PRESBYTERIAN SENIOR LIVING

BENEFITS GUIDE 2023

ENROLLMENT & ELIGIBILITY • MEDICAL • DENTAL • VISION • PRESCRIPTION
CALL TO HEALTH • EMPLOYEE ASSISTANCE PROGRAM • GROUP LIFE INSURANCE
SHORT-TERM DISABILITY • COST OF BENEFITS COVERAGE

For more information on PSL Benefits visit:
www.psl.org/benefits
Or you may also scan the QR code.

Documents and more information can be found on: 'MyHR'

EASY AS...
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Our Mission

Guided by the life and teachings of Jesus, the mission of Presbyterian Senior Living is to provide compassionate, vibrant, and supportive communities and services to promote wholeness of body, mind and spirit.

PSL Benefits Guide

Table of Contents

The information on the medical plans, prescription medication, Call to Health and Employee Assistance Plan has been provided by The Board of Pensions of the Presbyterian Church (U.S.A.).

Your Eligibility/Enrollment Process

This guide is for open enrollment, new hires, and other benefits eligible employees.

About this Guide

PSL realizes how important benefits are for you and your family. This booklet offers information on benefits offered, eligibility, how and when to enroll. This guide is intended to provide an overview of the medical, prescription, dental, vision, EAP, life, short-term disability and Call to Health well being benefits. PSL offers benefit plans that include high quality benefits as well as employee choice. If you have questions about the plans, additional information is available in the PSL benefits section on the 'My HR' home page. After you make your benefit decisions you need to complete the enrollment process through 'My HR'. There are time frames for both initial enrollments by newly hired or newly eligible employees, as well as, set Open Enrollment periods for ongoing participants. It is the employee's responsibility to enroll within the appropriate time period.

Current Benefit Eligible Employees

During Open Enrollment, you can enroll or decline in the PSL benefits on 'My HR'. Your benefit selections will be in effect January 1 through December 31 of the next calendar year. Each Fall, you have the opportunity to make changes to your benefits in the designated Open Enrollment period. At that time, you will be able to change your benefits for the following year.

Newly Eligible Employees

If you are a new hire or newly benefits eligible employee, you will have the opportunity to make your benefit elections on 'My HR' within 30 days of your new hire (hire date) or newly benefits eligibility date (transfer date to new benefits eligible position). For example: If you have recently changed to a full time position then you will have 30 days to enroll / decline in the benefits on 'My HR' from the date of your new position start date. If you are a new hire to PSL then you have 30 days to elect benefits from your original hire date as long as your position is eligible for PSL benefits.

Qualifying Life Event

If you have a qualifying life change event, you have 30 days from the date of the event to make changes to your benefits. You may make the changes and elect benefits on 'My HR'. You must provide supporting documentation of the life change event to your Human Resources department.

Qualifying life events such as:

- The birth, adoption or loss of a dependent;
- Your marriage or divorce; or
- A change in your or your spouse's employment status, or that of an eligible dependent, that affects eligibility for coverage.

Qualifying events may also require a name change or update to beneficiaries for the group life insurance and retirement benefits. Name changes can be done on 'My HR' / Menu / Myself / Name, address, and telephone / edit. Submit the name change request on 'My HR' after visiting your community HR department for the review of the Social Security Card (a copy is not made). Workflow approval to Payroll Manager (community HR).

Note: If the employee submits this request prior to sharing the card with the new name then your community HR will reach out to the employee prior to approving the workflow, updating the I-9.

If applicable, please refer to the Prudential Group Life and Conrad Siegel website to update beneficiaries to those benefits.

Your Eligibility/Enrollment Process

Your Eligibility and Benefits Effective Dates

Your benefits eligibility date and the start date in which the benefits become effective differ. Please make sure you make your elections within 30 days of your new hire start date or your newly benefits eligible position date.

Full-time employees are eligible for Presbyterian Senior Living insurance plans:

- 403B retirement plan and EAP – upon hire the employee can enroll. There is no waiting period to elect and start saving for retirement. 403b enrollment and changes in contributions can be done at any time. Please refer to the Retirement Program Snapshot document on 'My HR' for more information.
- Voluntary short-term disability- Benefits will begin on the first of the month following 30 days from date of benefits eligibility.
- Medical (including Call to Health and prescription drug coverage) – Benefit will begin on the first of the month following 60 days from date of benefits eligibility. Dental – Benefit will begin on the first of the month following 60 days from date of benefits eligibility. Vision– Benefit will begin on the first of the month following 60 days from date of benefits eligibility.
- Group Life Insurance – Benefit will begin first of the month following 90 days from date of benefits eligibility.

All benefits with the exception of the Voluntary Short-term Disability benefit will be available to you to elect during the annual open enrollment period. More information on part time eligibility is available from your Human Resources department.

Dependent Eligibility for Coverage

Dependents eligible for coverage are (i) your spouse, (ii) a married or unmarried child to the age of 26 (including stepchildren, legally adopted children, and children placed with you for adoption); (iii) an unmarried, physically or mentally handicapped child who is covered under the Program before reaching age 26 and who is dependent upon you for support and qualifies as a dependent for federal income tax purposes.

Premium Costs

The benefit premium deductions will appear on your pay stub on a bi-weekly basis for 24 pays. There are typically 26 pays in a payroll calendar. If you select the Voluntary Short-term Disability benefit, you will see a XVSTD deduction on every bi-weekly payroll. There is not a pre-tax option available for the voluntary short term disability benefit.

Premium Conversion Plan

Section 125 of the Internal Revenue Code allows Presbyterian Senior Living to set up a plan allowing the employee's share of benefit costs (health and prescription, dental, vision and/or voluntary short-term disability coverage) with pre-tax dollars. The cost for coverage is automatically deducted from each paycheck and payment is made before Federal, State, Medicare and Social Security taxes are withheld.

Upon initial enrollment in our benefit plans, an election may be made to have deductions taken on a post-tax basis. The election of the voluntary short term disability benefit will always be at a post tax basis. The election may be changed during Open Enrollment for benefits each year.

COBRA*

Presbyterian Senior Living abides by the Department of Labor's Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation of coverage for the dental and vision benefits. PSL will continue to use the third party COBRA provider, Ameriflex, to administer the Dental and Vision continuation of coverage.

COB*

Continuation of Benefit (COB) coverage for the medical plans will be administered through The Board of Pensions of the Presbyterian Church (U.S.A.). Please see the medical section of this guide for more information on the continuation of benefits.

***Note**: **PSL benefits (medical, prescription, dental and vision) run until the end of the month following the date of ineligibility and the employee is responsible for any premium costs.**

How to Navigate 'My HR'

MyHR.psl.org

Open Enrollment Benefit Instructions

- Click on this link to view the "How to Make Open Enrollment Elections in 'My HR'"
- Follow the steps below if you would like to make changes to your Open Enrollment elections
- Click on the **Open Enrollment** link on your homepage of 'My HR'. You can also view the current benefit rates in the Open Enrollment link.
- Click on the **Open Enrollment Session**
- **Click on the pop up radio button "make new elections"**
- Benefits Enrollment Screen appears
- Click the **Next** button (Press the Draft button at anytime to save your elections)
- **Elect** or **Decline** each benefit in the Open Enrollment session
- Add dependents to the plans (if applicable)
- **Confirm** your elections or benefit changes
- Press the **Submit** button
- Confirmation message box will appear – Press **Ok**
- Print a copy for your records
- Click on the **Modify Elections** button if you need to make changes to the OE benefits elections
- Close the Enrollment session by pressing **Close**
- You have until the end of the designated Open Enrollment period to make changes and submit your elections
- If you do not want to make changes, no additional steps are required or you can select the pop up radio button "stay enrolled in current benefit plans"

New Hire or Newly Eligible Benefit Enrollment Instructions

- Click on this link to view the "How to make benefit changes in 'My HR'" as a new hire or newly eligible benefit enrollment instructions
- Go to the Menu on your homepage of 'My HR' and then click **Myself** link
- Click on **Life Events** and the event that applies to you i.e. 'I am a Newly Benefits Eligible Employee' for New Hire or Newly Eligible
- Benefits Enrollment screen appears
- Click the **Next** button
- Verify your dependent information
- Click on each benefit plan and **Elect** or **Decline** by following the benefits wizard
- Add dependents to the benefit plan selections if applicable
- **Confirm** your elections or changes
- Press the **Submit** button
- Review your benefit selections
- Print a copy for your records
- Close the session by pressing **Close**
- Your Benefit Enrollment is now in your Requests / Pending Approvals and will be reviewed and processed by your HR Department and AO Benefits Department

