



Wespath

BENEFITS | INVESTMENTS

SUMMARY PLAN DESCRIPTION

HealthFlex





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WELCOME

The Wespath has prepared this Summary Plan Description (SPD) to help you understand your group health plan and cafeteria plan coverage. Please read it carefully.

ABOUT THE PLAN

The General Conference of The United Methodist Church established a welfare benefit plan for clergy and lay employees effective January 1, 1961. Wespath maintains the HealthFlex Plan, for the benefit of clergy and lay Employees (and their eligible Dependents) of The United Methodist Church and related organizations.

The Plan is a “Church Plan” as defined in §414(e) of the Internal Revenue Code (Code), as amended, and §3(33) of the Employee Retirement Income Security Act of 1974 (ERISA). The Plan’s status as a Church Plan has a significant legal meaning; you can read more about it in the section titled *Miscellaneous Important Provisions*.

SERVING THE UNITED METHODIST CHURCH

The General Conference established Wespath to supervise and administer the employee benefit plans of The United Methodist Church. Wespath, in accordance with the provisions of *The Book of Discipline*, administers the Plan for the benefit of its Participants and Plan Sponsors to better enable them to serve the Church. You can help Wespath be a good steward by ensuring that the information you provide your Plan Sponsor and Wespath is timely and accurate.

EXPLANATION OF TERMS

You will find terms starting with capital letters throughout this SPD. Most of these terms are explained in the Definitions section of this SPD; others may be defined in the text.

PLAN SPONSOR

Your Plan Sponsor is the employer or Conference through which you have coverage under the Plan. Your Plan Sponsor has elected to participate in the Plan through an Adoption Agreement with Wespath. If you have questions about your benefits under the Plan, you may contact your Plan Sponsor in addition to Wespath.

YOUR RESPONSIBILITY TO PROVIDE ACCURATE INFORMATION

The Plan Administrator and its Claims Administrators rely on information provided by you when evaluating coverage and benefits under the Plan. All information you provide, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation or incorrect information may result in the denial of a Claim, cancellation or rescission of coverage or any other legal remedy available to the Plan.

QUESTIONS

If you have questions about the benefit plans administered by Wespath, please do not hesitate to contact us. For more information, please visit our website at wespath.org. Or you may call Wespath’s Health Team at **1-800-851-2201**.

IMPORTANT NOTICES

Right to Amend the Plan

Wespath reserves the right to amend or modify the Plan in any manner, for any reason permitted by law, at any time and without prior notification.

Coverage Not Vested or Guaranteed

Coverage through HealthFlex as an Employee, Participant, Dependent or retired Participant is not a vested benefit—i.e., it is not guaranteed to continue. Wespath unequivocally reserves the right to amend or terminate HealthFlex at any time. In addition, your Plan Sponsor has reserved the right to terminate its participation in the active participant and retiree portions of HealthFlex and may have reserved the authority to amend its cost-sharing policies or terminate its health plan for Employees and retired Participants.

Claims Administrators

The Claims Administrators for the Plan that Wespath has engaged through administrative service agreements, contracts and insurance policies (Contracts), provide the Plan's access to networks of health care providers, certain communications, identification cards, Claims processing, Claims payment, Claims determination and Claims appeals. Wespath has assigned many of its administrative duties with respect to the Plan to the Claims Administrators. In addition, pursuant to the terms of the Plan Document that governs HealthFlex, Wespath has delegated certain fiduciary responsibilities and duties to the Claims Administrators. Wespath has delegated the administrative authority to review, approve and deny Claims for medical, prescription drug, dental, mental health and vision benefits to the Claims Administrators. The Claims Administrators make all determinations of medical necessity or medical appropriateness; they have the duty and authority to determine whether a particular benefit, procedure or service is covered by the Plan. The Claims Administrators also hold the authority to hear and decide appeals of denied claims for benefits under the Plan. Wespath does not have the authority to hear or overturn the determinations of the Claims Administrators related to benefits or medical necessity or appropriateness. Please contact Wespath if you have questions regarding the manner in which the Claims Administrators and Wespath share duties under the Plan.

Moreover, certain Contracts with the Claims Administrators are insurance contracts and policies. As such, the terms of those Contracts with respect to the Participants covered under them will supersede the terms of this SPD where there is a conflict between the documents.

The Plan Is Not a Contract of Employment

Nothing contained in this SPD or the Plan will be construed as a contract or condition of employment between Wespath, any Plan Sponsor or any other employer and any Employee. All Employees are subject to discharge to the same extent as if their employer had never adopted the Plan.

ELIGIBILITY

If you are appointed to or work for a Plan Sponsor of HealthFlex, you may be eligible for coverage under the Plan. Your eligibility depends on the rules of the Plan and the choices of your Plan Sponsor. Contact your Plan Sponsor or Wespath if you have questions about your eligibility under the Plan. The descriptions below explain some general rules that govern the Plan.

Adoption Agreements

A Conference or Affiliated Organization that wishes to adopt HealthFlex must execute an Adoption Agreement with Wespath to become a Plan Sponsor. An Adoption Agreement is a contract through which a Plan Sponsor agrees to cover its Employees in the Plan and promises to abide by the terms of the Plan and assumes certain duties and obligations.

HealthFlex sets forth basic (i.e., required) and optional (i.e., discretionary) categories of coverage for clergy Employees (including deacons) and lay Employees. A Plan Sponsor must specify in its Adoption Agreement the optional categories of individuals that it wishes to make eligible under the Plan. The Adoption Agreement also defines eligibility as it pertains to a Plan Sponsor's Employees' Spouses, Dependents, surviving Spouses, surviving Dependents and retired Participants, as well as Employees on Continuation Coverage and leaves of absence under certain paragraphs of *The Book of Discipline*.

Some Plan Sponsors have age and service requirements that Employees must satisfy before they can participate in the Plan. A Plan Sponsor must offer HealthFlex participation in a nondiscriminatory manner to all persons described in the categories indicated on its Adoption Agreement.

Additionally, your Plan Sponsor's Adoption Agreement determines the medical, prescription drug, dental and vision Benefit Options available to you.

Eligibility for UMC Annual Conference or General Agency Plan Sponsors

If you are an Employee in one of the classes described below and your Plan Sponsor has adopted the Plan, you are eligible to participate in the Plan. However, the employee benefits policies and personnel rules of your Plan Sponsor also may affect your eligibility.

- A clergy Employee of a Conference, including a full, provisional or associate member who is appointed:
 - to full-time service in a local church in accordance with ¶337.1 or ¶346.1 of *The Book of Discipline*; or
 - full-time to an extension ministry in accordance with ¶344.1 of *The Book of Discipline*;
- A full-time local pastor;
- A lay Employee of a General Agency that has adopted the Plan who is normally scheduled to work 30 or more hours per week (excluding persons employed by General Agencies as missionaries);
- A clergy Employee of a General Agency; or
- A clergy Employee of a Disaffiliated Church.

If your Plan Sponsor has elected, pursuant to its Adoption Agreement, to cover the class of Employee below that describes you, generally you will be eligible to participate in the Plan. You should contact your Plan Sponsor for information about which of these categories is covered under your Plan Sponsor's Adoption Agreement.

- A clergy Employee of a Conference who:
 - is appointed to less than full-time service under ¶338.2 of *The Book of Discipline*, but who is appointed to at least half-time service;
 - is appointed beyond the local United Methodist Church under ¶344.1a of *The Book of Discipline*, including full-time local pastors so appointed under ¶316 of *The Book of Discipline*;
 - is appointed beyond the local United Methodist Church under ¶344.1b of *The Book of Discipline*;
 - is appointed beyond the local United Methodist Church under ¶344.1d of *The Book of Discipline*;
 - is granted a Leave of Absence;
 - is appointed to attend school under ¶416.6 of *The Book of Discipline*;
 - is on sabbatical leave under ¶351 of *The Book of Discipline*;

- has retired under ¶357.1 (mandatory retirement), ¶357.2b (with 35 years of service at age 62) or ¶357.2c (with 40 years of service at age 65) of *The Book of Discipline*;
- has retired with 20 years of service under ¶357.2a of *The Book of Discipline*; or
- has involuntarily retired under ¶357.3 of *The Book of Discipline*;
- A “part-time local pastor” as defined in ¶318.2 of *The Book of Discipline* who is appointed to at least a three-quarter time appointment;
- A student appointed as a local pastor under ¶318.3 of *The Book of Discipline*;
- A full-time local pastor who was eligible to participate in the Plan and who has been recognized as a retired local pastor under ¶320.5 of *The Book of Discipline*;
- A lay Employee of a Conference or Salary-Paying Unit within a Conference who:
 - is normally scheduled to work 30 or more hours per week; or
 - has retired under the retirement policy of his or her Salary-Paying Unit;
- A lay Employee of a Plan Sponsor other than a Conference or General Agency who is normally scheduled to work 30 or more hours per week; or
- A lay Employee of a General Agency or other Plan Sponsor who has retired under the retirement policy of his or her General Agency or Plan Sponsor.

Eligibility for All Other Plan Sponsors

A Plan Sponsor that is *not* a UMC annual conference or general agency may elect to cover any employee who is normally scheduled to work 30 or more hours per week. You should contact your Plan Sponsor for information about which employees are covered under your Plan Sponsor’s Adoption Agreement.

Other Categories

A Plan Sponsor, with the written agreement of Wespath, may enroll other individuals in a category not specifically described above, provided that the Employees are individuals who may participate in a cafeteria plan (under §125 of the Code) and a Church Plan. Such individuals will be subject to all other terms of the Plan.

Exclusions

A clergy Employee of a Plan Sponsor shall be excluded from the Plan when:

- He or she has a quarter-time or less appointment;
- He or she is granted honorable location as that term is defined in ¶358 of *The Book of Discipline*;
- He or she is placed on administrative location as that term is defined in ¶359 of *The Book of Discipline*; or
- His or her Conference relationship has been severed in any manner, e.g., by withdrawal, surrender of ministerial credentials or a penalty assessed by a trial court within the meaning of ¶360, ¶2719.2 or ¶2711.3 of *The Book of Discipline*, or surrender of the local pastor license as described in ¶320.1 of *The Book of Discipline*.

