2010 Open Enrollment
Benefits Update

Board Announces Zero Increase in Health Insurance Premiums

Reprinted from the August 31 Edition of E-Review
By Jenna DeMarco

While the nation debates the best way to provide and fund health care, the Florida Conference is finding solutions, particularly in the area of health-care costs.

Active clergy, laity and retired participants in the Florida Conference health insurance plan will see **no increase** in their premiums next year, thanks to aggressive action by the Conference Board of Pension and Health Benefits (CBOPHB).

After experiencing several years of double-digit increases in premiums charged by insurance providers, the conference board began exploring ways to stabilize rates. The board's recommendation and subsequent decision by the conference several years ago to adopt a "self-funding" model for health insurance is the primary reason those rates are stabilizing, said Mickey Wilson, Florida Conference treasurer.

Self-funding enables the conference to be a lower-cost provider than outside insurers because "we are not interested in making a profit" from health insurance, Wilson said.

With self-funded programs, organizations collect premiums and use that revenue to pay health insurance claims. A third-party administrator is often needed, however, to handle claim payment details. Ideally, the amount collected from participant premiums meets or exceeds what is needed to pay all claims, which has occurred so far in the plan, according to Wilson.

Open Enrollment
Oct. 26- Nov. 8
Benefits are effective
January 1 - December 31, 2010

Remember:

You must change or confirm your benefit elections for 2010 before the deadline of:
November 8, 2009
(You must re-enroll in the Health-care Spending Account and Dependent Childcare Account every year)

www.flumc.org
Visit the Florida Conference Website to:

- **View the Open Enrollment Webcast**
  October 27th at 10 a.m.
  Log on and select the open enrollment webcast link on the home page.
- **Get Information**
  Log onto *www.flumc.org* and you will see the link for Open Enrollment 2010 to enroll or change your benefits.
- **Enroll Online**
  Make all your open enrollment elections on our website.

Please see the contact list on page 11 insurance carrier phone numbers and websites.

Look for **$martTips** throughout this enrollment guide to learn how to become a smarter health care consumer.

Conference revenue from health insurance premiums is approximately $16 million to $17 million per year, which has been "sufficient," Wilson said, to pay all outstanding claims and a portion of anticipated claims. Any excess funds have gone into a reserve account, which could be used in 2010 if needed to help maintain the zero-percent increase.

The conference also purchases "stop-loss" or "excess carrier" insurance coverage, Wilson said, in the event that claims exceed revenue. This ensures that "we haven't exposed the conference assets" beyond the extent of the revenue, he said.

"To deliver a zero increase for active participants in this day and age is almost unheard of," said Wendy

McCoy, director of the conference's human resources and benefits department. "To do the same for retirees — who, statistics show, use the health insurance plan more than most — is completely unheard of."

The conference will continue to use United Healthcare as its plan administrator, McCoy said, and "all the provisions of the plan remain the same into 2010 as they were in 2009."

"We negotiated with several insurance companies to get a better deal for our participants. As a result, United Healthcare reduced their administrative fees, which gave us better pricing and, in part, contributed to savings for next year," she said.

The board conducted an external review of health insurance administrators to ensure the conference has the best plan available. In selecting a plan administrator, board members went through "an arduous and a very committed process" involving research, review, prayer and discernment, said the Rev. Barbara Riddle, chairwoman of the conference board.

Board members spent about 40 hours each reviewing materials and attending meetings, McCoy said, and were "conscientious" about giving the process the time and attention it required.

The board includes health insurance professionals, bankers, attorneys, physicians, private industry benefit professionals and clergy experienced in the area of health benefits. They redesigned the funding method and in 2007 recommended that the conference self-fund the program, rather than continue purchasing coverage from an insurance company.

"The Florida Conference is fortunate in that of the approximately 350,000 members, there is a large pool of qualified and experienced laity and clergy members who are willing to take time from their families, businesses and congregations to provide their expertise to the various committees on which they serve," McCoy said. "This is especially true of the members on the Conference Board of Pension and Health Benefits."

