 days;	Inpatient-60 days;
Chemical Dependency	Outpatient–60 visits	Outpatient-60 visits

ALTERNATIVES to a HOSPITAL STAY

After you have been hospitalized, or instead of a hospital stay, you may be able to receive care in a more comfortable environment. The plan will pay a percentage of expenses, after the calendar year deductible, for care in: your home by a home health care agency, up to 120 visits each year; a skilled nursing facility, up to 60 days each year; and a hospice facility.

While you are in the hospital, a case manager from UHC will stay in contact and work with your or your dependent's physician to explore home health care and other alternatives to an inpatient hospital stay. If you choose, the case manager will help arrange for home health care, a skilled nursing facility or hospice care.

Home Health Care

Home health care means professional care and therapy provided in your home by a home health care agency. Home health care does not include custodial care. After the deductible, the plan pays a percentage of home health care charges. Each covered person is allowed up to a maximum of 40 visits each calendar year. Each four-hour shift in a 24-hour period is considered a home health care visit. Covered expenses are the charges made by the agency for the following services and supplies ordered by a physician under the home health care plan and furnished in the patient's home. They include: part-time or intermittent skilled nursing care provided by a registered or licensed practical nurse; part-time or intermittent home health aide services primarily to provide medical care; physical, occupational or speech therapy by a qualified therapist; and medical supplies and medications prescribed by a physician and laboratory services by or on behalf of a home health care agency if these items would have been covered under the plan if the patient had been in the hospital.

Home health care benefits do not cover: services of a person who ordinarily lives in your home or is a member of your or your spouse's family; services of a person who is primarily engaged in homemaking; custodial care; maintenance care; transportation services; or services received during any period you are not under the continuing care of a physician.

Skilled Nursing Facility

After the calendar year deductible, the plan will pay a percentage of the charges incurred at a skilled nursing facility. Covered expenses include the nursing facility's charges for semi-private room and board, skilled nursing care and other services and supplies customarily provided to patients at a daily charge. In no event will partial reimbursement be made for charges incurred related to in excess of 120 days of skilled nursing services.

Hospice Care

Hospice care is a program of home and inpatient care for individuals who have a life expectancy of less than six months. Its aim is to provide care that meets the special needs of the patient and family during the final stages of a terminal illness. Services are provided by a medically supervised interdisciplinary team of professionals and volunteers. After the calendar year deductible is satisfied, the plan will pay 80% of all covered hospice charges, including three bereavement counseling sessions per occurrence. Covered expenses include: inpatient hospice facility services; physician's services; nursing services; home health aide services supervised by a registered nurse; social service guidance; dietary services; physical, speech and inhalation therapy; prescription drugs; medical-surgical supplies; and diagnostic testing and laboratory services.

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These benefits are in place of all benefits under any other part of the plan for the same charges.

If services are received as an inpatient, the services must be provided in a hospice, unless prior approval is obtained from a UHC coordinator for a nursing home or skilled nursing facility; and rendered by hospice personnel only.

Hospice care does not cover expenses for private duty nursing; chemotherapy and radiation therapy except for pain relief; financial, legal or estate planning; services performed by volunteers; or treatment other than for pain relief.