A Lay Employee may be excluded from the Plan as determined by the Plan Sponsor when:

- He or she normally is scheduled by his or her Plan Sponsor or Salary-Paying Unit to work fewer than 30 hours per week;
- He or she is a temporary or seasonal Employee, meaning he or she normally is scheduled by his or her Plan Sponsor or Salary-Paying Unit to work fewer than six continuous months during a Plan Year; or
- He or she normally is scheduled by his or her Salary-Paying Unit to work more than 30 hours per week during a period of time that is fewer than six continuous months, even if such Employee is normally scheduled by the Plan Sponsor or Salary-Paying Unit to work fewer than 30 hours per week beyond six months.

Any Employee who is reasonably expected to reside outside of the United States for more than six continuous months at a time is excluded from the Plan.

In addition, you will be excluded from the Plan for failure to make Required Contributions on a timely basis. This means that your coverage will terminate, and you will be excluded from coverage if you, your Plan Sponsor or the Salary-Paying Unit that is responsible for making Required Contributions on your behalf fails to make the Required Contributions.

Wespath will notify you and your Plan Sponsor of the failure to make Required Contributions and will request payment of delinquent contributions. If you do not make payment in full within 15 calendar days of this notice, you will cease to be a Participant. Termination of coverage does not excuse you or your Plan Sponsor from making payment in full of all Required Contributions. If your coverage terminates for failure to timely make Required Contributions, you will not be eligible for continuation coverage.

Your Spouse and Dependents

Your Spouse and Dependents may be eligible for coverage under the Plan depending upon:

- the choices elected by your Plan Sponsor on its Adoption Agreement, and
- the terms of applicable Benefit Options (such as limiting ages, etc.).

In certain circumstances, civil union partners and domestic partners of lay Employees may be covered, depending (1) upon the law of the State in which the lay Employee resides and Plan Sponsor is located, (2) the elections of the Plan Sponsor. For more about this coverage see the section of this SPD entitled *Domestic Partner Coverage*.

Plan Sponsor Rules

Your Plan Sponsor may have rules and personnel policies that will affect your eligibility under the Plan. Ask your Plan Sponsor for additional information about the rules and regulations for coverage under this Plan and all the employee benefit plans that your Plan Sponsor offers.

Waiting Periods

Your Plan Sponsor may determine the length of time you are required to be employed before you can participate in the Plan. However, under the terms of the Affordable Care Act (ACA), generally no waiting period can exceed 90 days.

Required Contributions

Your Plan Sponsor determines how much of the cost of coverage, the Required Contribution, you will share. Your Plan Sponsor designates the Premium Credit (Plan Sponsor portion of the Required Contribution) and you are required to pay the rest. Your Plan Sponsor might cover the entire Required Contribution of your plan(s) or might assign the entire Required Contribution of your plan(s) to you.

Benefit Options

Your Plan Sponsor offers a choice of medical, prescription drug, dental and vision Benefit Options under the Plan.

Right to Terminate

Your Plan Sponsor has reserved the right to terminate its sponsorship of HealthFlex, subject to the conditions of its Adoption Agreement with Wespath. If your Plan Sponsor terminates its HealthFlex participation, your coverage under the Plan terminates. In addition, your Plan Sponsor may have reserved the right to terminate its sponsorship of a group health plan.

Coverage While Working Past Age 65

Once you reach age 65, you will be entitled to coverage under Medicare Part A¹ even if you are actively working. You may not need to enroll in Medicare Part B if you are actively working and have active HealthFlex coverage. However, your Plan Sponsor's offering may be different for Medicare-eligible employees if you are working for a small employer, so you should check with your Plan Sponsor. This also applies if your Dependent becomes eligible for Medicare while you are actively working and have active HealthFlex coverage.

Participants working for a small employer that has elected the Medicare Secondary Payer Small Employer exception (and their Dependents) who meet the requirements for Medicare to act as primary payer for medical claims can elect to enroll in the Medicare Connector Program (i.e., Via Benefits™) if elected by the Plan Sponsor.

¹ You are generally entitled to coverage under Medicare Part A unless you are a clergyperson who has opted out of Social Security.

Coverage During Disability

If you are not actively working due to a disability, you may be eligible to continue to participate in HealthFlex as long as you remain disabled, provided that your Plan Sponsor continues to cover you under its policies and rules, and subject to certain limitations set forth below. You should check with your Plan Sponsor to confirm its policy.

A Plan Sponsor's personnel policies (and for Conferences, *The Book of Discipline*) have significant impact on coverage in disability. The Plan Sponsor can establish its own rules about cost sharing for disabled Employees (as long as they aren't discriminatory to other similarly situated Employees) provided the disabled individual remains an Employee. For clergy Employees, if the Participant terminates Conference relationship, then the Plan Sponsor's policies regarding continued membership, coverage and cost sharing of premiums will apply. That may require the terminated, disabled Participant to pay the entire Required Contribution or terminate coverage entirely. If a Plan Sponsor's personnel policy indicates a termination of employment for lay Employees who become disabled (e.g., after 24 months of disability), then that policy will govern continued coverage and cost sharing. The Plan will allow the disabled Participant to continue coverage if the Plan Sponsor's rules allow it, but it does not require such coverage. When Plan coverage ceases, Continuation Coverage may be available if the affected individual is not eligible for Medicare.

If you are receiving long-term disability benefits (e.g., from the Comprehensive Protection Plan or UMLifeOptions), remain in HealthFlex under your Plan Sponsor's policy, and you or your Dependent become eligible for Medicare for any reason, Medicare will begin paying primary to HealthFlex for you or Dependent, as applicable, once you've received disability benefits for six months.² If the individual who is eligible for Medicare fails to enroll in Medicare, that individual may incur a lifetime late enrollment penalty assessed by Medicare upon later enrollment. In addition, if you are Medicare eligible due to disability and enroll in a HealthFlex Benefit Option, the Plan automatically assumes *you are enrolled in* Medicare Part B when it calculates benefit payments. The Plan pays after Medicare pays (i.e., the Plan is the secondary payer). If you are eligible for Medicare Part B due to disability, but you do not enroll in Medicare Part B, you will incur additional out-of-pocket expenses that the Plan will not pay.

Disabled Participants and Dependents who meet the requirements for Medicare to act as primary payer for medical claims can elect to enroll in the Medicare Connector Program (i.e., Via Benefits™) if elected by the Plan Sponsor.

² You are generally entitled to coverage under Medicare Part A unless you are a clergyperson who has opted out of Social Security.

Coverage in Retirement Prior to Age 65

The following rules govern HealthFlex coverage for retired Participants prior to Medicare eligibility.

General Eligibility

You must meet certain criteria to enroll in HealthFlex as a retired Participant. You must meet the Plan's criteria and the eligibility rules of your Plan Sponsor.

For example, your Plan Sponsor may require that you be covered by its group health plan or have served or been employed longer than the five-year continuous coverage requirement under the Plan. Some Plan Sponsors require more than five years of service for eligibility in retirement. Your Plan Sponsor might not offer benefits to early retirees. Your Plan Sponsor's additional eligibility requirements can be more restrictive than the Plan's general rules, but they cannot be more generous.

Electing Coverage or Postponing Your Election

You must enroll in the Plan as a retired Participant within 30 days of your retirement unless you have Other Health Coverage at the time of retirement. Retirement in this context means early or normal retirement, as soon as you first become eligible for coverage as a retiree under the Plan and your Plan Sponsor's rules, regardless of whether you are eligible yet for Medicare. If you have Other Health Coverage at the time of retirement, you may be eligible for HealthFlex retiree coverage if you lose the Other Health Coverage, depending on the rules of your Plan Sponsor. Your Plan Sponsor is obligated to provide you with the necessary forms and information prior to that date.

Required Contributions

The amount you will pay for coverage as a retired Participant can vary. Your Plan Sponsor determines how much of the cost of coverage, the Required Contribution, you will share. Your Plan Sponsor designates the Premium Credit (Plan Sponsor portion of the Required Contribution) and you are required to pay the rest. Your Plan Sponsor might cover the entire Required Contribution of your plan(s) or might assign the entire Required Contribution of your plan(s) to you. Your Plan Sponsor should have a written policy that describes how it shares the cost of coverage with you. Be sure to obtain cost-sharing information from your Plan Sponsor annually.

Pre-Tax Premium Contributions and Flexible Spending Accounts (FSAs)

Generally, retired Participants are not eligible for the cafeteria plan to (i) pay for coverage on a pre-tax basis, or (ii) defer money to flexible spending accounts. A limited exception applies to retired Participants who are actively at work and enrolled in the Plan as an active Employee. The portion of the Required Contribution paid by your Plan Sponsor may be a tax-free benefit to you as a result of your "former employment relationship." Contact your tax adviser for additional information.

Spouses and Dependents

Your Spouse at the time you retire is eligible to become a retired Participant if he or she has met any additional requirements of your Plan Sponsor, such as a longer period of coverage. Your Spouse or other Dependent will immediately lose eligibility if you lose eligibility, other than if you die. Your Spouse is subject to the Plan's rules for coverage in retirement, as well as the eligibility rules of your Plan Sponsor. Contact your Plan Sponsor for more information.

Generally, a new Dependent acquired by a retired Participant after his or her retirement date is not eligible for HealthFlex.

Surviving Spouses and Dependents

Plan sponsors can elect to cover surviving Spouses and surviving Dependents of active and retired Participants. The same general rules apply to surviving Spouses and Dependents as apply to retired Participants. If a surviving Spouse remarries, he or she may retain HealthFlex coverage as a surviving Spouse. However, he or she may not enroll new Dependents acquired after the primary Participant's death; those Dependents are ineligible for coverage under HealthFlex. A surviving Dependent who is the child of a deceased Participant may continue coverage as a surviving Dependent under the Plan until he or she no longer meets the Plan's definition of a Dependent child (e.g., by reaching a limiting age).

Divorced Spouses

If you are the former Spouse (Divorced Spouse) of a Participant, i.e., you are divorced or legally separated from the Participant, you may be eligible to participate in the Plan if the Participant is made responsible through a court order for:

- the majority of your financial support; or
- your medical or other health care expenses.

You or the Participant must notify Wespath or your Plan Sponsor of a divorce in a timely manner.

In the event that the Participant is not required to cover you by court order, you may be eligible for up to 24 months of Continuation Coverage. See the section entitled *Continuation Coverage* for additional information.