The board's decision to use the self-funded insurance model "was good work," according to Shane McIntosh, chairman of the board's health insurance subcommittee.

The 5,000-plus employees and dependents in the health insurance program are a statistically significant number, McIntosh said, making it possible to "predict with very good certainty what our claims experience should be."

Those claims were well below expected for the first year of the plan, McIntosh said, even with rising medical costs, which he estimates at about 7 percent per year.

Michele Maier, chairwoman of the Preacher's Relief Board and a CBOPHB member, said she is "thrilled" the health insurance premiums are stabilizing. By not passing any increases on to clergy, "we are helping people that deserve to be helped," she said.

Additional improvements to the health insurance program could be possible in the coming years, according to both McIntosh and Maier. Some ideas include promoting more widespread use of health risk assessments and offering wellness programs, nutrition counseling, smoking cessation incentives and alternative plan designs. Identifying additional program cost savings should be under consideration too, McIntosh said.

"The less we have to spend on insurance, the more we can use for God's work," McIntosh said.

The zero increase in rates applies only to health insurance and not to the optional dental insurance plan. Those who elect to participate in the dental coverage will incur a "modest increase" in premiums, McCoy said. The conference anticipates improved dental insurance benefits, however, as it switches from its current insurance carrier to a new provider, she said.

2010 Monthly Health Insurance Rates	Single	Single +1	Family
Clergy	$96	n/a	$236
Local Church Lay Employee	$545	$964	$1,318

Network Availability

The Choice Plus (in-and out-of-network benefits) plan uses an extensive network of physicians, hospitals, and other health care providers. Visit UHC's website at www.myuhc.com to see if your doctors and other providers are in the UHC network to avoid surprises that could cost you time and money. Simply look under the Links & Tools sidebar on the home page and select "find physician".

$martTip: *In-Network Advantage*

Use network doctors and facilities to save money for yourself and the plan. You get the advantage of discounted costs that are usually significantly lower than out-of-network costs. In addition, you will not be balanced billed* by a network provider.

* *Balanced billing occurs when the amount the plan pays (allowable charges) is less than the amount the out-of-network provider charges and you have to pay the difference between the two. This payment is in addition to your coinsurance.*

Prescription Drug Benefits

All plans include prescription drug coverage. Prescription drugs are divided into three levels or tiers based on UHC's Prescription Drug List (PDL). You pay a different co-payment for each tier. The Choice Plus plan has a prescription deductible of $50 per individual and $100 per family. These pharmacy deductibles are separate from the deductible on Choice Plus or Options PPO medical plans.

$martTip!

Stretch Your Prescription Drug Dollars

In-network Retail Pharmacy	**Co-pay**
Tier 1: Lowest Cost (most generics)	**$10**
Tier 2: (most brands)	**$25**
Tier 3: (most non-preferred brand)	**$40**

Save more on a generic prescription: Generic drugs are FDA-approved and may be just as effective as brand-name drugs. Talk to your doctor to see if a generic drug is right for you.

The PDL consists of medications that have been reviewed by physicians and pharmacists and includes a wide selection of FDA-approved generic and brand-name drugs. For more information or to get a copy of the PDL, visit www.myuhc.com.

Mail-order Prescription Service

If you or a dependent takes medicine for an ongoing condition, like high blood pressure, you pay just two retail co-payments for a 90-day supply when you use the mail-order service. In other words, you get 30 additional days of medication at no cost if you use the mail-order service. Visit www.myuhc.com for more information on how to begin mail-order service.

$martTip!

Ways to Control Your Costs

There are things you can do to lower your own health care costs and keep the Florida Conference's health care costs in check. When using your benefits:

- Talk to your doctor about using the generic version of a brand name drug to save money. For maintenance medications, consider using the mail order pharmacy.
- Save time and money by using an urgent care center rather than an emergency room for non-life-threatening emergencies.
- Understand your plan and know your benefit limits.
- Use in-network doctors and facilities whenever possible.
- Become aware of your health measurements (blood pressure, weight, cholesterol) and learn how they impact your health.
- Log onto *www.myuhc.com* and take the Health Risk Assessment to track your health progress.
- Review the explanation of benefits from your carriers and your providers' bills.