MEDICAL EXPENSES NOT COVERED

The plan will not pay benefits for the following medical expenses, even though they may be medically necessary: cosmetic or reconstructive surgery, unless required as a result of an accident, birth defect, replacement of diseased tissue, or a mastectomy; dental or periodontal care, except as required for repair due to accidental injury to sound natural teeth and continuous care is started within 12 months of the accident (cracking or breaking a tooth by biting into a solid object is not considered an accidental injury); air conditioners, humidifiers, purifiers, exercise equipment or nutritional supplements; charges by a physician for traveling expenses, broken appointments, interest charges, transportation costs, completion of claim forms or for advice given by a physician by telephone or other means of telecommunication; personal convenience items or special medical equipment determined not to be medically necessary; treatment (such as implants) of sexual dysfunction or inadequacies (such as impotence), except as specifically covered under the mail order prescription program; sexual transformations; reversal of sterilization; tobacco abuse treatment; obesity or weight reduction therapy; custodial care; maintenance care; educational care; voluntary donation of organs to individuals not participating in the plan; medications, services, supplies or surgical procedures considered experimental or investigational as defined by the plan; testing and storage of blood for future use; equipment or supplies made or used for physical fitness, athletic training or general health up-keep; unnecessary weekend hospital stays; developmental speech therapy; inpatient diagnostic or pre-surgical testing, inpatient physician visits or hospital days not determined to be medically necessary; routine foot care; appliances and treatment of Temporomandibular Joint Syndrome (TMJ) unless treatment consists of surgery that is certified by UHC; radial keratotomy or any other surgery to correct or improve myopia when the condition can be corrected to at least 20/70 with eyeglasses or contact lenses; music therapy treatments; services of a naturopath or homeopath; or any charges or expenses for nutritional therapy.

PRESCRIPTION DRUG PROGRAM

If you enroll in the HealthFlex Plan, you are automatically eligible for prescription drug benefits. The prescription drug program is provided through Medco. Participants in an HMO will not receive the prescription drug benefits described in this section. However, benefits may be offered by the HMO you choose (contact the NGAC Benefits Office for more information).

The prescription drug program offered under the NGAC HealthFlex Plan has two components: the retail program for short-term medications; and the Medco by mail program for maintenance medications. The Medco Retail Refill Allowance program allows up to 3 fills of a maintenance drug at the retail pharmacy for co-payment price.

Subsequent refills will cost 100% of the discounted cost. The Generic First feature requires you to pay the generic co-payment plus the difference in cost between the generic and brand name drug when the brand name is chosen and a generic is available. Appeal can be made in the case of medical necessity for the brand name over generic.

Retail Program

The retail program is for immediate drug needs or short-term prescriptions (a 30-day supply or less). To get the greatest savings, simply present your UHC/Medco I.D. card at any participating pharmacy.

Your out-of-pocket expenses for retail service at a participating pharmacy will be \$50 individual / \$100 family annual retail deductible (not applicable to mail service), plus \$10 for generic prescriptions, for up to a 30-day supply; \$20 for preferred name-brand prescriptions, for up to a 30-day supply; and \$35 for non-preferred name-brand prescriptions, for up to a 30-day supply- this payment does not apply to annual co-payment maximum.

If you choose a non-participating pharmacy benefit is limited to amount plan would have paid a participating pharmacy. If a network pharmacy is not available, a paper claim must be filed to receive 100% of Reasonable & Customary after deductible and co-payment are taken.

Mail Service Program

The mail service program provides a convenient way for you to order up to a 90-day supply of maintenance medication for direct delivery to your home.

Your out-of-pocket expenses for each prescription filled through the mail service program will be \$20 for generic prescriptions; \$50 for preferred name-brand prescriptions; and \$88 for non-preferred name-brand prescriptions. This payment does not apply to annual co-payment maximum. You can track your prescription or order refills at www.medco.com or 1 800 841-2806.

Annual Co-Payment Maximum for Pharmacy: \$2,000 individual/\$4,000 family. Accumulation excludes the non-preferred brand name co-payments and additional cost when generic is available.

For new maintenance medications, ask your physician for two prescriptions: one for up to a 30-day supply that you can have filled immediately at a local pharmacy; and another prescription for up to a 90-day supply (that may include up to three refills).

Send your 90-day prescription, a mail service order form/patient profile and the appropriate payment for each prescription to Medco (see Prescription Drug Claims for address information). Be sure to include your original prescription, not a photocopy. A pharmacist will review your prescription and check it against the completed patient profile on your order form for possible allergic reactions or negative interaction with other drugs you may be taking. The drug is dispensed and verified by a registered pharmacist before it is mailed to you.

You will receive your prescription within 14 days after Medco receives your order. Included with each shipment will be a new mail service order form/patient profile and pre-addressed envelope.