Medical Reimbursement and Dependent Care accounts are not available to you as a Divorced Spouse. If you remarry, you remain eligible under the Plan, unless the court order provides otherwise. New Dependents acquired after the divorce are not eligible for coverage through a Divorced Spouse under the Plan. If a former Spouse is covered through Continuation Coverage (see below), then Dependents acquired after the divorce may be eligible for coverage for the remainder of the Spouse's Continuation Coverage. Divorced Spouses are subject to the same one-time election and continuous coverage rules that apply to retired Participants (see above). As a Divorced Spouse, you, or the Participant on your behalf, must pay the Required Contribution for coverage.

Domestic Partner Coverage

A Plan Sponsor may elect, through its Adoption Agreement, to offer coverage for the same-sex partner (Civil Partner) of a Participant who has entered a civil union or domestic partnership, which, under the law of the State in which the Participant resides, generally provides the same substantive and procedural rights, privileges and immunities as marriage. Such coverage shall be subject to the limitations of federal law, i.e., with respect to the Code, and the conditions described in Judicial Council Decision Nos. 1030, 1075, and 1264, and *The Book of Discipline*, as explained below.

Under federal law, health insurance benefits for Civil Partners is considered taxable income to the employee (participant). If a plan sponsor or employer were to pay for the coverage of a Civil Partner under HealthFlex, (i.e., pay the same share of the premium as it does for a spouse), then the fair-market value (i.e., the difference in premium) of that additional employer-paid coverage is treated as imputed income to the employee—subject to federal income and employment (FICA) taxes. However, for state income tax purposes, this coverage may be treated as tax-exempt (depending on the state's income tax laws), so the employee may not be subject to state income tax on the value of the added coverage of a Civil Partner.

In addition, unless his or her Civil Partner is a tax dependent under Code §152, an employee may not make pre-tax contributions to a cafeteria plan on behalf of a Civil Partner. As such, the employee responsibility portion of the premium that is attributable to the Civil Partner coverage generally must be paid on an after-tax basis. An employee also may not receive reimbursement for expenses of the Civil Partner from flexible spending accounts (FSAs) under HealthFlex, unless the Civil Partner is a Code §152 dependent. An employee may receive reimbursements for eligible medical expenses of a Civil Partner from health reimbursement accounts (HRAs) under HealthFlex; however, the contributions to the HRA must be treated as imputed income to the participant, subject to federal income and employment taxes.

The Judicial Council of The United Methodist Church has ruled, in Decision No. 1075, that an annual conference health plan providing health benefits to domestic partners of lay employees did not violate *The Book of Discipline*. The plan in that case required the employee to pay the full additional premium cost for the coverage of his or her partner. The Judicial Council held that the plan did not violate ¶1806.9 or ¶1613.19 of *The Book of Discipline*, because the annual conference council on finance and administration (CCFA) had determined that the plan did not inappropriately use church funds to promote the acceptance of homosexuality. Plan Sponsors considering providing this coverage should review Decision No. 1075.

On April 28, 2014, the Judicial Council ruled in Decision No. 1264 that expanding the definition of “spouse” in the General Agencies Welfare Benefits Program [GAWBP, the health plan maintained by the General Council of Finance and Administration (GCFA) for the program agencies] to include same-sex spouses and Civil Union partners in states that have established civil unions is not a violation of ¶806.9 of *The Book of Discipline*. The Judicial Council ruled that GCFA was authorized by ¶806.9 to make this determination. Furthermore, for the GAWBP, the general agency paying the cost of health coverage for the employee and his or her spouse or partner does not violate ¶806.9. HealthFlex plan sponsors considering covering Civil Partners should consult with their CCFA and consider Decision Nos. 1030, 1075 and 1264.

One Type of Coverage

You may not participate in this Plan as an Employee and as a Dependent, and your Dependent may not participate in this Plan as a Dependent of more than one Employee. You may not participate in this Plan and the Medicare Connector Plan (i.e., Via Benefits™).

Waiting Periods

Contact your Plan Sponsor for details regarding your waiting period, if any.

Effective Date of Your Coverage

You will become a covered Participant on the date you elect coverage by signing an approved *HealthFlex Enrollment/Change Form (Enrollment Form)*. You will not be denied enrollment for coverage due to your health status. It is your Plan Sponsor’s responsibility to provide all completed enrollment materials, including your *Enrollment Form*, to Wespath within 30 days of your eligibility date. Failure by your Plan Sponsor to perform this duty may subject you to adverse consequences.

Coverage for your Dependents, if they are eligible, will be effective on the date you elect such coverage on an approved *Enrollment Form*. Your Dependents will be covered only if you are covered under the Plan.

Newborns

Any Dependent child born while you are covered under the Plan will become covered on the date of his or her birth if you elect Dependent coverage no later than 60 days after the birth. If you do not elect to cover your newborn child within 60 days, coverage for that child will end on the 31st day.

Adopted Children

Any child whom you adopt, including a child who is placed with you for adoption, will be eligible for Dependent coverage upon the date of placement with you. The Plan will consider a child placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption. If a child placed for adoption is not adopted, all health coverage ceases when the placement ends and will not be continued.

Grandchildren

Any grandchild born while your Dependent is covered under the Plan will become covered on the date of his or her birth. Coverage will terminate on the last day of the month in which the child is 31 days old. Coverage will include only normal newborn charges incurred during the inpatient stay (such as initial facility, physician visit and lab service). Any charges for additional services beyond the specified normal newborn charges will not be covered.

Termination of Coverage

Termination of Coverage—Employees

Your coverage will cease on the last day of the month in which the earliest of the following dates occurs:

- the date you cease to be in a class of eligible Employees as described above;
- the last day for which you have made any Required Contributions for coverage;
- the date Wespath terminates the Plan;
- the date Your Plan Sponsor terminates its participation in the Plan; or
- your employment ends.

Leave of Absence

If your employment ceases due to a leave of absence, your coverage will be continued according to the terms set by your Plan Sponsor. However, the coverage will not continue beyond the date your Plan Sponsor ceases paying Required Contributions for you.

Other Events Ending Your Coverage

When any of the following happen, Wespath may terminate your coverage, and it or the Claims Administrator will provide you written notice that your coverage has ended.

- **Fraud, Misrepresentation or False Information**—You commit fraud or misrepresentation, or you knowingly Wespath or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent.
- **Material Violation**—You materially violate the terms of the Plan.
- **Improper Use of ID Card**—You permit an unauthorized person to use your ID Card, or you use another person's card.
- **Threatening Behavior**—You commit an act of physical or verbal abuse that poses a threat to Wespath's staff, the Claims Administrator's staff, a provider or other Participants.

Termination of Coverage—Dependents

Coverage for your Dependents will cease on the earliest of the following dates:

- the date your coverage ends;
- the last day for which you have made any Required Contributions for coverage; or
- the last day of the month in which your Dependent ceases to be a Dependent as defined in the Plan.

Generally, when your coverage terminates, you will have the opportunity to elect Continuation Coverage for you and your Dependents.

Continuation Coverage

The Plan does not offer Continuation Coverage under the terms of COBRA³. COBRA is the federal Continuation Coverage law that applies to most employer group health plans. Because HealthFlex is a Church Plan, the Plan is exempt from COBRA requirements by federal law⁴.

However, Continuation Coverage that is similar to COBRA coverage in some (but not all) respects is offered by the Plan. If you lose coverage⁵ under the Plan under certain circumstances, you may elect Continuation Coverage. Medical, mental health and prescription drug coverage are included in the Plan's Continuation Coverage, as well as wellness benefits typically included in the plan. Continuation Coverage does not include dental, vision or health care flexible spending account coverage, because they are limited scope benefits. A dependent care flexible spending account is not considered a health plan and therefore is not part of Continuation Coverage. Generally, the Plan offers Continuation Coverage for 18 months from the date you lose coverage⁶. The individual who elects Continuation Coverage will remain in his or her then-currently elected Benefit Options for the remainder of the Plan Year in which the loss of eligibility occurred.

Continuation Coverage for a Spouse who loses coverage in the case of a divorce from a Participant is 24 months. Generally, if you were a primary Participant in HealthFlex, HealthFlex will consider your newly acquired Dependents during a period of Continuation Coverage to be eligible for coverage for the remaining period of your Continuation Coverage (however, you must pay an additional Required Contribution for such coverage). However, if you were a Dependent in HealthFlex, HealthFlex will not consider your newly acquired Dependents to be eligible for coverage for the remaining period of your Continuation Coverage.

³ The Consolidated Omnibus Budget Reconciliation Act of 1985.

⁴ Under §4980B(d) of the Code and Treasury Regulation §54.4980 B-2, Q. and A. No. 4.

⁵ Loss of coverage may be, for example, by reason of termination of employment, attainment of a limiting age, divorce or death.

⁶ The Plan may offer longer periods of coverage in certain circumstances.

You must notify your Plan Sponsor and Wespath of events that may cause a loss of coverage under the Plan, such as a divorce or a child reaching a limiting age. Generally, when you or your covered Dependents lose coverage under the Plan, coverage terminates at midnight on the last day of the month in which the event ending eligibility occurs. Wespath or its agent will inform you of the termination of coverage and opportunity to elect Continuation Coverage, if applicable, within 10 business days of when Wespath is notified.

The Plan will only offer Continuation Coverage to you if you have been covered under the Plan for at least ninety (90) days. In addition, Continuation Coverage is not available to you or your Dependents if your participation in HealthFlex is ending due to failure to pay Required Contributions timely either by the Plan Sponsor or by you as determined by Wespath.

If you are offered Continuation Coverage, you have 60 calendar days from the date you lose coverage to elect Continuation Coverage. If you do not elect Continuation Coverage within this time limit, you forfeit coverage. If you elect Continuation Coverage, you must pay the entire cost of coverage, in other words, the Employee and employer portions of the Required Contribution, on an after-tax basis. In addition, the Plan Sponsor may elect to impose a 2% administrative surcharge on the premiums for Continuation Coverage.

Continuation Coverage will cease on the earliest of the following:

- the last day for which you have paid the Required Contribution for Continuation Coverage;
- the date you become eligible for coverage under another group health care plan, policy or under Medicare;
- the last day of the month of such Continuation Coverage in accordance with the terms of the Plan;
- the date the Plan terminates; or
- the date your Plan Sponsor terminates participation in the Plan.