Employee Assistance Program

There isn't a person on this planet that doesn't have problems. Some problems are easier to handle than others. Then there are times when these problems seem overwhelming. Well, you don't have to go it alone. Live and Work Well, our Employee Assistance Program (EAP), is a free, confidential resource that's available 24 hours a day – seven days a week at no cost to you. And you can utilize our EAP, regardless of whether you are enrolled in an FLUMC medical plan.

The EAP provides up to eight free counseling sessions per separate issue per year for you and your family members (including students away at college).

The health professionals at Live and Work Well can help you and your loved ones deal with family problems, stress-related issues, depression, eating disorders, problems at work, and financial crises. No issue is too large or too small. Call 800-788-5614 or visit www.liveandworkwell.com.

UHC Benefits At-a-Glance	Choice Plus		Options PPO
	In-Network1	Out-of-Network1	Out-of-Area Only
Deductible (applies to OOP maximum)	$500 Individual; $1,000 Family	$1,000 Individual; $2,000 Family	$500 Individual; $1,000 Family
Annual out-of-pocket (OOP) maximum2	$2,250 Individual; $4,500 Family	$4,500 Individual; $9,000 Family	$2,250 Individual; $4,500 Family
Physician Services			
Office Visits	$20 co-pay	30%*8	20%*
Specialists	$35 co-pay	30%*	20%*
Urgent care11	$50 co-pay	30%*	20%*
Emergency Room (Waived if admitted)	$100 co-pay	$100 co-pay	20%*
Ambulance (Medically necessary)	20%*	20%*	20%*
X-Ray/Diagnostic Services	$35 Co-pay X-ray; 20% for CT/PET/MRI/ Nuclear Medicine after deductible	30%*	20%*
Hospital Services			
Inpatient	$250/day co-pay (max. 3 days)3	30%*	20%*
Outpatient 6	20%*	30%*	20%*
Surgery, outpatient 6	20%*	30%*	20%*
Home Health Services	20%*	30%*	20%*
Skilled nursing facility4	20%*	30%*	20%*
Outpatient Therapy 10	$20 co-pay	30%*	20%*
Vision Exam7	$20 co-pay	30%*	20%*
Pharmacy Prescription – Prescription Drug List (PDL); 31-day supply			
	$50 individual deducible $100 family deductible		$50 individual deductible $100 family deductible
Tier 1 (most generics)	$10 co-pay9	$10 co-pay5,9	$10 co-pay5,9
Tier 2 (most brands)	$25 co-pay9	$25 co-pay5,9	$25 co-pay5,9
Tier 3 (most non-preferred brands)	$40 co-pay9	$40 co-pay5,9	$40 co-pay5,9
Mail-order Prescription Service – Prescription Drug List (PDL); 90-day supply			
	$50 individual deductible $100 family deductible		$50 individual deductible $100 family deductible
Tier 1 (most generics)	$20 co-pay	N/A	$20 co-pay
Tier 2 (most brands)	$50 co-pay	N/A	$50 co-pay
Tier 3 (most non-preferred brands)	$80 co-pay	N/A	$80 co-pay

Percentages shown are the coinsurance amounts you pay after you meet the deductible. Out-of-network coinsurance is based on reasonable and customary (R&C) charges determined by the plan.