Qualifying Life Event Instructions

- Click on this link to view the "How to Make Benefit Changes in 'My HR'" due a qualifying event
- You have 30 days from the date of the event to make changes to your benefits. You must provide supporting documentation of the life change event to your Human Resources department.
- Go to the Menu on your homepage of 'My HR' and then click **Myself** link
- Click on **Life Events** and the event that applies to you i.e. 'I have a Qualifying Life Event Change'
- Benefits Enrollment screen appears
- Enter the date of the event and select the life event reason from the drop down selections
- If applicable select if you and/or spouse are tobacco free
- Click the **Next** button
- Verify your dependent information
- Click on each benefit plan and make the necessary changes based on the life change event
- **Confirm** your changes
- Press the **Submit** button
- Review your benefit selections
- Print a copy for your records
- Close the session by pressing **Close**
- Your Benefit Enrollment is now in your Requests/ Pending Approvals and will be reviewed and processed by your HR Department and AO Benefits Department

Contact Information

If you have benefits questions:

1. Call the plan provider (Express Scripts, Cigna Behavioral Health, Delta Dental, Davis Vision)
2. Call Quantum Health for medical, prescription, EAP or well-being questions: 1-855-497-1237 (Monday-Friday; 8:30 a.m. to 10 p.m. ET).

If you need a new ID Card, please contact the carrier directly. Please see the full listing below.

Quantum Health

Medical, prescription, EAP or well-being questions: 1-855-497-1237
www.myqhealthpcusa.org
(Monday-Friday; 8:30 a.m. to 10 p.m. ET)

Call to Health

The Board of Pensions (BOP): Questions about challenges or points: 1-800-773-7752
(Monday-Friday; 8:30 a.m. to 6 p.m. ET)
Limeade: Questions about registering or 1-855-451-6754 or support@limeade.com (technology issues)
www.calltohealth.org
Registration for Call to Health can be done when medical and prescription coverage is effective.

Dental Coverage

Delta Dental: 1-800-932-0783
www.deltadentalins.com
ID cards are not automatically issued when a member adds a dependent. Print ID cards online.

Employee Assistance Plan (EAP)

Cigna Behavioral Health (24/7): 1-866-640-2772
www.myCigna.com
Employer ID: pcusa

Further (Health Savings Account)

1-800-859-2144
www.hellofurther.com

Medical Coverage

Quantum Health
Member Services: 1-855-497-1237
www.myqhealthpcusa.org
Teladoc: 1-800-835-2362
www.teladoc.com/enter
Eye Exam Benefit
(included with medical coverage)
VSP: 1-800-877-7195
www.vsp.com or www.vsp.com/choice
(to locate VSP providers)

Prescription Drug Coverage

Express Scripts: 1-800-344-3896
www.express-scripts.com
Specialty Medications (Accredo): 1-800-803-2523

Prudential Life AD&D

Prudential: 1-800-842-1718
www.prudential.com/mybenefits
Employer ID (Control Number): 53307

Retirement Program Conrad Siegel Actuaries

1-800-577-3675
Retirement questions hotline: 717-502-8857
www.myconradsiegel.com

Vision Coverage

Davis Vision 1-877-923-2847
www.davisvision.com
For information prior to enrolling use the client code 7055.

Voluntary Short-Term Disability Coverage

(non-exempt full-time participants)
Prudential: To initiate a VSTD claim call: 1-800-842-1718
www.prudential.com/mybenefits

PSL Benefits Questions:
1-717-502-1868
benefits@psl.org

For more information on PSL Benefits visit: www.psl.org/benefits
Or you may also scan the QR code.

Documents and more information can be found on: 'MyHR'

Employee Assistance Plan

Employee Assistance Plan

The Employee Assistance Plan (EAP) is a benefit for all full-time and part-time regularly scheduled employees, provided through Cigna Behavioral Health (Cigna) 24 hours a day, seven days a week, at 1-866-640-2772. EAP services include the following:

- Unlimited phone consultations with licensed clinicians for routine or urgent concerns
- Counseling (up to six free private counseling sessions per issue, per year for you and anyone who lives with you)
- Online counseling through smartphone, tablet, or computer, as an alternative to a in-person visit (covers the same number of sessions available for in-person counseling, per issue per year)
- Financial resources
- Legal assistance
- Resources for child care, senior care, and pet care

To learn more, refer to the PSL Employee Handbook or call Cigna anytime at 1-866-640-2772.

To access the many resources available through the EAP, or to live chat with an EAP advocate, log in to mycigna.com as a member:

- Click **REGISTER** to set up a user ID and password.
- Skip the steps under Before you continue and simply click the **START REGISTRATION** button (a Social Security number, Cigna ID number, or other form of identification is not required).
- Enter your name, date of birth and ZIP code, then click **NEXT**.
- Follow the step-by-step instructions to enter your name, date of birth and ZIP code, clicking **NEXT** after completing each step.
- For "What best describes you", select I want to register for the Employee Assistance Program ONLY.
- When you reach the Confirm Your Identity screen, follow these instructions:
  - For Employer Name or ID, enter **pcusa**
  - For Your Relationship to the Employee, select Employee (PSL employee) or Other Person Living in the Home (household member).
- Choose your security questions.
- Create a username and password that you will use to access your EAP benefits on mycigna.com, enter your email address, and click **CREATE ACCOUNT**.

If you or a member of your household has any problems with the EAP registration process explained above, call the customer support line at 1-800-853-2713. When asked for an ID number or Social Security Number, simply state, "I don't have it," to connect to a customer service representative.

Dental Benefit

Standard and Buy Up Plan

Presbyterian Senior Living offers a choice of two dental plan options through Delta Dental. Both plans offer the same network, the same preventive services and the same maximum benefit. The difference between the plans is in the coverage of certain procedures. There is a difference in employee premium cost. Please review the coverage and choose the plan that is best for you and your family.

Deductible

Both plan options have a deductible that is waived for diagnostics and preventive services. The In and Out of PPO Network deductible for both plan options (standard and buyup) are $50 per person, $150 per family per plan year.

Annual Maximum

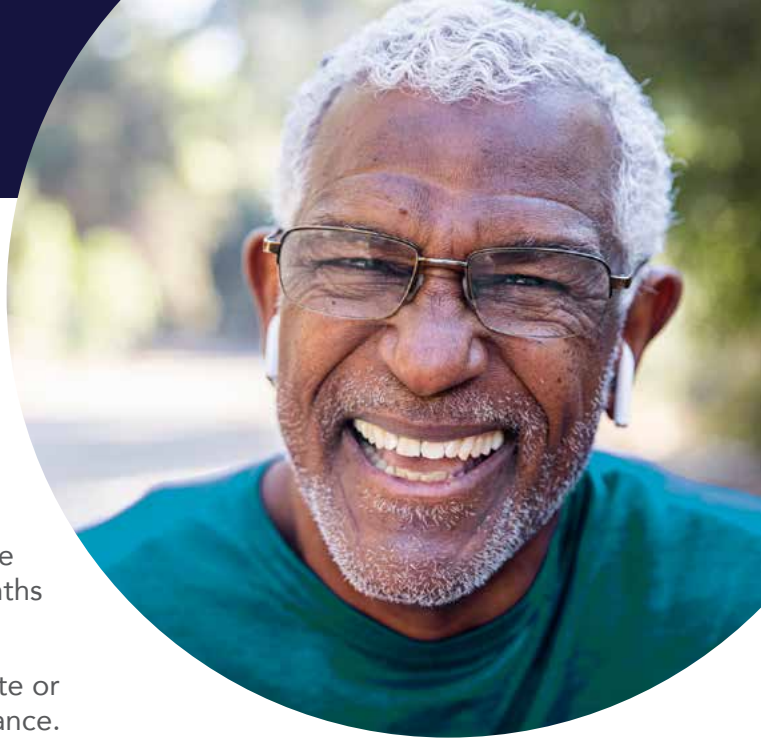
The maximum benefit paid per plan year is $1,000 per person in and out of PPO network.