If you are eligible for Medicare when your HealthFlex coverage ends, you will not be eligible for Continuation Coverage. If you are on Continuation Coverage and then become eligible for Medicare, your Continuation Coverage will end on the last day of the month that follows the month in which you became eligible for Medicare. You should contact your Plan Sponsor or Wespath if you have questions about Continuation Coverage. Also, if you elect Continuation Coverage, you are responsible for paying the required premiums to your Plan Sponsor. Wespath does not collect premiums from participants.

If you lose coverage under the Plan, there may be other coverage options for you and your family. Under the Affordable Care Act, you can purchase coverage through the online Health Insurance Marketplace (healthcare.gov). In the Marketplace, you may be eligible for an income-based tax credit (Premium Tax Credit, PTC) that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for Continuation Coverage does not limit your eligibility for coverage or for a premium tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees, if you request enrollment within 30 days.

PREMIUM CONVERSION PLAN

Pre-Tax Contributions

Through the "cafeteria plan" provisions of the Plan, you can pay the Required Contributions, often called premiums, for coverage under the Plan and its Benefit Options on a pre-tax basis. This is known as a premium conversion plan. You may do so if you are actively at work (i.e., not on a leave or assigned any non-salaried status). Your Required Contributions are deducted from your gross income each payroll period. Your new gross (taxable) income is your salary less the pre-tax contributions to the cafeteria plan. Alternatively, you can forego the benefits of the premium conversion plan, paying all Required Contributions on an after-tax basis. By choosing the latter, you are choosing cash, in the form of your full salary, over qualified benefits.

Wespath administers the Plan as a cafeteria plan under §125 of the Code. As such, you can only change your Benefit Options during Annual Election Periods and on account of certain Life Status Events. Please refer to the section of this SPD entitled *Life Status Events* for more information.

After-Tax Contributions

If you are not actively employed but remain covered (e.g., you are on a covered, unpaid leave of absence), you must pay the Required Contributions for your Benefit Option coverage on an after-tax basis.

Retired Participants and disabled Participants generally cannot participate in the cafeteria plan. In certain cases, you can request that Wespath deduct Required Contributions directly from your pension or welfare plan benefit payments on an after-tax basis, if they are administered by Wespath. In other cases, your Plan Sponsor will collect Required Contributions directly from you. Certain retired Participants who continue to work beyond retirement age or who return to work after retirement can continue to participate in the premium conversion plan and flexible spending accounts.

Elections

Generally, you are allowed to elect or change coverage (i.e., your Benefit Options and your flexible spending account contributions) only during each Annual Election Period. You may revoke or change your elections at other times of the year only as permitted by the Plan.

Because the Plan is designed to provide tax-advantaged benefits under §125 of the Code as a cafeteria plan, once you make your benefit elections for a Plan Year, you cannot change them, except in limited circumstances. The circumstances under which you may change your benefit elections are called Life Status Events, and they include rights stemming from Special Enrollment Events, as defined in HIPAA. Life Status Events and Special Enrollment Events are described below. Life Status Events are sometimes called “change of status events.”⁷

The rules that govern changing elections apply to Employees as well as Spouses and Dependents, surviving Dependents, retired Participants, Divorced Spouses, individuals on Continuation Coverage and all other Participants.

Changing Your Elections (the Cafeteria Plan Rules)

You may change your Benefit Option elections only under the following circumstances:

- during the Annual Election Period;
- if you experience a Life Status Event (as described below); or
- if you experience a Special Enrollment Event (as described below).

It is very important that you inform your Plan Sponsor of any Life Status Event within 31 days of the event. If you or your Plan Sponsor fails to inform Wespath of such an event in a timely manner, it may jeopardize your ability to make election changes and it can have adverse tax consequences or cause you to lose coverage.

Life Status Events

If you experience certain changes in your family’s status, you may be permitted to make limited changes to your HealthFlex elections. These Life Status Events include:

- marital status changes (e.g., marriage, divorce, legal separation);
- changes in the number of Dependents (e.g., an increase through birth or adoption or a decrease through death);
- Dependent ceases to qualify as a dependent under the Plan (e.g., reaching a limiting age) or regains eligibility;
- change in employment status⁸ of you or your Dependent that affects eligibility for the Plan (e.g., changing from full-time to part-time employment, commencement of or return from an unpaid leave of absence);
- HIPAA Special Enrollment Events (see below);

⁷ If you have an HSA, you can change the HSA election and contribution at any time without a Change of Status event. However, you cannot reduce your contribution mid-year to an amount less than what you have already contributed year-to-date into the HSA.

⁸ Appointment changes within a Conference and compensation changes alone are not considered Change of Status Events.

- change in residence⁹ that affects eligibility (e.g., moving out of the coverage area for a managed care option, such as an HMO); and
- You would like to cease coverage under HealthFlex in order to purchase coverage through a competitive Marketplace established under the Affordable Care Act.¹⁰

Any election changes you make based upon a Life Status Event must be on account of and consistent with such a Life Status Event. For example, when you acquire a new Dependent, the election change you would make for that Life Status Event would be to add coverage for that Dependent, not to drop coverage for other Dependents¹¹.

In certain other limited circumstances, you may make changes to your elections. These additional Life Status Events are:

- judgment, decree or order (i.e., a Qualified Medical Child Support Order);
- Medicare Entitlement (or loss of such entitlement);
- mid-year Plan changes (e.g., significant changes in the cost of coverage or significant curtailment of coverage during a Plan Year); and
- certain required circumstances under the Family and Medical Leave Act where applicable to your employer.

HIPAA Special Enrollment Events

If you decline coverage under the Plan, in certain situations you may be able to enroll in the Plan at the time you lose Other Health Coverage. This rule would also apply if you were assigned “No Coverage” by the Plan due to noncompliance with the 31-day Plan Sponsor signature requirement for enrollment.

The situations in which you may enroll in HealthFlex upon the loss of Other Health Coverage or in which you may make changes to certain elections are called Special Enrollment Events and are as follows:

- You decline coverage under HealthFlex for yourself because you have Other Health Coverage, COBRA or other continuation coverage, then you lose the Other Health Coverage because you are no longer eligible (e.g., due to an employment status change, divorce, death of a spouse etc.) or because the employer failed to pay the required premium, or you exhaust the COBRA or other continuation coverage period.
- You or your eligible dependent become eligible for a premium subsidy for coverage under HealthFlex through Medicaid or a state Children’s Health Insurance Program (CHIP).
- You decline coverage under HealthFlex for your spouse or dependent because your spouse or dependent has Other Health Coverage, COBRA or other continuation coverage, then your spouse or dependent loses the Other Health Coverage because he or she is no longer eligible (e.g., due to an employment status change, limiting age, etc.), because the employer failed to pay the required premium, or he or she exhausts the COBRA or other continuation coverage period.
- You gain a new dependent due to marriage, birth, adoption, placement for adoption or legal guardianship.
- Your plan or the plan of your spouse or dependent no longer offers a benefit option to an entire class of similarly situated individuals that includes you or your spouse or dependent.
- You are assigned “No Coverage” under HealthFlex because of non-compliance with the time requirements for Change of Status Events (see “Important Time Requirements for Change of Status Events” on page 3) and one of the above events occurs.

⁹ Changes in residence that affect eligibility for certain Benefit Options do not qualify as Change of Status Events for flexible spending accounts. Some events may qualify as Change of Status Events for flexible spending accounts (for example: marriage, divorce or birth of a child).

¹⁰ Participants must adhere to Plan Sponsor rules before waiving the plan. Participants who are declining coverage for certain reasons—as allowed under the Plan and permitted by their Plan Sponsor—do not trigger the Plan’s mandatory charges under its Preferred Risk Pool. Participants must contact their Plan Sponsor before waiving the plan.

¹¹ In accordance with IRS guidance, however, you can add other Dependents in addition to the newly acquired Dependent under what is known as the “tag-along” rule.

- You become ineligible for a Premium Tax Credit in the Affordable Care Act's Health Insurance Marketplace (Exchange).

In order to enroll in the Plan as a result of a Special Enrollment Event, you, your Spouse or Dependent must be otherwise eligible for coverage under the Plan, e.g., under your Plan Sponsor's Adoption Agreement.

If you do not experience a Life Status Event, you cannot change your elections at any time during the Plan Year.

Effective Dates of Coverage Changes Due to a Special Enrollment Event or Life Status Event

When you elect HealthFlex coverage due to a Special Enrollment Event or make an election change due to a Life Status Event, the effective date of the change will be as follows:

- **Special Enrollment Event—loss of Other Health Coverage:** HealthFlex coverage will be effective as of the first day you are without Other Health Coverage.
- **Special Enrollment Event—exhaustion of COBRA coverage or other continuation coverage:** HealthFlex coverage will be effective as of the first day you are without the COBRA coverage or other continuation coverage.
- **Special Enrollment Event or Life Status Event wherein you add a new Dependent to your family:** HealthFlex coverage will be effective as of the date of the marriage, birth, adoption, placement for adoption or legal guardianship, which is the basis for acquiring the Dependent.
- **Life Status Event wherein a Dependent regains eligibility:** HealthFlex coverage will be effective as of the date the Dependent first meets the eligibility requirements.

Although coverage may be effective retroactively on account of these events, pre-tax cafeteria plan elections cannot be retroactive. Required Contributions for retroactive coverage must be paid on an after-tax basis. If you make a change to your health care flexible spending account or dependent care flexible spending account on account of a Life Status Event, when permitted under the Plan, the effective date of that change will be the first day of the month following the election change. When you lose or decline HealthFlex coverage due to a Change of Status Event, termination is effective on the last day of the month in which the Change of Status Event occurred. *(See examples that follow.)*

Example 1:

John has declined HealthFlex coverage because he has coverage through his spouse's employer. John's spouse subsequently loses the Other Health Coverage because her employment is terminated. The last day of coverage under the Other Health Coverage plan is March 31. John notifies his Plan Sponsor and receives a *HealthFlex Enrollment/Change Form*. He completes and returns the *Enrollment/Change Form* to his Plan Sponsor's office. All of this must be done so that the Plan Sponsor can sign the *Enrollment/Change Form* by the end of the business day on April 30. Coverage is effective April 1.