Medical Plan Comparison Chart Footnotes (for chart on page 5)

* After deductible

1. Pre-service notification required on certain services
2. Doctor's office visits, hospital co-pays, and prescription drug co-pays do not apply toward the out-of-pocket (OOP) maximum
3. This service is not subject to individual deductible and coinsurance and will be paid at 100% once the member has satisfied the 3-day maximum co-payment of $750.
4. 60 visits maximum per calendar year (pre-service notification required)
5. When you use a non-network pharmacy, you pay your co-pay plus the difference between what the non-network pharmacy charges and the amount UHC would have paid to a network pharmacy
6. Outpatient surgery deductible and/or coinsurance payable in addition to any applicable office co-pay if performed in a physician's office
7. One visit every other calendar year
8. No benefits for preventive care
9. Retail pharmacy deductible of $50 per individual and $100 per family
10. Twenty (20) visits per year for physical, occupational, speech, and pulmonary therapy, and/or chiropractic (pre-service notification required); 36 visits per year for cardiac therapy
11. Office co-pay, if applicable, plus deductible and/or coinsurance for pharmaceutical products, PT, CT, MRI, and/or surgery.

Medical Plan Features

Feature	Details
Network	The Choice Plus plan offers an extensive network of physicians, hospitals, and other health care providers. The Options PPO is available for participants who do not have access to network providers.
Open Access	All plans offer open access, meaning you don't need to select a primary care physician (PCP) or get referrals to specialists. • You have the freedom to use any provider—the Choice Plus plan covers out-of-network services, but you will pay more. • The Options PPO plan provides the same level of coverage (80% of reasonable and customary charges after deductible) whether you use in- or out-of-network providers. OUT-OF-NETWORK CAUTION Choice Plus: You will pay a higher percentage of coinsurance based on reasonable and customary charges.
www.myuhc.com	Register for UHC's personalized online health and wellness tools to access a variety of services, information, and resources to help you get the most from your benefits. Personalized access will be available January 1 for new enrollees.

The information on pages 5-6 highlights your medical benefits. Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between this insert and the official documents, the official documents will prevail.

Conference Announces New Dental Plan for 2010

The Florida Conference is making a change to its dental insurance effective January 1, 2010. The current Humana/CompBenefits DHMO and Indemnity plan will terminate on December 31, 2009. The **FLUMC Dental Plan**, administered by WEB-TPA Employer Services, will replace Humana/CompBenefits. ***All members currently enrolled in dental insurance will be automatically enrolled in the new FLUMC dental plan.***

The *new* FLUMC Dental Plan is self-funded like the medical plan. This allows the Conference to design a plan of benefits that better meets the needs of participants. This new plan will work much like the former Humana/CompBenefits indemnity plan in that you can choose any dental provider. There is no network of dentists that you have to use to receive reimbursement under this new plan.

Reimbursement under the plan is based on Usual & Customary fees after you satisfy the deductible. The plan will pay claims based upon the Usual and Customary fee allowance (also called Reasonable and Customary fee). The Usual and Customary fee is defined as the charge for dental care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

When the dental plan disallows a portion of a charge as being in excess of the Usual and Customary fee, it means only that the charge is in excess of the standard rate used to determine Usual and Customary. Providers are free to charge whatever fee for service they choose. Your insurance coverage is designed to provide benefits up to the plan's Usual and Customary fee and is priced accordingly.

Remember, your coinsurance amount is calculated **after** the Usual and Customary fee is determined. Here is an example: You live in Jacksonville and your dentist charges $100 for a routine filling. The dental plan will reimburse the dentist 80% of the usual and customary fee after you satisfy the deductible. Let's assume for this example you have already met the individual deductible ($50). The U&C fee for a routine filling in Jacksonville is $90. The plan would reimburse 80% of the $90 U&C fee or $72.

Because this plan does not use a designated provider network with negotiated fees, you may be responsible for the difference between the U&C fee and the provider's charge. If your dental provider agrees to accept the U&C fee as payment in full – you will not have any further responsibility. However, many dentists will not accept U&C fees as payment in full. In the event the dentist will not accept the plan reimbursement of $72 - you are responsible for the difference between what the plan paid ($72) and the provider's full charge of $100.