	STANDARD PLAN		BUY-UP OPTION	
	IN-PPO NETWORK**	OUT-OF-PPO NETWORK**	IN-PPO NETWORK**	OUT-OF-PPO NETWORK**
Diagnostic & Preventative Benefits -Oral Examinations, routine cleanings, x-rays, fluoride treatment, space maintainers, sealants	100%	100%	100%	100%
Basic Benefits -Fillings, posterior composites	50%	50%	50%	50%
Major Benefits -Crowns, inlays, onlays and cast restorations	0%	0%	50%	50%
Endodontics -Root canals	50%	50%	50%	50%
Periodontics -Gum treatment	50%	50%	50%	50%
Oral Surgery -Incisions, excisions, surgical remoal of tooth including simple extractions	50%	50%	50%	50%
Prosthodontics -Bridges, dentures	0%	0%	50%	50%

*Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.

**Fees are based on PPO fees for In-PPO Network dentists and the MPA (maximum plan allowance) for Out-Of-PPO Network dentists. Reimbursement is paid on Delta Dental contract allowances and not necessarily each dentist's actual fees.

Vision Care Benefit



Presbyterian Senior Living offers vision coverage through Davis Vision.

The employees must pay a portion of the premium, but the cost, regardless of the contract level, is the same. The Davis Vision benefits of an eye examination and choice of eyeglasses or contact lenses are available every 12 months with no in-network copayment.

Exclusions do apply, please consult the Davis Vision website or member services for more information on the Vision insurance.

Eye Examination

The eye examination is covered in full by Davis Vision every 12 months if you utilize the in network benefits and select a provider that accepts Davis Vision.

Eyeglasses/Contact Lenses (In-Network)

Spectacle lenses are covered in full by Davis Vision every 12 months for standard single vision, lined bifocal, or trifocal lenses. Any fashion frame from the Davis Vision collection with a value up to $100 are covered every 12 months or there is a $60 retail allowance toward any frame from provider. Contact lens evaluation, fitting and follow up care are available to you every 12 months. Contact lenses from the Davis Vision collection , in lieu of eyeglasses, are covered in full or a $75 retail allowance toward the provider supplied contact lenses.

There are additional discounted lens options and coatings such as scratch resistance coating, polycarbonate lenses, standard progressive lenses (no bifocal line) and much more.

You can use your vision care benefits to buy eyewear online from:

1-800 Contacts is one of the most recognized online contact lens retailers in the industry. They have an established reputation for their customer service, backed by an industry-leading Net PromoterScore of 76.

Befitting.com has artificial intelligence-driven tools to find the perfect pair of eyeglasses with personalized, curated recommendations. Shop for single and progressive lenses, prescription sunglasses, and advanced blue light blocking lenses. Free shipping and returns are also included.

Glasses.com is one of the most trusted online stores for popular eyewear brands, including prescription glasses and sunglasses.

Visionworks allows you to look up your benefits and see the savings on thousands of different frames and contact lenses as you shop.

What kind of brands do the online retailers carry? All of the online retailers feature top brands of both frames and contacts.

Do I need a prescription to order products online? Yes; you will need to enter your prescription at the time of purchase, and require a recent valid prescription to purchase contact lenses online.

Are the benefits the same as other retail stores? Yes; you can use your full benefit.

Is the Davis Vision Exclusive Collection included? No; the Exclusive Collection is not offered at this time.

Group Life and AD&D Insurance Benefit

Beginning on the first of the month following 90 days of employment, full time employees are enrolled in a group term life insurance benefit. This benefit pays two times the annual base salary with double indemnity for an accidental death or dismemberment. As a participant of the Prudential Life and AD&D benefit, there are additional benefits available to you such as preparation of a living will and much more. More information on the additional benefits and a full benefits summary Prudential has to offer can be found on 'MyHR' Benefits.

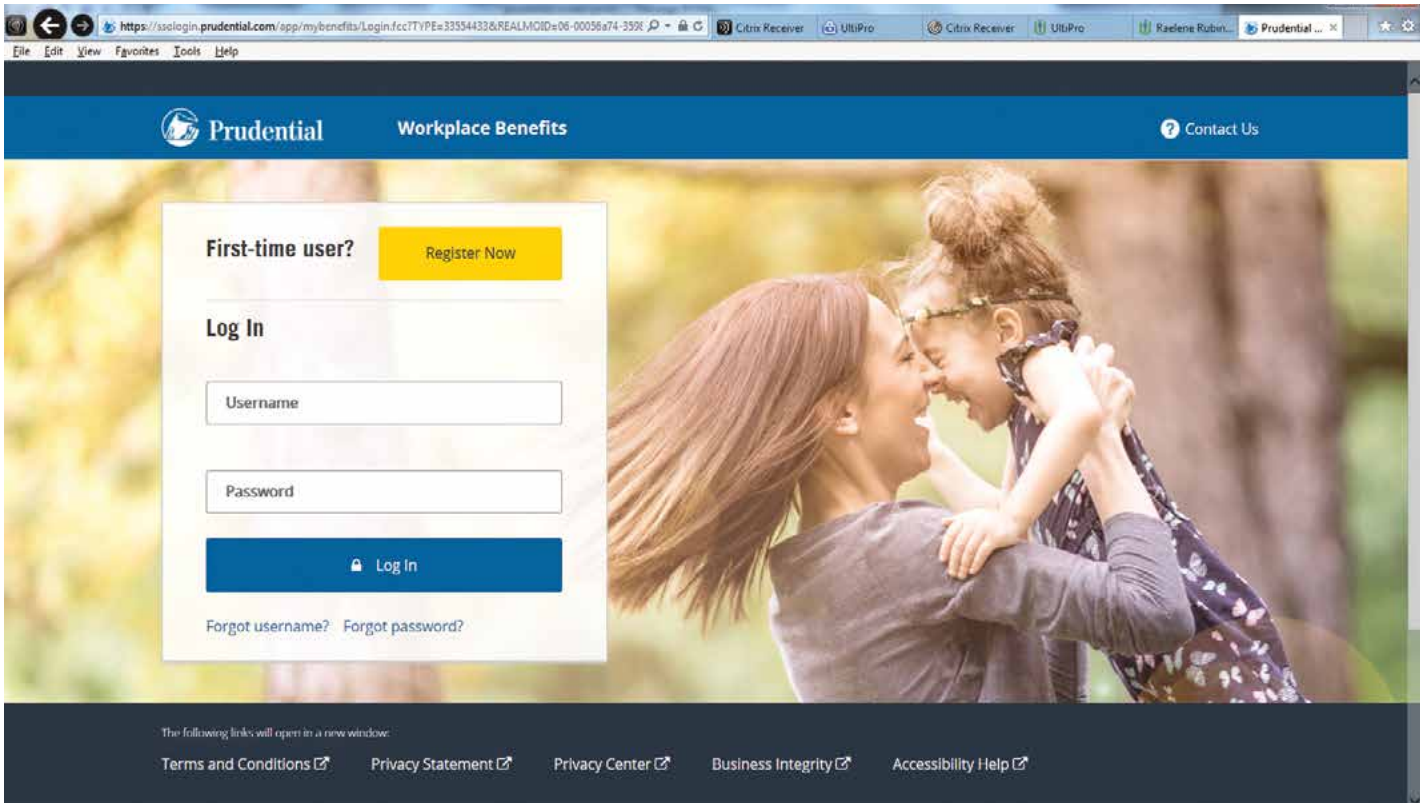
Dependents are not eligible for life insurance or accidental death and dismemberment coverage. This benefit is offered through Prudential. The premium for this benefit is paid for by Presbyterian Senior Living. It is the employee's responsibility to submit and update the beneficiaries online. The steps to access the Prudential website and submit a beneficiary are listed below.