Example 2:

Susan is covered under HealthFlex. She also covers her husband and son. On May 12, Susan gives birth to her daughter, Alicia. Susan notifies her Plan Sponsor of the birth and receives an *Enrollment/Change Form*. She completes the *Enrollment/Change Form*, adding Alicia as a covered Dependent and returns it to her Plan Sponsor's office. All of this must be done so that the Plan Sponsor can sign the *Enrollment/Change Form* by the end of the business day on July 11. Coverage is effective May 12.

If you fail to meet the timeliness requirement, you cannot make coverage or election changes due to the Life Status Event (Special Enrollment Event or otherwise), and you will have to wait until the next Annual Election Period to make the change.

Other Life Events

In addition to the events described above, certain other events can change your coverage and elections:

- **Disability Medicare Entitlement:** When you become eligible for Medicare due to disability, you may elect to change coverage to Medicare supplemental coverage offered by your plan sponsor, if any.
- **Medicare Secondary Payer Small Employer Exception (MSPSEE):** If you are a Medicare-entitled Participant actively working for a small employer in the MSPSEE program, you may be covered under the Medicare supplemental coverage offered by your plan sponsor, if any.

Termination of Employment

If you terminate employment, you will no longer be eligible to participate in the premium conversion plan. Typically, your pre-tax contributions (and Plan coverage) will continue through your last regular payroll period. Contact your Plan Sponsor for more information regarding pre-tax contributions if your employment terminates. If you terminate employment, your participation in the health care FSA and dependent care FSA will terminate at the end of the month in which you terminated employment.¹² You must submit your Claims within 90 days of termination to receive reimbursement for eligible expenses incurred prior to termination.

If you terminate employment and are rehired in the same calendar year, you must make a new FSA election or wait until the next Plan Year to participate (i.e., your FSA from before termination are not automatically renewed if you are rehired).

Key Provisions of the Flexible Spending Accounts

- To use an FSA each year, you must elect to contribute part of your compensation to the FSA during the Annual Election Period or upon enrollment in the Plan. If you make no election, you will not have an FSA for that year; your contributions will be zero. *FSA elections do not carry over from year to year.*
- For the health care FSA, the total annual amount that you elected to contribute for the Plan Year is available at any time during the Plan Year (reduced by the amount of prior health care FSA reimbursements already paid to you). For the dependent care FSA, only the amount your employer has withheld from your pay, minus expenses already reimbursed, is available to you at any time during the Plan Year.
- You must incur the eligible expenses during the Plan Year. Expenses are incurred when services are performed, not necessarily when payment is made (subject to certain exceptions for orthodontia and eyeglasses).
- The amount you elect to contribute is for a Plan Year (calendar year), not a conference or appointment year or season. If you enroll in the program mid-year and elect to contribute to an FSA, your election will apply to the remaining portion of the Plan Year.
- If you terminate from HealthFlex, you have **90 days** from the date of termination to submit all Claims you incurred before your termination date (see *Termination of Employment* above).
- Eligible health care FSA expenses must be allowed as deductions for medical expenses as described in §213(d) of the Code, other than premiums for health insurance or coverage (Required Contributions). Eligible health care FSA expenses may include Deductibles, Co-payments and amounts over the maximum the Plan pays for reasonable and customary care. Other health care charges that may be reimbursed include routine physicals, vision care, hearing care, dental care and orthodontic care. In addition, expenses for many over-the-counter medications may be reimbursable.
- Examples of expenses specifically non-reimbursable under the health care FSA include cosmetic surgery that does not treat an illness or disease, gym membership fees, costs of weight loss programs done for your general health, long-term care expenses and premiums you pay for insurance coverage.
- Expenses that are reimbursed through the health care FSA cannot also be used as deductible expenses when filing your personal income tax return. However, the health care FSA allows you to reduce taxes on many health-related expenses, even if the expenses do not exceed the 7.5% of your gross income required to claim them as a deduction on your personal income tax return.
- You cannot change the amount you elected to set aside in your FSAs during the Plan Year. Generally, you may contribute a minimum of \$300 and up to the IRS maximum for the dependent care FSA and the health care FSA, to be deducted from your pay in equal amounts throughout the year. However, certain Life Status Events may allow you to make election change during the Plan Year [see *Life Status Events* under *Changing Your Elections (the Cafeteria Plan Rules)* above].
- The Claims Administrator will reimburse your dependent care FSA Claim up to the available balance in your dependent care FSA at the time you submit the Claim. If there are insufficient funds in your dependent care FSA to

¹² If you terminate on the first day of the month, your participation in an FSA will terminate on the last day of the prior month.

reimburse the entire Claim, the remaining amount of the Claim will be paid as soon as there have been enough payroll deductions credited to your dependent care FSA. You will not have to re-submit the Claim.

- You have tax reporting requirements related to the dependent care FSA that you should make sure you understand. You are responsible for complying with all tax requirements.
- Wespeth may amend or terminate the cafeteria plan at any time. Your consent is not required to terminate the Plan.

Tax Consequences for You

There are important tax implications associated with electing to pay your Required Contributions through the cafeteria plan and with contributing to an FSA. You may want to speak with your tax adviser before electing to participate in the FSA if you have questions about the tax savings and implications. Salary reduction contributions will reduce your gross taxable income for Social Security purposes. This means that your future Social Security benefits could be impacted by the decreased amount of taxable income considered for Social Security purposes.

YOUR HEALTHFLEX BENEFITS

Benefit Options

Plan Sponsors offer a choice of medical/behavioral health, prescription drug, dental and vision Benefit Options to their Employees. A Participant must be covered under a Benefit Option in order for Dependents to be covered under that Benefit Option, unless the Participant is eligible for a Plan Sponsor's Medicare Benefit Option and Dependents are eligible for the HealthFlex Benefit Options.

HealthFlex makes available all of the HealthFlex Benefit Options (i.e., medical/behavioral health, prescription drug, dental and vision) to eligible Participants. Each medical Benefit Option includes behavioral health services and is coupled with a prescription drug plan. The Plan Sponsor may offer a Premium Credit as a component of HealthFlex. The Premium Credit is a fixed amount that the Plan Sponsor allocates to each HealthFlex Participant, depending on eligibility status. A Participant must be covered under the medical Benefit Option in order to be eligible for the Premium Credit. Each Plan Sponsor determines the Premium Credit amount(s) for the applicable subgroups of its population. The Premium Credit is credited toward the overall cost of the plan(s). As the participant, your Required Contribution is the remainder of the plan cost after the Premium Credit has been applied. If you elect Benefit Option(s) that cost less than the Premium Credit, the excess Premium Credit will be deposited into your health account: into a health reimbursement account (HRA) if a preferred provider organization (PPO) or HRA plan Benefit Option is elected, or into a health savings account (HSA), if an HSA plan Benefit Option is elected. If you elect a Benefit Option that costs more than the Premium Credit, the remaining Required Contribution will be deducted on a pre-tax basis from your paycheck. Your Salary Paying Unit is responsible for implementing the deduction of the remaining Required Contribution. The Required Contribution deducted from your paycheck is eligible for the Premium Conversion portion of the Plan's cafeteria plan.

Wespeth can add new Benefit Options and can eliminate or discontinue any existing Benefit Options at any time. However, Wespeth will provide you and your Plan Sponsor reasonable notice in such cases, barring extraordinary circumstances.

For detailed information about the Plan's Benefit Options and the specific terms and conditions of the benefits offered under each, please review the benefit summaries and the *HealthFlex Benefit Booklet* (available online) for the Benefit Options in question, or the certificate of insurance applicable to each Benefit Option. Go to **BenefitsAccess.org**, select the **Health** tab, and then select **Plan Details** on the Health tab.

Medical Benefit Options for Medicare-Eligible Participants

Participants who are enrolled in Medicare (e.g., enrolled in Medicare due to disability or enrolled through the Medicare Secondary Payer Small Employer Exception) are not eligible to contribute to an HSA and therefore should consider not electing an HSA plan.

You and your Dependents generally must be covered under the same Benefit Option, even if you live in different geographic areas. In certain circumstances, you and your Dependent can be covered under different Benefit Options due

to factors such as age and Medicare eligibility. For example, a retired Participant who is older than age 65 will be covered in a Medicare supplement plan outside of HealthFlex while his or her Spouse or Dependent who is younger than age 65 will remain enrolled in a medical Benefit Option for active Participants.

Coverage and Benefits—HealthFlex Benefits

You can find detailed descriptions of your HealthFlex Benefit Option and the rules governing it, including coverage, exclusions, network restrictions, covered procedures and specific costs, in the *HealthFlex Benefit Booklet*. In addition, you can find summary information in the benefit summary applicable to your Benefit Option online at BenefitsAccess.org (log in to **Benefits Access**; select the **Health** tab at the top of the page, and then select “**Plan Details**” at the top of the Health page. You can also call your Claims Administrator or the Wespath Health Team for information about your coverage and benefits.

Other Claims and Appeals Procedures

The following appeals procedures apply when you wish to appeal a Claim regarding your elections, eligibility, enrollment, or reimbursement from a health reimbursement account, health savings account, flexible spending account.

HealthFlex Election, Eligibility and Enrollment Appeals

As the Plan’s administrator, Wespath is charged with determining:

- your eligibility for coverage under the group health plan, flexible spending account and health savings account components of the Plan in accordance with the Plan and your Plan Sponsor’s Adoption Agreement;
- premium conversion plan benefits;
- your ability to make elections and the validity thereof; and
- your proper enrollment.

If you have a Claim under the Plan related to eligibility, enrollment or elections, you must submit the Claim in writing to Wespath at:

Wespath
Attention: *Health Team*
1901 Chestnut Avenue
Glenview, Illinois 60025

You may also submit the Claim via email to healthteam@wespath.org.

Wespath will treat Claims submitted in writing as initial Claims. In addition, Wespath, in its discretion, can treat a Claim raised by telephone with the Health Team as an initial Claim. Moreover, in its discretion, Wespath can treat an inquiry raised by your Plan Sponsor or other representative as an initial Claim.

Wespath will promptly consider your Claim and notify you in writing of the Plan’s decision within 30 days of receipt of the Claim. This period may be extended one time by the Plan for up to 15 days, provided that Wespath both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If Wespath denies any Claim under the Plan, in whole or in part, Wespath will provide you written notice setting forth:

- the specific reason or reasons for the denial;
- reference to pertinent provisions of the Plan on which the denial is based;
- a description of any additional material or information necessary for adjudicating the Claim and an explanation of why such material or information is necessary; and
- an explanation of the Plan’s appeals procedures.