Prior Authorization for Certain Prescriptions

You must obtain prior authorization from Medco before HealthFlex will cover its share of the cost of Cox 2 anti-inflammatory drugs such as Celebrex. You must also obtain prior authorization before HealthFlex will cover its share of the cost of Proton

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Pump Inhibitors (PPI), such as Prevacid. Prior approval must also be obtained for Lamisil and Sporonox. To obtain prior authorization for any of the foregoing medications, your physician should call MEDCO 1-800-841-2806 to document medical necessity of these medications.

Insulin and Insulin Syringes

Insulin and insulin syringes are available through the mail service program if you submit a physician's prescription. However, you need a prescription for the insulin and a separate prescription for the syringes.

Payment

You may make payment by check, money order or credit card. For credit card payments, simply include your Visa, Discover or MasterCard number and the expiration date in the space provided on the mail service order form/patient profile.

Mail Service Refills

You can refill maintenance medications by phone, Internet or mail through Medco's system. Place an order three weeks before your current mail service prescription runs out. Suggested refill dates will be included on the prescription label you receive from Medco.

In an Emergency

There will be times when you need a prescription filled immediately. On these occasions, have your prescriptions, if possible, filled at a Medco participating pharmacy. If you need medication immediately but may be taking it on an ongoing basis, ask your doctor for a second, 90-day prescription. As soon as you and your doctor are certain that you have adjusted to the medication and that you will need to take it on an ongoing basis, order the 90-day prescription through the mail order service.

Expenses Not Covered

The prescription drug program does not cover over-the-counter drugs (drugs that can be bought without a physician's prescription) except insulin; contraceptives (except those obtained through the mail order program); fertility drugs such as Pergonal in excess of \$2,000 per course of treatment; weight reduction drugs; drugs that are not medically necessary, for example: minoxidil (Rogaine) for treatment of baldness, Retin-A or any other drug used to reduce the signs of aging; self-injectibles (except those prescribed for the treatment of a medical condition and only through the mail order program); drugs to stop smoking, such as Nicorette; or prescription drugs for treatment of sexual dysfunctions or inadequacies (except for those sexual dysfunction or inadequacies prescriptions obtained through the mail order program; no more than six pills per calendar quarter are covered).

Drug Utilization Review Program

The HealthFlex Program has a drug utilization review program for conditions including cancer, high-risk diabetes, high-risk pregnancy, infectious diseases, organ transplant and renal disease. UHC will ask specialized physicians to review the medications being used in the treatment of these conditions. No action needs to be taken by you or your family for this additional service. There will be no change in your medications unless your attending physician agrees.

COORDINATION of BENEFITS (COB)

How COB Works

The HealthFlex Plan coordinates benefits with other group plans to reimburse you

or your dependents up to the allowable payment from these plans. An allowable expense is any expense covered at least in part by the NGAC plan.

Here is how benefits are coordinated when a claim is made:

If HealthFlex is the primary plan, it determines its benefits first without regard to any other plan; and if HealthFlex is the secondary plan, benefits from HealthFlex will be adjusted so that the total benefit payable will not be greater than the maximum reimbursement under our plan. When HealthFlex is the secondary plan, you will receive benefits from HealthFlex only if it would have provided a greater benefit than the primary plan.

HOW TO FILE CLAIMS

This section provides instructions on how to file a claim for health care expenses. You can get claim forms for medical and prescription drug benefits from the NGAC Benefits Office. If you are submitting a bill, it will need to contain the following information: your Social Security number; the name of the patient; the date, charge and description of each service; the illness or injury for each charge; and the name and address of the provider.

To be eligible for reimbursement, all bills must be submitted within six months from the end of the calendar year in which the charge was incurred.

Medical Claims

If you receive supplies or services from in-network providers under the NGAC HealthFlex Plan, you do not have to file claims. If you receive services from an out-of-network or an out-of-area provider, you will need to complete and submit a claim form. Only one claim form needs to be completed each plan year for each covered person. Claims and bills must be submitted to:

United Healthcare
P O Box 740800 Atlanta GA 30374-0080
1-800-901-1939

Prescription Drug Claims

For prescription drugs that are not purchased from a Medco participating pharmacy or if your card is not available at the time the prescription is purchased, you will need to complete claim forms, which are available from the NGAC Benefits Office, and submit them as follows:

Direct Reimbursement- Contact Medco at 1-800-841-2806 for forms and instructions.