Prudential's Group Insurance *My Benefits* website provides you with convenient access to information and services related to your Group Life and/or Disability/Absence employer provided and voluntary benefits. Depending on the Benefit Plans and arrangements your employer has with Prudential, through this website you may be able to:

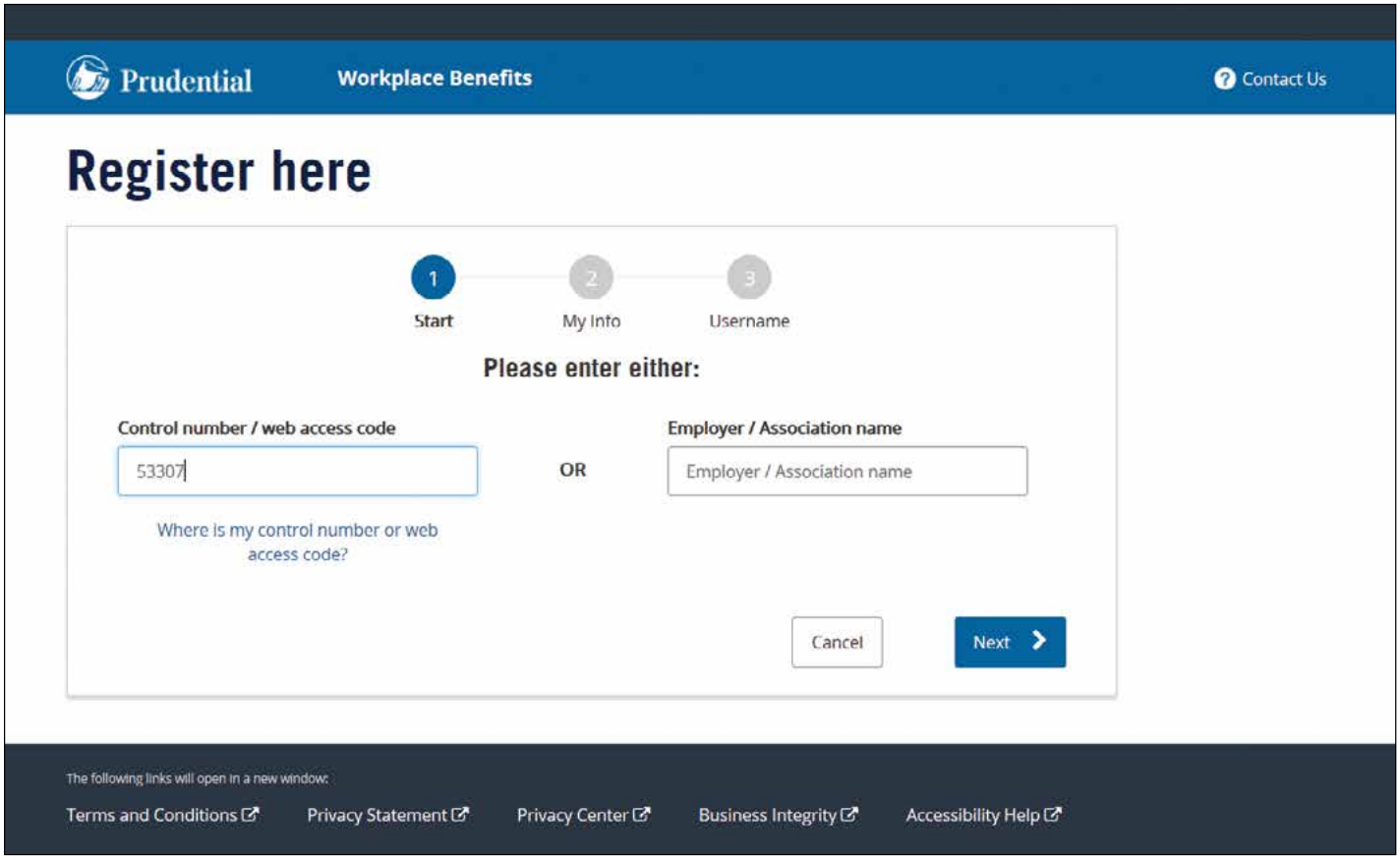
- Examine your personal benefits coverage portfolio
- View and change your beneficiary(ies)
- Access and download documents
- Learn more about your benefits, get help, and assess your coverage needs

Getting Started – Registering as a First Time User

When visiting the site for the first time, you will be required to create a unique User ID and Password to access the site. In order to create your User ID and Password, click "Register Here" on the Login Page, located at www.prudential.com/mybenefits.



Group Life and AD&D Insurance Benefit



Getting Your User ID and Password

Creating your unique User ID and Password is an easy 3-step process.

Step 1 – Identify Your Employer:

After clicking "Register Here" on the Login Page, you will be prompted to identify your employer, PSL, by entering Control Number 53307. Click "Next". Clicking "Next" will prompt additional questions to appear. You will be required to identify yourself by entering your *Social Security Number*** and *Date of Birth*. Click "Next" to move to Step Two.

Step 2 – Provide Login Information

Here, you will create your unique *User ID and Password**. You will be asked to re-enter your password to confirm. Then enter your *E-mail Address*, choose a *Security Question* and provide the answer. Click "Complete registration" to proceed.

The system will then reserve this User ID and Password for you. You will use this User ID and Password to access the site from this point on.

Note: If you ever forget your User ID or Password, the login page contains convenient *Forgot User ID? and Forgot Password?* functions, that will allow you to easily retrieve them.

*User IDs and Passwords are case-sensitive and must be alphanumeric (containing both numbers and letters). Clicking the "i" icons will provide additional details on User ID and Password requirements.

Voluntary Short-term Disability Insurance Benefit

Prudential

Beginning on the first of the month following 30 days of employment, non-exempt, full-time employees may elect to participate in the voluntary short-term disability program. This benefit is offered through Prudential. Newly benefits eligible employees have 30 days to elect the benefit. If the benefit is not elected within 30 days and the employee wishes to enroll then the employee will need to complete an Evidence of Insurance Eligibility form and submit to Prudential for Prudential to determine enrollment. This benefit will only be offered during the annual Open Enrollment to current participants of the plan to update the benefit election based on salary.

This benefit is fully funded by the employee through voluntary payroll deductions on a post-tax basis. Premiums are based on the amount of coverage purchased. Presbyterian Senior Living offers this opportunity as a service to our employees and is not endorsing any specific product type or level of coverage.

Elimination Period:

- There is a 12 month pre-existing condition clause.
- There is a 14 day elimination period during which no disability benefits will be paid.
- During the elimination period, the member must use any applicable accumulated time off.
- Both Annual Leave and sick bank hours will be applied as appropriate.
- If accumulated time off is not available, the elimination period will be unpaid.
- The employee may not receive both payment from Presbyterian Senior Living and disability program payments for the same absence from work.
- If the employee is not awarded disability benefits, accumulated time off will be applied retroactive to the end of the elimination period.

For a full summary of the benefit including offset payments due to other income received are found on ‘My HR’.

Call to Health/Key Definitions

Health and Wholeness: Call to Health

Call to Health is a well-being initiative for employees enrolled in PSL medical coverage. Enrolled spouses may also participate.

Participants use the Call to Health website to complete required health actions, called challenges, including getting a preventive exam and taking the confidential Well-Being Assessment, plus other optional challenges that span the four dimensions of wholeness: spiritual, health, financial, and vocational.

Each challenge has an associated point total. Complete the challenge and earn points.

Employees who complete Level 1 (1,000 points including required challenges) qualify for reduced medical deductibles in the following plan year. Both employees and spouses who reach designated point levels will earn gift cards. More detailed information is available on 'My HR'.

Important! Employees must complete Call to Health Level 1 during the current plan year to receive lower Call to Health deductibles for the following plan year. (Refer to Deductibles under About the PPO & EPO, later in this section.)

A Successful Partnership

PSL continues to partner with The Board of Pensions of the Presbyterian Church (U.S.A.) (BOP) to offer medical and prescription drug coverage, Call to Health, and Employee Assistance Plan services to PSL employees. (Even though part of the name is pensions, there is no connection to our current retirement program.)

A non-profit agency of the PC(USA), the BOP provides benefits to employees of churches and affiliated organizations — educational institutions, camps and conference centers, retirement and senior housing communities, and human services organizations. The BOP serves approximately 65,000 members with professional expertise and care.

Working with the BOP provides PSL the opportunity to be part of a group with significantly more buying power, which helps to contain costs.

We are confident that this ongoing partnership will enable PSL to continue to ensure that employees have access to competitive, affordable benefits with access to a network of providers across all PSL communities.

Key Definitions

To assist you in understanding the medical options; these are some key definitions.