First Appeal

You or your representative then has 45 days from the date of the notice of denial from Wespath in which to submit an initial appeal (Initial Appeal). The Claim denial from Wespath should contain a *Notice of Initial Appeal*. You should carefully read the *Notice of Initial Appeal* and follow the time frames set out therein.

On appeal, you may submit documentation that supports your Claim, such as additional facts, information, documentation or arguments, to the Initial Appeal Committee. The Initial Appeal Committee will only consider those issues and supporting documents that are submitted with the Notice of Initial Appeal, except by its leave or discretion. The Initial Appeal Committee will be guided by an assigned Compliance Specialist. The Compliance Analyst, at her or his discretion, may speak with you to gather more facts and allow you to explain your Claim and argument. The Initial Appeal Committee will review and consider: (i) the facts and circumstances; (ii) your argument; (iii) the applicable provisions from the Plan Document, *Summary Plan Description*, *HealthFlex Benefit Booklets* and other pertinent documents; and (iv) any mitigating circumstances, and then make its determination.

The Initial Appeal Committee will grant or deny your Claim and notify you of the decision within 45 days of receiving your *Notice of Initial Appeal*. If the Initial Appeal Committee denies your appeal, you will receive a letter of denial that sets forth the specific reason for the denial.

Intermediate Appeal

If your claim for benefits is fully or partially denied by the Initial Appeals Committee, your appeal will be referred to the Intermediate Appeals Committee for consideration. The Intermediate Appeals Committee is free to reconsider all aspects of the Claim and the evidence anew and is not bound by any decision or theory of the Claim at a lower level. The Intermediate Appeals Committee will decide your appeal within 90 days.

The Intermediate Appeals Committee will notify you in writing of its decision, citing the specific reasons for the decision and the provisions of HealthFlex upon which the decision is based.

Final Appeal

You may appeal the Intermediate Appeal Committee's denial of your Claim by submitting, within 90 days of the notice of denial from the first appeal, a *Notice of Final Appeal* and documentation that supports your Claim, such as additional facts or information tending to dispute Wespath's interpretation of the Plan or the facts upon which Wespath based its Claim denial decision. The Final Appeals Committee will only consider those issues and supporting documents that are submitted with the *Notice of Final Appeal*, except by its leave or discretion. You must file your appeal on the forms required by Wespath.

The Final Appeals Committee will hold a hearing of the intermediate appeal within 60 days of the date that Wespath receives both the *Notice of Final Appeal* and all supporting documentation. Upon receipt of your completed Notice of Final Appeal, Wespath will send you a letter 1) confirming receipt of the *Notice of Final Appeal* and supporting documentation, if any, and 2) informing you of a scheduled hearing date. You may request a delay of the scheduled hearing for up to 45 days. The Final Appeals Committee will respond to you in writing with a decision within 30 calendar days after you requested a delay. If the Final Appeals Committee requires more time or information to make its determination, the Final Appeals Committee will notify you in writing within the initial 30 days to request an extension of up to 45 calendar days, if, at the discretion of the Final Appeals Committee, such extension is necessary, and to specify any additional information the Final Appeals Committee requires to complete the review.

You or your duly authorized representative may present your appeal to the Final Appeals Committee in person or by conference call. If you or your representative choose to appear at the hearing in person, you will be wholly responsible for all costs associated with such appearance.

Health Reimbursement Account (HRA), Health Savings Account (HSA) and Flexible Spending Account (FSA) Claims

You must submit Claims for reimbursement from the health care or dependent care FSA to Health Equity. Through contracts with Health Equity, Wespath has delegated administrative duties to process and review only initial Claims. If Health Equity denies your Claim for HRA, HSA or FSA reimbursement and you wish to appeal the denial, you must follow the appeals process outlined above for eligibility, enrollment and election Claims.

Addresses and other details for filing claims with Health Equity are provided in the *HealthFlex Benefit Booklets* or accessed through **BenefitsAccess.org**. Click the **Health** tab at the top of the page and then select **Plan Details** on the Health Tab. Additional information is found in the **Reference Center**.

ERISA and DOL Regulations Inapplicable

The Plan is a Church Plan. As a Church Plan, the Plan is exempt under §4(b)(2) of ERISA from all the requirements of Title I of ERISA. The Plan is not subject to most of the regulations promulgated by the U.S. Department of Labor.

Grievances

If you have a concern regarding a person, a service, the quality of care or benefits under the Plan, you can write to Wespath to explain your concerns. If you are unhappy with Wespath's customer service or with the design of the Plan (i.e., specific exclusions under the Plan), or if you have other complaints or concerns, you should explain your grievance in writing and send it to Wespath at:

Wespath
Attention: Legal Services Department
1901 Chestnut Avenue
Glenview, Illinois 60025

You may also submit grievances to your Plan Sponsor.

Legal Action Against the Plan

No Participant or other Claimant may sue or pursue a cause of action in law or equity in state or federal court against the Plan, Wespath, any of the Claims Administrators or insurers, or Plan Sponsors, with respect to any Claim of any kind until the Participant or Claimant has exhausted these Claims and appeals procedures. The Participant or Claimant must sue within three (3) years of the time the Claim arose, unless the law in the area where the Participant or Claimant lives allows for a longer period of time.

LIMITATIONS AND EXCLUSIONS

Please consult the HealthFlex Benefit Booklet for Plan limitations and exclusions.

Coordination with Medicare

A series of federal laws, collectively referred to as the Medicare Secondary Payer (MSP) laws, regulate the manner in which the Plan may offer group health care coverage to Medicare-eligible Employees, Spouses and, in some cases, Dependents.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (GHP) coverage (HealthFlex coverage), as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

- A GHP that covers individuals with end-stage renal disease (ESRD) during the first 30 months of Medicare eligibility. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."
- In the case of individuals age 65 or older, a GHP of an employer that employs 20 or more people, if that individual or the individual's Spouse (of any age) has "current employment status." If the GHP is a multiemployer or multiple employer plan that has at least one participating employer that employs 20 or more people, the MSP rules apply,

even with respect to employers of fewer than 20 people (unless the Plan elects the small employer exception under the statute, which HealthFlex has done for some Plan Sponsors).

- In the case of disabled individuals younger than age 65, a GHP of an employer that employs 100 or more people, if the individual or a member of the individual's family has "current employment status" with the employer. If the GHP is a multiemployer or multiple employer plan that has at least one participating employer that employs 100 or more people, the MSP rules apply, even with respect to employers of fewer than 100 employees.

Please note: Contact Wespath or your Claims Administrator if you have questions regarding the ESRD period or other provisions of the MSP laws and their application to you.

When HealthFlex Pays Secondary to Medicare

The Plan will pay secondary to Medicare only as permitted by the MSP rules for the following:

- a *former or retired* Employee or Participant who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;
- a *former or retired* Employee's or Participant's Dependent or a former Dependent Spouse who is eligible for Medicare for any reason and whose coverage is continued for any reason as provided in this Plan;
- an Employee or Participant who is not actively working and is eligible for Medicare due to disability;
- an Employee or Participant or a Dependent of an Employee or Participant of an employer who has fewer than 20 employees, if that person is eligible for Medicare due to age and the Plan Sponsor has elected the Medicare Secondary Payor Small Employer Exception (upon CMS approval); and
- an Employee or Participant, former or retired Employee or Participant, Employee's or Participant's Dependent or retired Employee's or Participant's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

In addition, the Plan will pay secondary to Medicare as permitted by the MSP rules for an Employee or Participant who is not actively working due to disability and is receiving long-term disability benefits (e.g., from the Comprehensive Protection Plan or UMLifeOptions) or a Dependent of such an Employee or Participant once the Employee or Participant has received such benefits for six months.¹³

The Plan will not cover the cost of claims that would be paid:

- under Medicare Part A, if a person is eligible for Part A without premium, even if he or she has not applied; and
- under Medicare Part B, if a person is entitled to Part B, but did not enroll in Part B.

Your Medicare Secondary Payer Responsibilities

In order to assist your Plan Sponsor and Wespath in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claims Administrator, your Plan Sponsor and Wespath regarding your Medicare eligibility or that of your Spouse and Dependents. In addition, if you, your Spouse or your Dependents become eligible for Medicare, or have Medicare eligibility terminated or changed, please contact your Plan Sponsor or Wespath promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

¹³ Medicare may start paying primary earlier if the Participant is a clergy member and had a break in employment service prior to commencing long-term disability benefits. This must be determined based on the relevant facts and circumstances related to the break in employment status. This special rule will not apply when the Participant started receiving long-term disability benefits immediately or shortly after any applicable sick pay or short-term disability benefits ceased, even if the long-term disability benefits were paid retroactively.

REIMBURSEMENT

Recovery of Excess Benefits

If Wespath or the Claims Administrator makes payments for benefits that should have been paid by a Primary Plan (under *Coordination of Benefits*, above), or if Wespath or the Claims Administrator makes payments in excess of those for which the Plan is obligated to provide under its terms, the Claims Administrator and Wespath will have the right to recover the actual payment made, pursuant to a claim in equity. Wespath and Claims Administrator will have the discretion to seek such recovery from any person to, or for whom, or with respect to whom, such payments were made by any insurance company, Other Health Coverage or other organizations. You are required to execute and deliver to Wespath or the Claims Administrator the instruments and documents necessary to secure this right of recovery.

Expenses for Which a Third Party May Be Liable

The Plan does not cover expenses for which another party may be responsible as a result of having caused or contributed to the injury or illness. If you incur an expense for a covered service for which, in the reasonable opinion of the Claims Administrator, another party may be liable:

- The Claims Administrator shall, to the extent permitted by law, be subrogated (meaning it will stand in your place legally) to all rights, claims or interests that you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Plan. You or your representative may be required to execute the documents necessary to secure the Claims Administrator's subrogation rights.
- Alternatively, the Claims Administrator may, at its sole discretion, pay the benefits otherwise payable under the Plan. However, you must first agree in writing to refund to the Claims Administrator the lesser of: a) the amount actually paid for the covered services by the Claims Administrator, or b) the amount you actually receive from the third party for the covered services at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration, award or otherwise.