PRE-TAX REIMBURSEMENT ACCOUNTS

This section explains how paying for various benefits and expenses on a before-tax basis can lower your taxable income and, therefore, increase your take-home pay. There are three ways you can save on taxes:

- by paying your Mandatory Clergy Salary Deduction (“MCSD”) contributions on a before-tax basis;
- by electing to have your portion of life insurance premiums paid on a pre-tax basis; and
- by making contributions to the Flexible Spending Account Plan spending accounts on a pre-tax basis.

The Flexible Spending Account Plan spending accounts help you save money by offering you the ability to set aside money on a before-tax basis for eligible expenses not covered by the other benefit plans. There are three types of accounts: the

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HealthFlex Medical Reimbursement Account for eligible medical, dental and vision expenses; and the Dependent Care Reimbursement Account for eligible expenses related to the day care of your dependents while you and your spouse, if applicable and is working. Examples and worksheets are included to help you decide how to use these accounts to your advantage. If you have any questions after reading this section, contact your North Georgia Annual Conference representative.

PAYING for YOUR BENEFITS on a BEFORE-TAX BASIS

Medical coverage under the Mandatory Clergy Salary Deduction (“MCSD”) program, life insurance, and coverage for you and your dependents, and dependent care assistance can be paid for on a before-tax basis. You may make separate elections for each of these benefits once a year during the annual switch enrollment. If you enroll at the beginning of the year for coverage effective January 1, the total premium for the benefits you have elected to purchase will be deducted monthly from your regular pay periods. Once you have made your pretax election, you cannot change it during the year unless you, your spouse or dependent child has a qualifying status change. In general, the status change must affect eligibility for plan benefits. In addition, the change you request must be consistent with the gain or loss of eligibility.

ADDING MEDICAL COVERAGE DURING the YEAR

To enroll for medical (on a before-tax or after-tax basis) you must experience an event during the year that would allow you to change your coverage. For more information on events that would allow you to enroll yourself or your dependents for medical coverage during the year, see the Health Care section.

DROPPING MEDICAL or CHANGING SUPPLEMENTAL AD&D COVERAGE

If you are paying for medical coverage on a before-tax basis, you can drop coverage during the year only if one of the events listed below occurs:
a change in your marital status: marriage – you enroll in your new spouse’s plan; death of a spouse; divorce, legal separation or annulment; a change in the number of your dependents by birth, adoption or placement for adoption*; you and your new dependents enroll in your spouse’s plan: no longer eligible for coverage or first eligible for coverage due to age, student status or similar event, death, a change in your employment status or that of your spouse or your dependent (employment starts or ends); a change in your work schedule or that of your spouse or your dependents (change between full-time and part-time work, a strike, lockout or the start or end of an unpaid leave of absence); a change in your location (residence or work) or that of your spouse or your dependents; or you, your spouse or your dependents become eligible for Medicare or Medicaid.

If you pay for life and AD&D coverage on a before-tax basis, you can change (add, drop, increase or decrease) coverage during the year if any of the events listed above occurs.

All benefit changes must correspond with your change in status or location. You must notify the North Georgia Annual Conference within 31 days of the event if you wish to change or cancel your coverage. If you fail to notify the North Georgia Annual Conference in this time period, premium payments will not be refunded later on and your requested change will not become effective.

* Placement for adoption means that, in anticipation of a child's adoption, the person with whom the child is being placed has the legal obligation for total or partial support.

Every year during the fall switch enrollment period, you have the opportunity to change your benefit elections for the following January 1. Premiums group term life insurance for yourself or your spouse may be paid on a pre-tax basis.

MEDICAL COVERAGE

You **cannot** enroll for medical coverage during the year, even on an after-tax basis, unless an event occurs that would allow you to change your coverage. For more information on events that would allow you to enroll yourself or your dependents during the year, see the Health Care section.