- **Deductible** – specified annual dollar amount that you must pay for covered services before the plan begins to pay benefits.
  - Under the PPO, deductibles are based on a percentage of your salary, as shown in the PPO Deductibles chart.
  - Under the EPO and HDHP, deductibles are flat dollar amounts, as listed in the Key Provisions: PPO, EPO and HDHP chart.
- **Copay** – specific, up-front dollar amount that you must pay for certain services, such as doctors office visits, when using network providers.
- **Coinsurance** – the percentage of the plan allowance for covered services that is your responsibility after you've met the deductible, up to a defined maximum.

Medical Benefit

- **Medical Out-of-Pocket Maximum (PPO only)** – the most you will pay in the form of coinsurance in a year. The medical out-of-pocket maximum is based on a percentage of your salary, as shown in the PPO Out-of-Pocket Maximums chart. Only one out-of-pocket maximum applies per family. There is a separate out-of-pocket maximum of $3,000 for prescription drugs.
- **PPO** – preferred provider organization
- **EPO** – exclusive provider organization
- **HDHP** – high deductible health plan
- **Total Maximum Out of Pocket Limit (TMOOP)** – the most you will pay in a year in the form of deductibles, copays, and coinsurance. If your covered out-of-pocket expenses reach the total maximum out-of-pocket amount, the plan will pay 100% of allowable costs for the rest of the year.

Medical Coverage

There are three medical coverage options available with Highmark Blue Cross Blue Shield (BCBS):

- Preferred Provider Organization (PPO)

  or
- Exclusive Provider Organization (EPO)
- High Deductible Health Plan (HDHP)

All options provide coverage for the following:

- preventive, routine, and catastrophic medical care
- behavioral health and substance use disorders
- prescription drugs (administered by Express Scripts)

The following pages describe the two options and how they work. The Key Provisions: PPO, EPO and HDHP chart shows what you pay under each option for certain services.

You may elect to waive medical coverage if you have coverage through another source, such as a spouse's plan.

About the Medical Network

All medical options provide access to the national Blue Cross Blue Shield (BCBS) network, one of the largest in the United States. However, only the PPO provides out-of-network benefits. The EPO and HDHP do not cover care received from out-of-network providers except for emergency services.

All covered participants are encouraged to use network providers. The contracted rates established with network providers result in savings to both you and the plan, and you can receive services from any network provider without coordinating your care through a primary care physician. Network doctors, hospitals, and other medical providers can be located on www.myqhealthpcusa.org, or by calling Quantum Health at 1-855-497-1237.

Care Navigation

Care navigation, offered by the Board of Pensions in partnership with Quantum Health, brings added value to your PSL medical coverage by helping you and your covered family members navigate today's complicated healthcare system.

Quantum Health's Care Coordinators can assist with anything to help make the healthcare experience easier, from answering questions about medical claims or bills and finding network providers to helping you manage a health condition and serving as your advocate within the healthcare system.

PPO – Option 1

About the PPO

The Preferred Provider Organization (PPO) offers members the freedom to seek care from any eligible licensed provider; however, the member's out-of-pocket costs are typically lower when using network providers.

Copays

Except for preventive care, members are responsible for a fixed copay for each network office visit (in-person or virtual): $25 for primary and behavioral healthcare visits, $45 for visits to a specialist or when seeking care at an urgent care center, and $10 when using the telemedicine benefit through Teladoc. Copays do not count toward the plan deductible or medical out-of-pocket maximum.

Deductibles

For other types of care, such as inpatient hospital stays, surgery, diagnostic tests, and emergency room visits, members must first satisfy an annual deductible before the plan pays a portion of covered expenses. The deductible amount is based on the employee's salary, as shown in the PPO Deductibles chart below. Members with covered spouses and/or children are responsible for two medical deductibles, one for themselves and one for all other family members combined.

Employees can reduce their deductible amounts by participating in Call to Health, a well-being initiative that focuses on the four dimensions of wholeness: spiritual, health, financial, and vocational. Employees must complete Call to Health Level 1 during each plan year to maintain reduced Call to Health deductibles for the following plan year (refer to Health and Wholeness: Call to Health in the beginning of this section).

PPO Deductibles			
Salary Range	**Network Deductible[1]**		**Out-of-Network Deductible[1]**
	Without Call to Health	Call to Health	
Up to $48,759	$660	$440	$1,100
$48,760-$53,514	$735	$490	$1,220
$53,515-$58,269	$805	$540	$1,340
$58,270-$63,024	$875	$585	$1,460
$63,025-$67,779	$950	$635	$1,580
$67,780-$72,534	$1,020	$680	$1,695
$72,535-$77,289	$1,090	$730	$1,815
$77,290-$82,044	$1,160	$775	$1,935
$82,045-$86,799	$1,235	$825	$2,055
$86,800 or more	$1,305	$870	$2,170

1 Members with covered spouses and/or children are responsible for two medical deductibles, one for themselves and one for all other family members combined.

Note: If your salary changes during the year and you enter a new salary range, your deductible will be adjusted to reflect the new salary range as of the date the BOP is notified of the change in salary, and you will receive a new ID card.

PPO – Option 1

Coinsurance
After reaching the deductible amount, members are still responsible for paying a defined percentage of the cost for certain services — called coinsurance — up to a maximum annual amount. For network services, the coinsurance is 20% of the allowable charges; for out-of-network care, it is 40% (50% with no deductible for doctors office visits).

The medical out-of-pocket maximum is based on the employee's salary. Unlike deductibles, only one medical out-of-pocket maximum applies per family (see PPO Medical Out-of-Pocket Maximums chart below). After a member's out-of-pocket costs (not including office visit copays and deductibles) reach the medical out-of-pocket maximum, the plan pays 100% of all additional eligible expenses incurred by the member for the remainder of the year. However, the member is still responsible for office visit copays until they reach the total maximum out-of-pocket amount.

PPO Medical Out-of-Pocket Maximums[1] *(does not include office visit copays, deductibles, or prescription drug costs)*		
Salary Range	**Network**	**Out-of-Network**
Up to $48,759	$2,200	$6,600
$48,760-$53,514	$2,440	$7,320
$53,515-$58,269	$2,680	$8,040
$58,270-$63,024	$2,915	$8,745
$63,025-$67,779	$3,155	$9,465
$67,780-$72,534	$3,390	$10,170
$72,535-$77,289	$3,630	$10,890
$77,290-$82,044	$3,865	$11,595
$82,045-$86,799	$4,105	$12,315
$86,800 or more	$4,340	$13,020

1 After a member reaches the annual medical out-of-pocket maximum; the Medical Plan pays 100 percent of eligible expenses up to the plan allowance, except for office visit copays. The medical out-of-pocket maximum applies to the member and family combined. Total network out-of-pocket expenses, including office visit copays and deductibles, are capped annually at $5,000 per member and $10,000 per family.

Note: If your salary changes during the year and you enter a new salary range, your medical out-of-pocket maximum will be adjusted to reflect the new salary range as of the date the BOP is notified of the change in salary, and you will receive a new ID card.

EPO – Option 2

About the EPO

The Exclusive Provider Organization (EPO) provides access to the same national network of physicians, hospitals, and other healthcare providers as the PPO. However, unlike the PPO, members must use network providers; the EPO does not cover care received from out-of-network providers except for emergency services.

Copays

Except for preventive care, members pay a fixed copay for most outpatient services (in-person or virtual): $40 for primary and behavioral healthcare visits, $60 for specialists or when seeking care at an urgent care center, and $10 when using the telemedicine benefit through Teladoc. Copays do not count toward the plan deductible, but do count toward the total maximum out-of-pocket (see EPO Total Maximum Out-of-Pocket Amounts chart below). There are different copay requirements for certain other covered services, such as X-rays and laboratory tests, as shown on the Key Provisions: PPO and EPO chart.

Deductibles

For in- and outpatient hospital services, emergency room visits, and certain other services, the member must satisfy an annual deductible before the plan begins to pay benefits. The deductible is a flat amount per individual or family, based on the coverage level elected, as shown in the EPO Deductibles chart. Members with covered spouses and/or children are responsible for two medical deductibles, one for themselves and one for all other family members combined.