Dental Plans Benefits at a Glance	FLUMC Dental Plan Administered by WEB-TPA Employer Services Plan reimbursement is based on Usual & Customary fees
Calendar Year Deductible Individual Family	 $50 $150
Calendar Year Maximum	$1,000
Preventative & Diagnostic Treatment Routine exams, cleanings, x-rays, sealants	100% Deductible does not apply
Basic Treatment Simple fillings & extractions, oral surgery	80%
Major Treatment Crowns and dentures, Root Canal, Endodontic	50%
Orthodontics Children Adults	 $1,000 lifetime maximum per child Not Covered

2010 Monthly Dental Rates	Single	Single +1	Family
Clergy/Lay Employees	$25.78	$43.58	$55.50

All members currently enrolled in the dental plan will be automatically enrolled in the new FLUMC dental plan. Members can enroll or cancel their plan on-line at www.flumc.org

Discovery Benefits

Flexible Spending Accounts (FSAs)

Note: The deadline for filing 2009 FSA claims is March 31, 2010. **USE IT OR LOSE IT!**

You can choose to enroll in one or both of the Flexible Spending Accounts (FSAs): the Health-care Spending Account and the Dependent Childcare Account. Your contributions are deducted from your payroll before federal and Social Security taxes are withdrawn, saving you money on your taxes.

An FSA is like a personal checking account. You make regular deposits to your account(s) through tax-free payroll deductions. You use the money in the account(s) to pay for your eligible health or dependent day care expenses.

During Open Enrollment each year, you specify the dollar amount you'd like to direct into your FSA from each paycheck, up to an annual maximum of $5,000 for a Health-care Spending Account and $5,000 for a Dependent Childcare Account.

$martTip

FSA Resources

For more information and a list of most eligible and ineligible expenses, refer to your FSA materials or review the IRS Publications available at www.irs.gov:

- ✓ Publication 502, "Medical and Dental Expenses"
- ✓ Publication 503, "Child and Dependent Care Expenses"

There are two types* of FSAs available:

- ✓ Health-care Spending Account (HCRA) allows you to set aside money to pay for eligible health care expenses for you and your dependents. Examples of eligible expenses include deductibles, co-pays, coinsurance, LASIK eye surgery, certain over-the-counter medications, eyeglasses, and other expenses not covered under another plan.
- ✓ Dependent Childcare Account (DCA) allows you to set aside money to pay for eligible non-medical dependent day care expenses for your children or elderly parents so you and your spouse can go to work. Examples of eligible expenses include a child care or adult care center, a nursery school, summer day camp, or a caregiver for an incapacitated dependent. For detailed information on limitations for married participants and what is covered under the Dependent Childcare Flexible Spending Account, see www.irs.gov, publication 503

FSA Debit Card

For 2010, if you contribute to a Health-care Spending Account, you can use an FSA debit-type card to pay for eligible expenses at the point of purchase. In many cases, this eliminates the need to pay for expenses out of your own pocket and then wait for reimbursement.

A debit-type card and additional information will be mailed after you enroll in a Health-care Spending Account. Simply follow the instructions to activate the card.

If you currently have a Discovery Benefits debit card and you **re-enroll** in FSA for the 2010 plan year, you **will not** be issued a new card. Your current card will be loaded with your new 2010 benefit election.

Estimate Carefully! You'll need to carefully calculate the amount* you plan to contribute to your FSA(s). Typically, any unused dollars in your account(s) at the end of the plan year will be forfeited. However, as a result of the extended grace period allowed by the federal government, you have an additional 2-1/2 months (until March 15, 2010) to spend any unused funds in your FSA. You must submit claims by March 31, 2010 to be reimbursed for expenses incurred between January 1, 2009 and March 15, 2010. Most over-the-counter drugs or supplies used to treat an illness or injury are also eligible for FSA Spending. Log onto www.discoverybenefits.com and click on "FSA Savings Calculator" on the lower right side of the page to calculate your annual contributions.