MANDATORY CLERGY SALARY DEDUCTION

The Mandatory Clergy Salary Deduction Program, effective July 1, 2002, is based on your compensation and annual election of coverage. The MCS D contributions are used to pay the current clergy portion of applicable health care insurance.

The MCS D applies to all North Georgia Annual Conference clergy (deacons, elders, and full-time local pastors) who participate in HealthFlex. Lay personnel and part-time local pastors do not participate in this program.

Withholding of your MCS D contribution will be on a mandatory pre-tax basis and the local church will submit this contribution as a component of the HealthFlex bill.

LIFE INSURANCE BENEFITS

The North Georgia Conference of the United Methodist Church provides a group life insurance program to eligible active participants. The amount of the death benefit provided under this program is \$10,000 for the participant (on 65th birthday reduces to \$6,500), \$1,000 for the spouse, \$1,000 for a child 6 months or older, and \$500 for a child under six months of age. In addition to the death benefits available, the group insurance program also provides for accidental death or dismemberment benefits. Please contact the Benefits office of the NGAC for a detailed schedule of benefits available under the Accidental Death and Dismemberment program.

YOUR FLEXIBLE SPENDING PLAN ACCOUNTS

How Your Accounts Work

During the annual switch enrollment every fall (November), you decide how much you want to contribute to each account for the following year. You may choose to participate in all or no accounts, depending on your particular needs. If you elect to participate, your before-tax contributions will be deducted equally from 12 monthly pay periods.

When you incur eligible expenses, simply submit a claim form, along with proof of expenses for reimbursement. Contributions to the spending accounts are not taxed — you do not pay federal income or Social Security taxes or Georgia state income taxes on that money. See Requesting Reimbursement for more information.

Any amount remaining in your accounts at the end of the year will be forfeited, unless you submit a claim for eligible expenses by the required time, as explained in Requesting Reimbursement.

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How Much You Can Deposit

You can deposit up to the following amounts to the spending accounts: health care-between \$300 and \$5,000 a year; dependent care-between \$300 and \$5,000 a year.

Changing Your Deposits During the Year

Generally, once you choose which accounts to participate in and how much to deposit, you may not change for the entire year, unless you have a change in status. Different guidelines apply for status changes under the Health Care Spending Account than for the Dependent Care Spending Account. In general, the change in status must affect eligibility for plan benefits. In addition, the change you request must be consistent with the gain or loss of eligibility.

You must notify the North Georgia Annual Conference within 30 days of a status change if you wish to change the amount of your deposit. If you fail to notify the North Georgia Annual Conference, contributions to your account will continue to be deducted from your paycheck.

Changes in Status - Health Care Spending Account

You can change your contributions to the Health Care Spending Account only if one of the following events occurs: a change in your marital status: marriage; death of a spouse; divorce, legal separation or annulment; a change in the number of your dependents: birth; adoption; placement for adoption*; no longer eligible for coverage or first eligible for coverage due to age, student status or similar event; death; your spouse or your dependents lose COBRA coverage; a change in your employment status or that of your spouse or your dependent (employment starts or ends); a change in your work schedule or that of your spouse or your dependents (such as a change between full-time and part-time work, a strike, lockout or the start or end of an unpaid leave of absence); a change in your location (residence or work) or that of your spouse or your dependents that causes changes in plan; you, your spouse or your dependents become eligible for Medicare or Medicaid; or coverage for your child is required under the terms of a qualified medical child support order.

You may also change your contributions to the Health Care Spending Account if you experience an event as listed in the Health Care section.

*Placement for adoption means that, in anticipation of a child's adoption, the person with whom the child is being placed has the legal obligation for total or partial support.