Employees can reduce their deductible amounts by participating in Call to Health, a well-being initiative that focuses on the four dimensions of wholeness: spiritual, health, financial, and vocational. Employees must complete Call to Health Level 1 during each plan year to maintain reduced Call to Health deductibles for the following plan year (see Health and Wholeness: Call to Health earlier in this section).

EPO Deductibles	
Network Benefit	
Deductible (without Call to Health)	$2,000/member; $2,000/all other family members[1]
Deductible (Call to Health)	$1,500/member; $1,500/all other family members[1]

1 Members with covered spouses and/or children are responsible for two medical deductibles, one for themselves and one for all other family members combined.

Coinsurance

After reaching the deductible amount, members are still responsible for paying coinsurance — 20% of the allowable charges — up to a maximum annual amount for essential health benefits. The maximum annual amounts, or out-of-pocket limits, are shown below. These amounts include network deductibles and office visit copays, as well as coinsurance and prescription drug copays:

EPO Total Maximum Out-of-Pocket Amounts	
$5,000 per member	$10,000 per family

How the Medical Options Compare

Choosing which option is best for you and your family is an individual decision based on your circumstances and needs. While all three medical options provide access to the same provider network and cover mostly the same services, there are differences in how much members pay in the form of deductibles, copays, and coinsurance under each option. The following chart shows the member's out-of-pocket costs for certain services.

HDHP – Option 3

The High Deductible Health Plan (HDHP) provides access to the same national provider network as the PPO and EPO and, like the EPO, the HDHP does not cover care received from out-of-network providers except in emergencies.

The HDHP has a higher deductible than both the PPO and the EPO. If you enroll in the HDHP, you may be eligible to set up and contribute to a tax-advantaged health savings account (HSA) and use those funds to help pay your deductible and other eligible healthcare expenses.

Copays
There are no copays for medical care and treatment. Except for preventive care and designated preventive drugs, all covered medical and prescription drug expenses are subject to the annual deductible.

There are separate copay requirements for the vision exam benefit (see the Key Provisions: PPO, EPO and HDHP chart) and preventive prescription drugs (see Prescription Benefit).

Deductibles
Like the EPO, the HDHP deductible is a flat dollar amount per individual or family based on the coverage level elected, as shown in the HDHP Deductibles chart; however, the HDHP deductible amounts are higher. And, if you enroll any family members, you are responsible for paying the entire family deductible before the plan pays benefits for care for you or your family that is not preventive. There is no individual deductible amount that applies when one or more eligible family members are enrolled in the HDHP.

Except for preventive care, if you are enrolled in the HDHP, you pay out of pocket for all covered healthcare services — including network office visits, telemedicine consultations through Teladoc and visits to an urgent care center — until your expenses reach the deductible amount. The HDHP deductible also applies for covered prescription drugs unless the drug is designated as preventive (see Prescription Benefit).

Employees can reduce their deductible amounts by participating in Call to Health, a well-being initiative that focuses on the four dimensions of wholeness: spiritual, health, financial and vocational. Employees must complete Call to Health Level 1 during each plan year to maintain reduced Call to Health deductibles for the following plan year (refer to Health and Wholeness: Call to Health in the beginning of this section).

HDHP Deductibles	
Network Benefit	
Deductible (without Call to Health)	$3,000; member only/$6,000 member and family[1]
Deductible (Call to Health)	$2,250; member only/$4,500 member and family[1]

1 Members with covered spouses and/or children are responsible for the entire family deductible amount.

Coinsurance
After reaching the deductible amount, members are still responsible for paying coinsurance — 20% of the allowable charges — up to a maximum annual amount for essential health benefits. The maximum annual amounts, or out-of-pocket limits, are shown below. These amounts include network deductibles and coinsurance as well as prescription drug copays:

HDHP Total Maximum Out-of-Pocket Amounts	
$5,000 per member	$10,000 per family

HDHP – Option 3

Health Savings Account
A health savings account (HSA) is an employee-owned account that can be used to pay for qualified healthcare expenses, including the HDHP deductible, coinsurance and more. HSAs are considered tax-advantaged because, under Internal Revenue Service (IRS) rules, you don't pay taxes on your contributions, any investment growth is tax-free and so are withdrawals for qualified expenses, which are healthcare expenses that can be claimed as a tax deduction.

HSA Contributions
If you enroll in the HDHP you may be eligible to set up and contribute to an HSA up to annual limits set by the IRS. To contribute to an HSA, you cannot be covered by any other medical plan that is not an HSA-compatible health plan, including a spouse's medical plan.

The annual contribution limits for 2023 are $3,850 if you enroll for employee-only coverage and $7,750 if covering any family members. If you will be age 55 or older during the year, you may make additional catch-up contributions of up to $1,000.

In addition to any HSA contributions you elect, PSL will be contributing up to $600 for member only and $1200 for family to the HSA annually, which will be provided incrementally over the course of the year. Both your contributions and PSL's contributions count toward the annual IRS limit and are processed through PSL payroll. In the event that you do not receive a paycheck through PSL payroll, you may not be eligible for the PSL employer contribution. Regardless of a paid or unpaid leave of absence, FMLA eligibility warrants a PSL employer contribution.

How It Works
1. You decide how much to contribute to your HSA for the upcoming year, subject to IRS limits (this is called your election).
2. PSL deducts your election from your pay on a pretax basis and directs it into your HSA. HSA contributions become available for use as they are deposited in your account.
3. When you have a qualified healthcare expense during the year, you decide whether to:
    - pay it with available HSA funds using the Visa healthcare debit card issued by Further, the HSA administrator, or by submitting the expense for reimbursement (withdrawals to pay for qualified expenses are tax free), or
    - pay it out of pocket and allow your HSA balance to grow.
4. The HSA earns interest tax-free; you also may invest your account when the balance reaches $1,000.
5. Unused HSA funds roll over from one year to the next with no limits.
6. You own your HSA, so it goes with you if you change medical plans, start a new job or retire.

Qualified Expenses
You may use funds from the HSA to pay for qualified expenses, which are medical, dental and vision expenses that can be claimed as a tax deduction. Examples include, but are not limited to, deductible and coinsurance amounts, dental or orthodontia treatment not covered or reimbursed by any healthcare plan, and prescription drugs. Eligible healthcare expenses are outlined on the Further site at www.hellofurther.com or in IRS Publication 502 at www.irs.gov. These expenses can be for yourself or for any family member that you can claim as a dependent for tax purposes. The family member does not need to be enrolled in medical coverage.

Medical Benefit

Key Provisions: PPO, EPO and HDHP				
Network Benefit	**PPO**		**EPO**	**HDHP**
	Lowest Salary Band	Highest Salary Band		
Deductible (without Call to Health)	$660/member[1] + $660/all other family members[1,2]	$1,305/member[1] + $1,305/all other family members[1,2]	$2,000/member + $2,000/all other family members[2]	$3,000/member only or $6,000 member + family[3]
Deductible (Call to Health)[3]	$440/member[1] + $440/all other family members[1,2]	$870/member[1] + $870/all other family members[1,2]	$1,500/member $1,500/all other family members[2]	$2,250/member $4,500 member + family[3]
Spending account compatibility	N/A		N/A	Health savings account (HSA)
Medical coverage after deductible (coinsurance)	Member pays 20%		Member pays 20%	Member pays 20%
Preventive care[4]	Covered 100%		Covered 100%	Covered 100%
Telemedicine (Teladoc)	$10 copay		$10 copay	Member pays 100% up to deductible amount; after deductible, member pays 20%
Primary and behavioral office visit	$25 copay		$40 copay	
Retail clinic visit	$25 copay		$40 copay	
Specialist office visit	$45 copay		$60 copay	
Urgent care visit	$45 copay		$60 copay	
Basic diagnostic services (imaging, lab, X-rays, etc.)	Member pays 20% after deductible		$65 copay	
Advanced imaging (MRI, CT, PET, etc.)	Member pays 20% after deductible		$200 copay	
Physical, speech, and occupational therapy	Member pays 20% after deductible		$40 copay	
Spinal manipulations	Members pays 20% after deductible		$40 copay	
Hearing aid (device, fitting and repair) plan maximum of $2,500 every 3 yrs	Member pays 20% after deductible		Member pays 20% after deductible	
Hospital inpatient and outpatient	Member pays 20% after deductible		Member pays 20% after deductible	
Emergency room	Member pays 20% after deductible		Member pays 20% after deductible	
Infertility treatment (3 procedures/life maximum)	Member pays 20% after deductible		Member pays 20% after deductible	
ABA therapy	Member pays 20% after deductible		Member pays 20% after deductible	
Facility charges for select surgeries	Member pays 0%r after deductible for allowable facility charges when these select surgeries are performed in a BCBS Blue Distinction Center: bariatric surgery, knee replacement surgery, hip replacement surgery, spinal surgery, and transplants. Family travel benefit also available depending upon distance.			
Out-of-network benefit	PPO		EPO	HDHP
Deductible	$1,100/member[1] $1,100/all other family members[1, 2]	$2,170/member[1] $2,170/all other family members[1, 2]		
Coverage after deductible	Member pays 40%; 50% (no deductible) for doctors' office visits			
Medical out-of-pocket maximum (member and family combined)	$6,600	$13,020		