Visit the Discovery Benefits web site at www.discoverybenefits.com. You can check your real-time account status 24/7, see your profile, account balance, claims status, access, administrative forms, your history and deposits. You can even file a claim online and contact a Participant Services representative via email.

	HCSA	DCA	* Budget Carefully! Federal law requires that any money left in your account(s) at the end of the plan year grace period will be forfeited.
Maximum Annual Contribution	$5,000	$5,000	

Do You Have Any Of These Expenses?

Consider enrolling in an FSA if you:

- ✓ Pay deductibles, co-pays and/or coinsurance.
- ✓ Have upcoming dental and/or orthodontia expenses.
- ✓ Buy prescription eyeglasses, contact lenses, or saline solution.
- ✓ Pay a day care center or babysitter for care of your children while you and your spouse are at work.

$martTip

IMPORTANT: Due to IRS regulations, documentation will be required for debit purchases. Be sure to keep all of your receipts.

Discovery Benefits may send you a letter requesting substantiation of certain medical, dental or vision expenses. It will be necessary to mail or fax a copy of this letter with the receipts requested. Failure to do so may result in suspension of your debit card until the requested receipts are received and approved by Discovery Benefits.

Income Protection Plans

Basic Life and AD&D Insurance

Providing economic security for your family is a major consideration in personal financial planning. To help give your family some security in case something happens to you, FLUMC provides basic life and accidental

death and dismemberment (AD&D) insurance at no cost to you. All active clergy and lay participants enrolled in a medical plan are eligible to receive $10,000 of coverage.

Please note that basic life insurance benefits are reduced by 50% at age 65 and by 75% at age 70. Basic AD&D coverage ends after age 70.

Voluntary Life and AD&D Insurance – rates reduced for 2010

Voluntary term life and AD&D insurance offers you the opportunity to provide an even greater level of economic security for your spouse and children. You may elect coverage through Minnesota Life Insurance Company as shown in the charts below. Current members will see a small decrease in their premiums beginning in 2010.

Evidence of Insurability

During open enrollment you may elect Voluntary Life and AD&D for yourself and/or dependents for the first time or request increased coverage levels. **You will be required to submit Evidence of Insurability (EOI) to the insurance company by December 31, 2009. If the form is not submitted by the deadline your election will be invalid.** This form is available by clicking on the link provided in the Open Enrollment system. It is also available on the Florida Conference web site at **www.flumc.org/hr** .

Voluntary Life Insurance

Coverage for:	Benefit equal to:
Yourself	• Choice of $50,000, $100,000, $150,000, $200,000, and $250,000 • Guaranteed issue amount of $100,000 • Benefit reduction starting at age 65
Your Spouse	• Choice of $25,000, $50,000, $75,000, and $100,000, up to 50% of your coverage election • Guaranteed issue amount of $25,000
Your Child(ren)	• $1,000 for ages 14 days – 6 months • Choice of $5,000 or $10,000 for age 6 months and older

You must elect coverage for yourself to cover your dependents.

Voluntary AD&D Insurance

Coverage for:	Benefit equal to:
Yourself	Amount equal to your Voluntary Life Insurance election
Family coverage if family unit is:	
Spouse	50% of participant's Voluntary Life Insurance coverage
Child(ren)	15% of participant's Voluntary Life Insurance coverage
Spouse and child(ren)	• Spouse—40% of participant's Voluntary Life Insurance coverage • Each child—10% of participant's Voluntary Life Insurance coverage

Contacts

Plan and Provider	Phone	Website
Medical—UnitedHealthcare	1-866-633-2446	www.myuhc.com
Dental - WEB TPA	1-866-259-5145	www.flumc.org
Flexible Spending Accounts 2008—Discovery Benefits	1-866-451-3399 1-866-451-3245 (fax)	www.discoverybenefits.com
Employee Assistance Program—WorkingSolutions	1-800-788-5614	www.liveandworkwell.com Access code: FLUMC
Basic Life and AD&D—CIGNA	FLUMC Benefits Dept. 1-800-282-8011 ext. 135	N/A
Voluntary Life and AD&D—Minnesota Life Insurance Company	FLUMC Benefits Dept. 1-800-282-8011 ext. 135	N/A
FLUMC Benefits Department	1-800-282-8011 ext. 135	www.flumc.org Email: benefits@flumc.org