Changes in Status - Dependent Care Spending Account

Examples of status changes that allow you to change the amount of your contributions to the Dependent Care Spending Account include: a change in marital status (marriage, divorce, legal separation, death of a spouse); the birth or adoption of a child; the death of an eligible dependent; your child ceases to qualify for the dependent care account because he/she attains age 13; a change in your day care provider's rate or switching providers (however, you cannot change your pre-tax election due to a change in your day care provider's rates if the day care provider is your or your spouse's relative; a change in your work schedule or that of your spouse or your dependents (such as a change between full-time and part-time work or the start or end of an unpaid leave of absence).

Medical Reimbursement Spending Account

To decide how much to deposit to your Medical Reimbursement Spending Account, carefully estimate the eligible expenses you expect to incur during the year. You may wish to review your tax records, medical claims or checkbook to see what your out-of-pocket expenses were in the past.

Eligible Health Care Expenses

Eligible health care expenses are those that are not covered by a health care plan and that would qualify as medical expenses for the purposes of deductions on your federal tax return. The expenses can be incurred by you, your spouse or other dependents. The dependents are not required to be covered by the HealthFlex plan. Expenses must not have been reimbursed through any other source. Eligible expenses include: deductibles; coinsurance amounts, for example: doctor's office visits; eye exams; the purchase of eyeglasses, contact lenses and solutions; purchase of rental prosthetic devices; acupuncture treatments for pain control but not for behavior modification; orthopedic appliances prescribed by a doctor for personal use but not for business use; purchase or rental of wheelchairs; prescribed drugs; over-the-counter medications; ambulance services; oxygen and related equipment; blood and blood plasma; physical therapy or hydrotherapy; fees for lab tests and diagnostic testing; co-payments; charges above the reasonable and customary amount covered by a NGAC-sponsored plan; and expenses not covered by a medical plan, for example: smoking cessation classes.

For certain types of treatment or therapy (for example, acupuncture, hydrotherapy or massage therapy) you may be required to provide a medical diagnosis from a physician stating that the treatment is medically necessary primarily to alleviate or prevent a physical or mental defect or illness.

Non-eligible Health Care Expenses

You cannot use your Medical Reimbursement Spending Account to reimburse expenses for: amounts covered by any medical, dental or vision plan; insurance premiums; non-prescription devices; supplies not related to a disease or defect; charges for a nurse to care for a healthy baby; cosmetic surgery or procedures not related to an illness, injury or birth defect; medical care for which you take an itemized tax deduction on your federal tax return; treatment or care that is merely beneficial to one's general health such as expenses for recreation, health clubs and nutrition, even if prescribed by a physician; and long-term care insurance premiums and expenses.

WORKSHEET to DETERMINE ELIGIBLE EXPENSES

Use the worksheet below to estimate the amount of eligible health care expenses you may want to pay through your Medical Reimbursement Program Spending Account. Review your out-of-pocket expenses from the past year to help you estimate expenses for the upcoming year. It is also helpful to consider your family's health status. For example, will you or any family member require extensive dental work such as crowns, bridges or braces in the coming year? Be sure to check your health care coverage so you understand which expenses are covered in full, in part or not at all.

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Your Out-of-Pocket Expenses	For You	For Your Spouse	For Your Children
Deductibles	\$	\$	\$
Copayments	\$	\$	\$
Coinsurance	\$	\$	\$
Medical doctors	\$	\$	\$
Hospitals	\$	\$	\$
Prescription drugs	\$	\$	\$
Hearing aids	\$	\$	\$
Prosthetics and braces	\$	\$	\$
Dentists	\$	\$	\$
Orthodontists	\$	\$	\$
Vision care	\$	\$	\$
Chiropractors and physical therapists	\$	\$	\$
Psychologists and psychiatrists	\$	\$	\$
Other eligible expenses	\$	\$	\$
Subtotal, eligible for Reimbursement	\$	\$	\$
TOTAL (Columns 1+2+3)	\$	\$	\$

Dependent Care Program Account

To decide how much to contribute to your Dependent Care Program Account, carefully estimate the eligible expenses you expect to incur over the year. You may wish to review your tax records, receipts or checkbook to see what your out-of-pocket expenses for child care have been in the past.

To qualify, your dependent must be under the age of 13 or physically or mentally unable to care for himself or herself. If care is provided outside your home for a disabled adult, this dependent must also regularly spend at least eight hours a day in your home.