1 See full deductible and medical out-of-pocket maximum charts for PPO deductibles and coinsurance maximums at all effective salary levels.
2 Members with covered spouses and/or children are responsible for two medical deductibles, one for themselves and one for all family members combined.
3 Coverage for preventive services exceeds ACA definition.
4 This amount includes network deductibles; medical out-of-pocket maximum (PPO only); prescription drug out-of-pocket maximum (PPO only); office visit copays; coinsurance; and prescription drug copays (non-formulary brand-name drugs excluded).

Medical Benefit

Using Your Medical Benefits

Get Advance Approval When Required

You must pre-certify non-urgent hospital admissions with Quantum Health. The pre-certification process is typically completed within two business days after Quantum Health receives all the information needed from your provider. You can check the status of a pre-certification request by logging on to www.myqhealthpcusa.org. If you do not pre-certify services when necessary, benefits may be denied.

You also must pre-certify certain tests and procedures; if you do not pre-certify the specified tests and procedures, you may be responsible for their cost. Most tests and procedures that require pre-certification are listed on the back of your medical ID card, along with the phone numbers to call.

Emergency and Urgent Care Services

If you need emergency care, call 911 and seek care from the nearest provider or hospital emergency room (ER), regardless of network participation. ERs are the most prepared and best equipped facilities to handle serious, potentially life-threatening medical needs.

You must notify Quantum Health within 48 hours of an inpatient emergency admission to have the admission certified and maximize your benefits. Notification is not required for an ER visit without admission.

Alternatives to the ER

If you are not sure whether you really need emergency care when your symptoms are not life-threatening, consider these alternatives (applicable copays, deductibles, and/or coinsurance apply):

- Contact your primary care physician. Your primary care physician is generally best suited to treat non-life-threatening conditions and manage your care over time.
- Use the telemedicine option, provided by Teladoc. This care option can be especially helpful when common, acute issues, such as ear infections, sinusitis, or the flu, develop in the middle of the night or while traveling. See Teladoc below for more details.
- Go to an urgent care center. A freestanding healthcare clinic, an urgent care center generally is staffed by physicians who can treat serious but non-life-threatening accidents and injuries, such as burns, cuts, and sprains, or common illnesses like the flu, allergic reactions, and infections. No appointment is generally necessary.
- Visit a retail medical clinic (typically in a pharmacy). Use a pharmacy medical clinic — generally staffed by certified registered nurse practitioners — for more minor ailments in after hours situations.

Teladoc

Teladoc provides 24/7 access to U.S. board-certified doctors through the convenience of phone, video, or mobile app visits for less than the cost of a regular doctor's office visit, making it a convenient, affordable option when a trip to the doctor's office isn't practical.

Teladoc doctors can treat many acute medical conditions, including cold and flu symptoms, allergies, pink eye, sinus problems, and earaches, as well as prescribe medication when appropriate. To preregister and use the benefit, go to www.teladoc.com/enter or call 1-800-835-2362.

Carry Your Medical ID Card

If you newly elect medical coverage or change your medical option for 2023, you will receive a new medical ID card from Highmark showing you have medical coverage through PSL. Carry your ID card so that you have it available for emergency and routine use. You may request additional or replacement cards at any time by contacting Quantum Health or logging on to www.myqhealthpcusa.org. Be sure to destroy the old cards if you receive new ID cards.

Prescription Benefit

Prescription Drug Benefits

Express Scripts, the Medical Plan's pharmacy benefits manager, administers the plan's prescription drug program. Through this program, plan members can obtain the medications they require to treat an illness or ongoing condition. Express Scripts offers a network of participating providers (including a mail-service pharmacy), and maintains a formulary of preferred prescription medications.

Separate Prescription Drug ID Cards

If you enroll in PSL medical coverage, your coverage automatically includes prescription drug benefits for you and your enrolled family members. If you newly elect medical coverage for 2023, you will receive separate prescription ID cards (in addition to your medical ID cards) in the mail from Express Scripts. Show your prescription drug ID card at the pharmacy each time you fill a prescription.

Key Definitions

To assist you in understanding the prescription drug benefits; these are some key definitions.

- **Prescription Drug Formulary** – the prescription drug provider's list of preferred generic and brand medications.
- **Preventive Drug List** – the plan's list of select prescription drugs that are highly effective in preventing or managing chronic conditions, such as diabetes, asthma, high blood pressure, and depression.
- **Non-formulary Drug** — a drug, typically a brand name, which is not on the plan's prescription drug formulary. The EPO and HDHP does not cover non-formulary drugs.

Brand vs. Generic Drugs

The brand name of a drug, protected by a limited-time patent, is the product name under which it is advertised and sold. Once the patent has expired, a generic equivalent may be manufactured and sold under its chemical name. Chemically equivalent generics are required to have the same active ingredients as their brand-name counterparts and are subject to the same U.S. Food and Drug Administration (FDA) standards for quality, safety, purity, and effectiveness.

Before your doctor writes a prescription for a brand-name drug, ask if a generic is available and right for you. By using a generic, you'll pay less — sometimes a lot less — and by using Express Scripts home delivery service you save even more. The Prescription Drug Cost Comparison chart shows your costs for covered generic, formulary, and non-formulary drugs.

Mandatory Generic Provision

When a generic equivalent is available, the prescription drug program covers only the cost of the generic drug. If a plan member purchases a brand-name drug when a generic is available, they will be responsible for any additional charge, plus the applicable coinsurance. The additional cost does not count toward the prescription out-of-pocket maximum.

Prescription Benefit

Preventive Drugs

Certain prescription drugs related to specific conditions are designated as preventive. Plan participants pay reduced copays for these designated preventive drugs. See the Prescription Drug Cost Comparison chart below for the copay amounts that apply. **The preventive drug list is available on 'My HR'.**

Prescription Drug Cost Comparison				
Preventive Drugs	**PPO**		**EPO**	**HDHP**
	Lowest salary band	Highest salary band		
Preventive prescription drugs generic retail (30/90)/mail (90)	$5/$15/$12.50		$6/$18/$15	$6/$18/$15 Not subject to HDHP deductible
Preventive prescription drugs formulary brand retail (30/90)/mail (90)	$20/$60/$50		$30/$90/$75	$30/$90/$75 Not subject to HDHP deductible
Generic retail (30/90)/mail (90)	$10/$30/$25		$12/$36/$30	
Formulary brand retail (30/90)	30% of cost; 30 days: $20 min to $100 max 90 days; $60 min to $300 max		35% of cost; 30 days; $35 min to $150 max 90 days: $105 min to $450 max	Member pays 100% up to deductible amount; after deductible, member pays 30% subject to $150 (30-day), $450 (90-day) or $375 (90-day mail) max
Formulary brand mail (90)	30% of cost; $50 min to $250 max		35% of cost; $85 min to $375 max	
Non-formulary brand retail (30/90)	50% of cost; 30 days; $50 min to $150 max 90 days: $150 min to $450 max		Not covered	Not covered
Non-formulary brand mail (90)	50% of cost; $125 min to $375 max		Not covered	Not covered
ANNUAL MAXIMUMS				
Medical Out-of-Pocket Maximum	$2,200/family[1]	$4,340/family[1]	Part of total maximum out-of-pocket	Part of total maximum out-of-pocket
Prescription Out-of-Pocket Maximum	$3,000/family[5] (member and family combined)		Part of total maximum out-of-pocket	Part of total maximum out-of-pocket
Total Maximum Out-of-Pocket	$5,000/member[6] $10,000/family[6]		$5,000/member[6] $10,000/family[6]	$5,000/member[6] $10,000/family[6]
VISION EXAM BENEFITS	**PPO**		**EPO**	**HDHP**
Vision Exam	$25 at VSP provider		$25 at VSP provider	$25 at VSP provider[7]