CONFIDENTIALITY, PRIVACY AND HIPAA

Wespath and all HealthFlex Plan Sponsors have a duty under HIPAA to maintain adequate separation of Plan functions and employment matters. Wespath permits disclosures relating to payment under, health care operations of, and other matters pertaining to the Plan in the ordinary course of business. Access to and use of personal protected health information (PHI) is limited to the minimum amount necessary to perform Plan administrative functions. Anyone employed by Wespath who does not comply with HIPAA and the related provisions of the Plan is subject to disciplinary action and sanctions.

PLAN SPONSOR DUTIES

Each Plan Sponsor has the following duties with respect to the Plan:

- to determine initial eligibility consistent with the terms of the Plan and to enroll clergy Employees and lay Employees within 30 days of each Employee becoming eligible;
- to maintain records of Employees' enrollment and elections;
- to remit Required Contributions to Wespath;
- to provide Wespath with notice of a Participant's termination of employment, termination of Conference relationship or Change of Status, where the Plan Sponsor is made aware of the Change of Status;
- to provide Wespath with statistical data and other information satisfactory in form and accuracy within a reasonable time after a request;
- to register with and report to government agencies, as appropriate;

- to comply with applicable federal and state laws and regulations, including, but not limited to, nondiscrimination requirements;
- to properly notify clergy Employees and lay Employees of their rights and obligations under the Plan, including giving notices required under the Plan, HIPAA or the Code;
- to comply with the terms of HIPAA; and
- to execute an Adoption Agreement indicating its elections of optional Plan provisions and providing any other information called for by the Adoption Agreement.

The Plan Sponsor may be deemed to satisfy its duties through actions by a Salary-Paying Unit (SPU) or other entity, but the Plan Sponsor remains responsible for the duties if they are not carried out in an appropriate manner or timely fashion.

PLAN SPONSOR AMENDMENT AND TERMINATION

Wespath may amend prospectively or retroactively any and all provisions of this Plan or an Adoption Agreement at any time by written instrument. A Plan Sponsor may amend its Adoption Agreement from year to year with respect to eligibility and Benefit Options.

Wespath may terminate a Plan Sponsor's association with the Plan for any reason by providing the Plan Sponsor 90 days' written notice. In addition, Wespath may terminate a Plan Sponsor for breach of the Plan's provisions or the terms of the Adoption Agreement, or for non-payment of Required Contributions if the Plan Sponsor does not rectify the breach or delinquency upon notice within 30 days. If a Plan Sponsor's participation in the Plan is terminated, the Plan Sponsor cannot re-adopt the Plan for a period of three years. The termination of a Plan Sponsor will not excuse the Plan Sponsor from making payment in full of all Required Contributions. Wespath will notify affected Participants in the case of a termination of a Plan Sponsor.

A Plan Sponsor may terminate its participation in the Plan by providing 180 days' notice to Wespath. Your Plan Sponsor must inform you of its termination from the Plan at least 60 days before the date of termination.

TERMINATION OF THE PLAN

Wespath has the right to terminate the Plan and the Trust at any time. The disposition of assets remaining in the Plan, if any, after all obligations of the Plan have been satisfied, will be at Wespath's discretion.

MISCELLANEOUS IMPORTANT PROVISIONS

Not Insurance

Use of the terms Co-insurance, Co-payment, Deductible and premium in this SPD or any other document related to HealthFlex does not imply that the Claims Administrators insure the Plan. Similarly, use of such terms does not imply that the Plan or Wespath is in the business of insurance. The Plan is offered by Wespath as a self-funded Church Plan only for the benefit of eligible clergy and Employees and their families of organizations affiliated with Wespath through The United Methodist Church.

Although Church Plans are considered employee welfare benefit plans under Section 3(1) of ERISA, as indicated by Section 4(b)(2) of ERISA, Title I of ERISA does not apply to Church Plans. Therefore, most regulations issued by the U.S.

Department of Labor do not govern the administration of the Plan. In addition, Church Plans are exempt from most state laws regulating insurers, such as state insurance licensing, solvency and funding requirements, by the Church Plan Parity and Entanglement Protection Act of 2000 (Parity Act). Self-insured Church Plans generally are not subject to many other

state laws and regulations that govern insurers because they are not in the “business of insurance,” and the Parity Act, along with certain state laws with respect to Church Plans, may exempt such Plans from state regulatory reach.

Interpretation of the Plan and Benefits

Wespath has sole and exclusive discretion to do all of the following:

- interpret the provisions and terms of and benefits available under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD; and
- make factual determinations related to the Plan and the benefits provided under it.

Wespath has delegated some of that authority to the Claims Administrators. Wespath has delegated the authority to adjudicate Claims and appeals to the Claims Administrators. Wespath and the Claims Administrators (with Wespath’s consent) may delegate this discretionary authority to other persons or entities that provide services to the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Wespath and the Claims Administrator may, in their discretion, offer benefits for services that would otherwise not be covered. The fact that Wespath and the Claims Administrators do so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

No Waiver

The failure of Wespath or the Claims Administrator to enforce strictly any term or provision of this SPD or the Plan will not be construed as a waiver of such term or provision. Wespath reserves the right to enforce strictly any term or provision of this SPD and the Plan at any time.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits under the Plan. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage or entitlements. Oral statements made by Wespath, the Claims Administrators or any other person will not serve to amend the Plan. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

Applicable Law

The Plan will be construed according to applicable federal law and the laws of the State of Illinois, other than its laws respecting choice of law, to the extent state laws are not pre-empted by federal law.

The Plan is intended to be and will be construed accordingly as:

- a cafeteria plan under Code §125(d) containing a medical expense reimbursement plan (health care FSA) under Code §105, a dependent care expense reimbursement plan (dependent care FSA) under Code §129, and a health savings account (HSA) under Code §223,
- an employee welfare benefit plan under ERISA §3(1), and
- a Church Plan under Code §414(e) and ERISA §3(33) exempt from Title I of ERISA by ERISA §4(b)(2).

In addition, state insurance laws and regulations will not apply to the Plan to the extent:

- they are pre-empted by federal law, including, but not limited to, ERISA, the Code, HIPAA and the Parity Act; and
- they are made inapplicable by state laws, regulations or case law that exempt self-insured plans from the applicability of state insurance statutes and regulations.

Plan Document Controls

If there are any discrepancies between this SPD and the terms and conditions set forth in the official plan document of the Hospitalizations and Medical Expense Program (Plan Document), the terms of the Plan Document will govern.

DEFINITIONS

Adoption Agreement

An Adoption Agreement is an agreement that is executed by each Plan Sponsor and becomes part of the Plan when it is accepted by Wespath. An Adoption Agreement is the means by which a Plan Sponsor adopts the Program and specifies any optional provisions, such as Benefit Options, that are a part of any Program as to that Plan Sponsor.

Affiliated Organization

The term Affiliated Organization means any of the organizations and corporations associated with Wespath through The United Methodist Church, as described in Section 414(e) of the Code.

Affordable Care Act (ACA or PPACA)

The Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act (Public-Law 111-152), i.e., the federal health care reform laws enacted in March 2010.

Annual Election Period

The term Annual Election Period means a period of time during which Participants and eligible Employees may elect Benefit Options for the following Plan Year for themselves and Dependents, by completing an election worksheet or making elections online through **BenefitsAccess.org** or the Annual Election portal. Wespath determines the period of time that is the Annual Election Period. For newly eligible Employees, there is a special enrollment period and election period that works as an Annual Election Period for the remainder of the Plan Year; this is the 31 days immediately following the date of hire by or appointment to the Plan Sponsor.

Benefit Option

Benefit Option means a qualified benefit under §125(f) of the Code that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan (such as a PPO or a HRA Plan option). In other words, under the Plan, generally, the B1000, HRA Plans, and HSA Plans for medical benefits with their corresponding prescription drug plans are considered separate Benefit Options. The Passive PPO and PPO dental plans, and the full-service and premier vision plans, also are considered separate Benefit Options.

The Book of Discipline

The Book of Discipline means the body of church law established by the General Conference of The United Methodist Church, as amended from time to time.

Calendar Year

The term Calendar Year means a 12-month period beginning on January 1 and each 12-month period thereafter (i.e., January 1 through December 31).

Church Plan

A Church Plan is an employee benefit plan established and maintained for its employees by a church or by a convention or association of churches as established in §414(e) of the Code and §3(33) of ERISA.

Claim

A Claim is notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, gender, identification number, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge and any other information that the Claims Administrator may request in connection with services rendered to you.

Claims Administrator

For medical and hospitalization services and mental and behavioral health benefits provided under the Plan's medical Benefit Options, the term Claims Administrator means Blue Cross and Blue Shield of Illinois with respect to first-level Claims and Quantum Health with respect to appeals of denied Claims. For administration of prescription drug benefits provided by the Plan, the Claims Administrator is OptumRx. For administration of dental benefits provided by the Plan, the Claims Administrator is Connecticut General Life Insurance Company (CIGNA). For administration of vision benefits provided by the Plan, the Claims Administrator is Vision Service Plan Insurance Company (VSP, Inc.). For administration of FSA or HRA Claims under the Plan, the Claims Administrator is Health Equity. Wespath has delegated certain administrative and fiduciary duties to the Claims Administrators pursuant to contractual arrangements, including, but not limited to, providing access to networks of providers, processing and paying Claims and hearing and deciding Claims appeals. The Plan's Claims Administrators may be changed at Wespath's discretion.

Code

The term Code means the Internal Revenue Code of 1986, as amended.

Conference

The term Conference means an Annual Conference, Provisional Conference or Missionary Conference of The United Methodist Church that is located in a Jurisdictional Conference in the U.S., as such entities are defined in *The Book of Discipline*.

Dependent

The term Dependent, for all Participants, regardless of a Participant's State of residence, means:

- your lawful Spouse; and
- any child of yours who is:
 - less than 26 years old; or
 - age 26 and older, unmarried and who is not self-supporting due to a physical or mental disability, provided the disability existed before the child attained the age of 26.

A child includes one who is in the custody of the Participant, pursuant to an interim court order of adoption or placement for adoption, whichever comes first, whether or not a final order granting adoption is ultimately issued. It also includes a stepchild who lives with you. It also includes a child living with you for whom you are the legal guardian. Benefits for a Dependent will continue until the last day of the calendar month in which age 26 is reached. No one may be considered as a Dependent of more than one Participant.