If you are married, there are certain restrictions on the use of the Dependent Care Spending Account: both you and your spouse must work (unless your spouse is a full-time student or is disabled); and you cannot be reimbursed for more than your earned income or your spouse's earned income, whichever is less.

Eligible Dependent Care Expenses

Eligible dependent care expenses are those that would qualify for a child care tax credit on your federal tax return. These expenses must be necessary in order for you (and your spouse, if you are married) to work. You may submit expenses for reimbursement from your Dependent Care Program Account for: a day care center, summer day camp or pre-school (if the facility provides care for more than six non-resident individuals, it must comply with all state and local regulations); and services inside or outside your home provided by anyone other than your spouse, your dependents for income tax purposes or one of your children under age 19.

If services are performed in your home, you are required by the IRS to file Form 942 — Employer's Quarterly Return for Household Employees. You must also pay Social Security and other applicable taxes on your household employee's wages.

- Non-eligible Dependent Care Expenses

You cannot use your Dependent Care Spending Account to reimburse expenses for: care provided by your spouse, your dependents for income tax purposes or your

children under age 19; housekeeping expenses not related to dependent care; overnight camp (prorating of daytime hours is not allowed); cost for clothing, entertainment or food; health care expenses (these should be considered for reimbursement through your Health Care Spending Account); expenses for which you claim a dependent care tax credit on your federal income tax return; educational expenses for kindergarten and higher; or agency referral charges and finder's fees.

GENERAL INFORMATION

This section applies to the Medical Plan.

Your Right to Receive a Certificate of Health Coverage

If your coverage under this plan stops, you and your covered dependents will receive a certificate that shows your period of health coverage under the plan. You may need to furnish the certificate if you become eligible under another group health plan if it excludes coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependents may also request a certificate within 24 months of losing coverage under this plan.

HIPAA Special Enrollment Rights

If you decline enrollment in the Plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the medical coverage feature(s) of this Plan, provided that you request enrollment within 30 days after your other coverage ends. If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be given the opportunity to provide details concerning your situation on a form provided by the Administrator if the Administrator requires you to do so in order to preserve your special enrollment rights under the Plan in the future. 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 in the medical coverage feature(s) of this Plan, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Coverage Continuation

When a covered participant and/or his dependent loses eligibility under the medical plan, coverage is lost the first of the month coincident with or next following the month in which the event that causes the loss of eligibility occurs. The person losing eligibility may continue medical coverage as a continuant for no more than twelve months from the date coverage is lost. Continuation of coverage is not available with respect to the medical or dependent care reimbursement accounts. Premiums for the coverage continuation are the responsibility of the continuant and are paid on an after-tax basis only.

SITUATIONS AFFECTING PLAN BENEFITS

If You Become Disabled

Total disability exists when, due to pregnancy, sickness or accidental injury, you are unable to perform, for wage or profit, the material duties of your own occupation. After 24 months, total disability exists when, due to sickness or accidental injury, you are unable to perform for wage or profit the material duties of any occupation for which

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you are reasonably qualified by your education, training or experience. To be considered totally disabled, you must also be under the regular care of a doctor and not be working at any job for wage or profit.

If you are enrolled in the HealthFlex Plan and become totally disabled, you may continue coverage as a continuant for no more than nine months from the date your coverage is lost (see Coverage Continuation above).

If you elect the HealthFlex Plan, coverage will continue until the date you become entitled to Medicare or you turn age 65 (whichever is earlier), provided you pay the cost of coverage to the NGAC Benefits Office, remain totally disabled and provide evidence of applying for Social Security benefits. If you elect to continue coverage under the HealthFlex Plan and then become entitled to Medicare, your coverage under the HealthFlex Plan will end and you will be covered under the Medicare Supplement under United HealthCare, which helps fill the gaps created by Medicare. If rejected by Medicare, medical coverage can continue for you and your dependents under the HealthFlex Plan if you pay the cost and continue to re-apply for Medicare as frequently as allowed.