This guide provides basic explanations of the FLUMC benefit plans. Complete details on each plan are set forth in the individual plan document and/or Certificate of Insurance. If there is any conflict between the information in this guide and a plan document, the plan document will control. FLUMC reserves the right, in its discretion, to amend, revise or terminate any benefit program at any time. Please consult your health insurance carrier to obtain more detailed information. The information contained herein does not constitute an insurance certificate or policy.

ATTENTION LOCAL CHURCHES

All Clergy and lay employees at local churches must print your confirmation statement upon completion of your open enrollment session and provide a copy to your financial administrator to set up your 2010 benefit payroll-deductions.

***Remember to* change and/or confirm your benefit choices during the open enrollment period: Oct. 26 – Nov. 8, 2009**

If you do not log on and make a new FSA election in the ADP/HRB Human Resources system during open enrollment you will not be enrolled in any Flexible Spending Accounts for 2010.

Legal Details

HIPAA—Continuation of Coverage

- The Health Insurance Portability and Accountability Act (HIPAA) helps protect your rights to medical coverage during events such as changing or losing jobs, pregnancy and childbirth, or divorce.
- Depending upon your group health plan limitations, HIPAA may also make it possible for you to get and keep health coverage even if you have past or present (preexisting) medical conditions.
- If you were covered under a medical plan, you will receive a certificate of creditable coverage from UHC upon termination.

HIPAA—Privacy Act Legislation

- FLUMC and your health insurance carrier are obligated to protect confidential health information that identifies you, or could be used to identify you, and relates to a physical or mental health condition or the payment of your health care expenses.
- FLUMC and UHC are required to notify you and your beneficiaries about their policies and practices to protect the confidentiality of your health information. To comply with this legislation, UHC provides a detailed description of your plan's privacy policy.

Women's Health and Cancer Rights Act of 1998

- The Women's Health and Cancer Rights Act of 1998 requires your health care plan to provide benefits for mastectomy-related services.
- These services include surgery and reconstruction to achieve symmetry between the breasts and prostheses due to complications resulting from a mastectomy (including lymph edemas).
- Coverage for these benefits or services will be provided in consultation with the participant's or beneficiary's attending physician.
- If you are receiving, or in the future will receive, benefits under any group medical contract in connection with a mastectomy, you are entitled to coverage for the benefits and services described above if you elect breast reconstruction.
- Please refer to your medical plan Certificate of Coverage for the full terms of coverage, restrictions, limitations, and exclusions, etc.
- Your qualified dependents are also entitled to coverage for those benefits or services on the same terms.
- Coverage for the mastectomy-related services or benefits required under the Women's Health law are subject to the same deductibles and coinsurance or co-payment provisions that apply to other medical or surgical benefits your group medical contract provides.

Newborns' and Mothers' Health Protection Act of 1996

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

Important Notice of Creditable Coverage

Your Prescription Drug Coverage & Medicare

For the Plan Year January 1 – December 31, 2010

Important Notice from
The Florida Conference of the United Methodist Church About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Florida Conference of The United Methodist Church and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

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

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

If you decide to join a Medicare drug plan, your current **The Florida Conference of The United Methodist Church** coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare Prescription Drug plan, you and your eligible dependents will still be eligible to receive all of your current heath and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current **The Florida Conference of The United Methodist Church** coverage, be aware that you and your dependents will be able to get this coverage back during the next open enrollment period.

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

You should also know that if you drop or lose your current coverage with **The Florida Conference of The United Methodist Church** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

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

Contact the FLUMC Human Resources & Benefits Office at 800-282-8011 ext. 135 further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through [Insert Name of Entity] changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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