1 See PPO Deductibles and Medical Out-of-Pocket Maximums for specific amounts at all effective salary levels. The medical out-of-pocket maximum is the most a member will pay in a year in the form of coinsurance. It does not include copays, deductibles, or prescription drug costs.
2 Members with covered spouses and/or children are responsible for two medical deductibles, one for themselves and one for all other family members combined.
3 Members with covered spouses and/or children are responsible for the entire family deductible amount.
4 Coverage for preventive services exceeds ACA definition.
5 Any costs for non-formulary brand-name drugs do not count toward the prescription out-of-pocket maximum.
6 The total maximum out-of-pocket includes network deductibles and coinsurance; medical out-of-pocket maximum (PPO only); prescription drug out-of-pocket maximum (PPO only); copays (PPO and EPO); and prescription drug copays (non-formulary brand-name drugs excluded).
7 Individuals enrolled in the HDHP will be automatically enrolled in the VSP vision exam benefit. The vision exam benefit is not considered part of the HDHP.

Prescripton Benefit

How to Fill Prescriptions

You can access your prescription drug benefits in one of two ways: Fill your prescription at your local participating pharmacy, using your Express Scripts ID card, or through mail order, using Express Scripts home delivery for the greatest possible savings.

At Your Local Participating Pharmacy

Use your local participating pharmacy to fill short-term prescriptions. Use your Express Scripts ID card with a pharmacy that participates in the Express Scripts network to pay at reduced rates. If you fill a prescription at an out-of-network pharmacy, you must pay the entire cost for the medication and then submit a claim form to Express Scripts for reimbursement. Your reimbursement will be based on the contracted rate for out-of-network prescriptions minus the applicable copay. Claim forms are available at www.express-scripts.com, or call Express Scripts at 1-800-344-3896. You may also call Quantum Health at 1-855-497-1237 for assistance.

Through Mail Order

To save money and to have your medications delivered to your home, use Express Scripts home delivery service to fill prescriptions for your maintenance medications — those you take on a regular basis (for example, medications to treat high blood pressure, high cholesterol, or thyroid conditions). If you choose to fill prescriptions for maintenance medications at your local pharmacy, typically you — and the plan — will pay more.

To order a 90-day supply of your medication through Express Scripts mail order service, do any of the following:

- Have your doctor e-prescribe the prescription to Express Scripts.
- Ask your doctor to fax the prescription to Express Scripts.
- Complete a prescription order form, available at www.express-scripts.com, and mail the form, plus the written prescription completed by your doctor, to the address provided on the form. You may also call Quantum Health at 1-855-497-1237 for assistance.

Shipping is free. You can also set up auto refill and auto renewal of your prescriptions.

Special Programs

Some drugs your doctor may prescribe are subject to step therapy, prior authorization, or specialty medication programs — additional ways the prescription drug program seeks to slow rising costs while providing you with safe and effective medications.

Step Therapy

Step therapy is a program that can make prescription drugs more affordable for most plan members and their families.

In step therapy, the covered prescription drugs are classified in steps, beginning with proven, cost-effective drugs, usually generics. These drugs have been approved by the FDA and have a history of successfully treating many medical conditions. More expensive drugs are then used only in the few situations where the generics fail to deliver the desired outcomes. Some conditions treated by medications that may be subject to step therapy follow:

- attention deficit disorder
- depression
- diabetes
- pain and inflammation
- skin inflammation
- stomach acid reflux

Prescription Benefit

Prior Authorization
When prior authorization is required, it means that more clinical information is needed about a patient's particular medical condition before Express Scripts can confirm the medical necessity for the prescribed drug. A doctor or nurse can provide that information and request a prior authorization.

The goal is to ensure patients receive appropriate medications for their diagnoses.

Quantity Limits
Certain drugs have quantity limits to encourage appropriate drug usage, enhance drug therapy, and reduce costs. The quantity limit is the maximum quantity that can be dispensed over a given period of time.

Specialty Medications
Specialty medications, typically used to treat complex conditions such as cancer, hepatitis, and multiple sclerosis, are limited to a 30-day supply due to the high cost, special storage needs, limited shelf life, and frequent dosage changes. You must purchase specialty drugs through Express Scripts specialty pharmacy, Accredo, to receive coverage under your prescription drug benefits; specialty medications are not available through Express Scripts home delivery service or your local retail pharmacy. Specialty medications are subject to the same coinsurance minimums and maximums as other prescriptions. Contact Express Scripts for more information.

Note: Prescription drugs administered during a hospital stay are considered medical expenses. Prescription drugs purchased at a hospital pharmacy for use at home are considered prescription drug expenses.

Drugs Not Covered

Prescriptions drugs are not covered that

- are not approved by the FDA;
- have over-the-counter equivalents;
- are on the plan's exclusion list (see Excluded Drugs);
- are appetite suppressants;
- are approved or prescribed for cosmetic purposes only; or
- are lost, stolen, spilled, or otherwise damaged.

If you purchase a prescription that is not covered, you will pay the full (unreduced) cost of the drug and that payment will not count toward your prescription out-of-of-pocket maximum (PPO only) or total maximum out-of-pocket limit. Note: The EPO and HDHP does not cover non-formulary drugs.

Excluded Drugs
Large pharmacy benefits managers such as Express Scripts negotiate with pharmaceutical companies to buy certain medications in volume at a discount, in exchange for excluding similar medications made by other drug companies. The Board of Pensions and Express Scripts are attempting to slow the spiraling rise in drug costs by excluding from coverage certain medications when less expensive, clinically proven alternatives are available on the formulary. To see which drugs are excluded, go to www.express-scripts.com. If you fill a prescription for a drug that is excluded from coverage, you'll pay the full (unreduced) cost of the drug. You may also call Quantum Health at 1-855-497-1237 for assistance if you are unsure whether a particular drug is excluded.

Your cost for prescription coverage is part of the medical premium cost and is shown in the Cost of Benefits Coverage, included in this electronic guide.

Additional Assistance Programs

The following Assistance Program grants, available through The Board of Pensions of the Presbyterian Church (U.S.A.) (BOP), provide financial assistance to employees enrolled for PSL medical coverage. Eligibility varies by grant. If you have any questions, contact the BOP at 800-773-7752.

Adoption Assistance
$6,500

You may receive assistance at the completion of an adoption to help with a portion of adoption-related expenses. Your adopted child must be a dependent under age 21 and can be adopted domestically or internationally.

Transition-to-College Assistance
Up to $3,000

Any dependent up to age 26 may be eligible to receive $2,000 for expenses, such as a computer, if entering a college, university, community college, or technical or trade school (excludes post-baccalaureate education). And, if the child attends a PC(USA) college or university, you may be eligible for an additional $1,000.

Emergency Assistance
Up to $5,000

If you need financial help because of an emergency, you may be eligible for a one-time grant for financial relief from a natural disaster or unexpected expense. Contact AO Benefits team at benefits@psl.org about applying for this type of assistance.

Employee Vocation Program
Up to $5,000 a Year for Up to Five Years, Totaling $25,000

This program combines debt relief with student loan debt coaching through PeopleJoy, an educational debt reduction firm. The BOP will contribute $5,000 a year for five years or until your debt is eliminated, whichever comes first, if you pay your loan servicer a specified amount monthly. Additionally, you must receive student loan debt coaching from PeopleJoy.

Medical Continuation Coverage

PSL notifies BOP that the employee's medical coverage will end. The employee receives a letter and election form from the BOP within 8 days of the date the BOP receives the notification from PSL.

Employee receives letter and form.

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Employee must choose to elect or waive coverage within 60 days.

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Employee receives a confirmation of the election or waiver.

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If BOP does not receive a response within 60 days, a letter is sent to the employee confirming that medical continuation coverage was not elected; the employee will be disenrolled from medical coverage and will not be eligible for any future medical coverage through PSL.

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