Your dependents continue receiving coverage under the HealthFlex Plan until the date they become entitled to Medicare, turn age 65 or no longer satisfy the plan's definition of dependent (whichever is earliest), provided that you pay the cost of coverage to the NGAC Benefits Office and continue coverage under the HealthFlex Plan or United Healthcare Medicare Supplement Plan.

If You Take a Family and Medical Leave of Absence (FMLA)

If you take a family and medical leave of absence, medical coverage will continue during your leave if the premiums for the time you plan to be absent are deducted from your last paycheck (on a before-tax basis) prior to your leave; or while on leave, you pay your share of contributions on an after-tax basis directly to NGAC.

If you do not return to work at the end of a family and medical leave of absence and the reason for your absence is to care for an individual other than yourself, you will have to pay the portion of your health care premiums paid by your employer while you were on leave.

If you return to work full-time, medical benefits can resume immediately.

If You Take a Personal Leave of Absence

If you take a personal leave of absence, you may continue medical if you pay the full cost of coverage (your portion plus your employer's portion) for up to 1 year.

If You Leave the NGAC

If you terminate your employment for any reason other than those described in this section, medical coverage for you and your covered dependents will stop at midnight on your last day of full-time active employment. You may purchase continued coverage for yourself and your eligible dependents for up to 12 months following your termination for reasons other than gross misconduct.

WHEN COVERAGE ENDS

Health care coverage for you and/or your dependents will end if you are no longer eligible (see the Eligibility section); you are in a specific class of employees that is no longer included in the plan; the plan is terminated; or you fail to pay required premiums.

CONVERSION RIGHTS

As a self-funded Church Plan, HealthFlex is not required to and does not offer conversion policies or conversion coverage.

FUTURE of the PLAN

While the NGAC intends to continue this plan indefinitely, it is difficult to predict the future; therefore, an unqualified commitment is impossible. The NGAC, by action of the Board of Pension of the UMC, reserves the right to modify (including the introduction of or increase in employee contributions), suspend or terminate these benefits, at any time and for any reason. No amendment, however, may deprive you of any benefits to which you are entitled at the time of amendment or termination. If the plan is modified, any claims incurred before the amendment date will be paid in accordance with the plan's provisions in effect before the modification. Any claims incurred on or after the amendment date will be paid in accordance with the new provisions.

If the plan terminates, all eligible claims incurred before the date of termination will be paid if submitted within a reasonable period of time, as determined by the plan administrator. Any claims incurred after the date of termination will not be considered for payment.

Loan Guarantee Committee Guidelines

1. The United Methodist Development Fund (the "Fund") was organized in 1960 for the purposes and shall operate under the policies set forth in ¶ 1313.1g of the *2008 Book of Discipline*.
2. The primary purpose of the Fund is to make loans to local Methodist churches for the construction of first worship facilities for new congregations, the expansion of facilities on existing sites, the renovation, remodeling and replacement of existing facilities, the relocation of existing congregations (including the purchase or construction of new worship facilities), the purchase of sites and the refinancing of existing loans in situations where local churches are unable to obtain loans from local financial institutions at acceptable rates of interest as a result of the requirements imposed under current banking regulations.
3. The Fund will make a loan to a local church if the church meets the Fund's loan criteria, or if the annual conference, one of its agencies or another connectional unit with sufficient resources, guarantees the repayment of the loan in full.
4. As a condition of the acceptance of a guarantee from the annual conference, one of its agencies or another connectional unit, the Fund requires that the guarantor establish and maintain a reserve account equal to twenty-five percent (25%) of the annual payments of the loans, in the aggregate, that it guarantees.
5. As a result of its guarantee of a loan, the annual conference may be called upon to make payments on a guaranteed loan if the borrower becomes delinquent in paying its loan.
6. Several annual conferences have authorized bodies within their annual conference to authorize on behalf of the annual conference, a guarantee of specific loans made or participated in with the Fund where the authorized body has reviewed and determined that such a guarantee was in the best interest of the borrowing entity and the Conference.