In addition, for purposes of the Health Care FSA, the term Dependent includes a Participant's child who has not attained age 27 as of the end of the Plan Year consistent with the tax exclusions for coverage and reimbursements under §105 and §106 of the Code.

For the purposes of the Dependent Care FSA, the term Dependent means an individual who is:

- a dependent (as defined in §152 of the Code) of a Participant: (1) who is physically or mentally incapable of caring for himself or herself, or (2) who is under the age of 13 and with respect to whom the Participant is entitled to a deduction under §151(c) of the Code; or
- a dependent (as defined in §152 of the Code) of the Spouse of a Participant, who is physically or mentally incapable of caring for himself or herself.

For 2020 and 2021 only, "age of 14" shall be substituted for "age of 13" in the first bullet above to the extent allowed by Section 214(d) of the Taxpayer Certainty and Disaster Relief Act of 2020 within the Consolidated Appropriations Act, 2021.

Disaffiliated Church

A Local Church that has disaffiliated from The United Methodist Church under the provisions of 2553 of *The Book of Discipline* or has changed its connectional relationship pursuant to 2548 or 2549 of *The Book of Discipline* or otherwise but retains common religious bonds and convictions with The United Methodist Church through shared heritage or Wesleyan/Methodist values and beliefs.

With respect to Disaffiliated Churches, certain terms of the Plan will be interpreted by Wespath in a manner that it deems reasonable and appropriate under the circumstances; for example, definitions that apply only to clergypersons of The United Methodist Church (such as “Under Episcopal Appointment”, “Conference”, or *The Book of Discipline* definitions) will be deemed inapplicable to clergypersons of a Disaffiliated Church, and will instead be interpreted in a manner that is reasonable and appropriate in that context.

Employee

For purposes of this SPD, the term Employee means a person who is described as an employee of a church in Sections 414(e)(3) or 7701(a)(20) of the Code, who is a clergyperson serving The United Methodist Church or a Disaffiliated Church or who is a common-law employee of Wespath or a Plan Sponsor, including a former Employee who has retired.

ERISA

The term ERISA means the Employee Retirement Income Security Act of 1974, as amended. The Plan is a Church Plan and therefore is generally exempt from ERISA regulations under ERISA §4(b)(2).

Health Savings Account (HSA)

Health Savings Accounts are employer-funded (i.e., funded by Plan Sponsor and Plan) for participants covered in an HSA Plan. HSAs also may be participant-funded, if elected. Contributions into the HSA are limited to a maximum amount each year. HSAs help Participants covered in the HSA Plan Benefit Option to satisfy higher deductibles and out-of-pocket expenses by reimbursing certain eligible medical expenses.

Health Reimbursement Account (HRA)

Health Reimbursement Accounts are health reimbursement arrangements as described in IRS Notice 2002-45. HRAs are accounts funded by the employer (i.e., Plan Sponsor and Plan) to help Participants covered in the HRA Plan Benefit Option satisfy higher deductibles and out-of-pocket expenses by reimbursing certain eligible medical expenses. HRA Accounts do not include any Participant contributions. Outside of the HRA Plans, Plan Sponsors may choose to offer an HRA with other PPO Benefit Options under the HealthFlex Plan.

HRA Plans

A Benefit Option under the Plan that is a HRA Plan is designed to drive Participants’ behavior toward informed medical decision-making and carries higher deductible and out-of-pocket limits than the PPO Benefit Options under the Plan. The HRA Plan is generally accompanied by an HRA, so Participants have Plan Sponsor- and Plan-provided financial assistance toward satisfying those higher deductibles.

HSA Plan

HSA Plan refers to a Benefit Option under the Plan that is an IRS-qualified high-deductible health plan. The HSA plans are designed to drive participants’ behavior toward informed medical decision-making and carries higher deductible and out-of-pocket limits than the PPO Benefit Options under the Plan. The HSA plans are accompanied by a health savings account (HSA), which provides Plan Sponsor- and Plan-provided financial assistance toward satisfying those higher deductibles. Participants may also contribute to the HSA.

HIPAA

The term HIPAA means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder by the Secretary of the Department of Health and Human Services. Most notably, HIPAA regulations aim to protect patient and Participant privacy.

ID Card

The term ID Card means the identification card that contains your Participant information, issued to you by the Claims Administrator.

Life Status Events

Life Status Events are the events that allow a Participant to change his or her elections during a Plan Year, as described in the section of this SPD entitled *Life Status Events*.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended. Medicaid eligibility is typically based on financial need.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended. Medicare eligibility is typically for persons age 65 and older or certain disabled adults of any age.

Medicare Secondary Payer (MSP)

The term Medicare Secondary Payer (MSP) means those provisions of the Social Security Act set forth in 42 U.S.C. w1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their Spouses and, in some cases, Dependent children.

Medicare Secondary Payer Small Employer Exception (MSPSEE)

The term Medicare Secondary Payer Small Employer Exception (MSPSEE) means an exception to Medicare Secondary Payer (MSP) rules. In general, HealthFlex pays primary for participants covered under both HealthFlex and Medicare. However, Medicare may pay primary for participants covered under both HealthFlex and Medicare if the participant's employer has less than 20 employees and other rules are met.

Other Health Coverage

Under HealthFlex, Other Health Coverage includes a self-insured group health plan; an individual health insurance plan (including coverage provided through a state or federal Health Insurance Marketplace ("Exchange") or group health insurance or HMO plan; Parts A and B of Medicare; Medicaid; a health plan for current and former members of the armed forces; a health plan provided through Indian Health Services; a state health benefit risk pool; the Federal Employees Health Program; a plan provided under the Peace Corps Act; a state, county or municipal public health plan; a State Children's Health Insurance Program (S-CHIP); health coverage provided under a plan established by a foreign country; coverage provided under state or federal health continuation mandates (e.g., COBRA); individual or group health insurance through an association; and an individual or group health conversion plan.

Participant

The term Participant means either the Employee, i.e., the primary Participant, or an enrolled Dependent. This term applies only while such person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Participant. The term also may include retired Employees of Plan Sponsors who are eligible to participate under the Plan's terms and the Plan Sponsor's Adoption Agreement.

Plan

The term Plan the HealthFlex Plan. The Plan is a Church Plan.

Plan Administrator

The Plan Administrator of the Plan is Wespath.

Plan Sponsor

The term Plan Sponsor means:

- The annual conference or other organization or corporation affiliated with The United Methodist Church; or
- Another denomination or organization,

that has adopted the Plan through an executed HealthFlex Adoption Agreement with Wespath.

Plan Year

The term Plan Year means the 12- month period ending on December 31 of each Calendar Year.

Premium Credit

The amount designated and provided by the Plan Sponsor to the Participant to apply toward Required Contributions for HealthFlex coverage (e.g., medical, dental, vision).

Required Contribution

Required Contributions include, but are not limited to, contributions or premiums due to the Plan for coverage under the Plan as calculated by Wespath in its discretion and any other amounts due as a condition of receiving coverage under the Plan. Contributions may be paid by the Primary Participant, Plan Sponsor or Salary-Paying Unit.

Salary-Paying Unit (SPU)

Salary-Paying Unit means any one of the following units associated with The United Methodist Church:

- a general agency of The United Methodist Church;
- a Jurisdictional Conference;
- a Conference and/or annual conference;
- a Conference board, agency or commission;
- a local church located in a Conference;
- any other entity to which a clergy person under Episcopal appointment is appointed;
- any other employer of lay Employees who are eligible to participate in a Church Plan.

Special Enrollment Events

Special Enrollment Events are certain events that, under HIPAA, allow a Participant to change his or her elections during a Plan Year, as described in the section of this SPD entitled *Special Enrollment Events*.

Spouse

The term Spouse, for purposes of the Plan, means a person who is married to a Participant (or to a surviving Spouse) in accordance with the law of the jurisdiction in which the Spouse resides, except that a person who is a “common-law” Spouse is not a Spouse for purposes of the Plan. A person who is a Spouse will still be a Spouse even if the person is geographically or legally separated (but not yet divorced) from the person to whom he or she is married.

Wespath

Wespath administers the HealthFlex plan and other health, welfare and retirement benefits and investments. Wespath is a general agency of The United Methodist Church.

GENERAL INFORMATION

Name and Address of the Plan Administrator

Wespath
1901 Chestnut Avenue
Glenview, Illinois 60025
1-847-869-4550
1-800-851-2201

Name and Address of the Designated Agent for Service of Legal Process

CT Corporation
208 S. LaSalle Street
Chicago, Illinois 60604
1-800-475-1212

Name and Address of the Third-Party Claims Administrators for Medical and Behavioral Health Benefits

First-Level Claims:

Blue Cross and Blue Shield of Illinois
300 E. Randolph Street
Chicago, Illinois 60601
1-866-804-0976

Appeals:

Quantum Health - Appeals Department
5240 Blazer Parkway
Dublin, OH 43017
Fax: 1-877-498-3681

Name and Address of the Third-Party Administrator for Prescription Drug Benefits

OptumRx
2300 Main Street
Irvine, California 92614
1-855-239-8471

Name and Address of the Third-Party Administrator for Dental Benefits

Connecticut General Life Insurance Company (CIGNA)
1000 Corporate Center Drive, Suite 500
Franklin, Tennessee 37067
1-888-336-8258

Name and Address of the Third-Party Administrator for Vision Benefits

Vision Service Plan Insurance Company (VSP)
3333 Quality Drive
Rancho Cordova, California 95670
1-800-877-7195

Name and Address of the Third-Party Administrator for Flexible Spending Accounts Benefits

Health Equity
15 W Scenic Pointe Dr, Ste 100
Draper, UT 84020
1-877-924-3967

Internal Revenue Service Identification Number

The corporate tax identification number assigned by the Internal Revenue Service to Wespath is **36-2166979**.

Method of Funding Benefits

Generally, health benefits are self-funded or self-insured from the Plan's trust. Certain Benefit Options may be fully insured, as specified in the Plan document. Payments out of the Plan to health care Providers on behalf of Participants will be based on the provisions of the Plan.





Wespath

BENEFITS | INVESTMENTS

1901 Chestnut Avenue
Glenview, Illinois 60025-1604
wespath.org