Wespath

BENEFITS | INVESTMENTS

a general agency of The United Methodist Church

HEALTHFLEX

Plan Sponsor Manual

January 1, 2024

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Note: This Plan Sponsor Manual is effective January 1, 2024 and supersedes all prior versions. Effective July 2016, General Board of Pension and Health Benefits is doing business as Wespath Benefits and Investments (Wespath).

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Introduction

As the Plan Sponsor, you should read this *HealthFlex Plan Sponsor Manual* (Manual) in its entirety. Plan Sponsors may be called on by Participants to provide information pertaining to the HealthFlex Plan. In this Manual, you will find answers to questions you may have or that Participants may ask you about eligibility, enrollment, terminations, elections, appeals and other Plan administrative matters under the HealthFlex Plan as administered by the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois. As of July 2016, the General Board is doing business as Wespath Benefits and Investments (Wespath).

The intent of this Manual is to give general process information, not to supersede the specific provisions of the official documents that govern the Plan, or *The Book of Discipline*. In the event of any discrepancy between this Manual and the Plan Documents[1] or *The Book of Discipline*, the provisions of the Plan Documents and *The Book of Discipline* will prevail. Contact Wespath if further clarification is required.

Wespath does not engage in rendering legal, accounting or other professional services. This Manual is provided to you with that understanding. If you (or a Participant) need legal advice or other expert assistance, you (or the Participant) should seek the services of an attorney or other professional advisor.

Questions And Information

Please call Wespath at **1-800-269-2244** and the appropriate extension to reach personnel business days from 8:00 a.m. to 6:00 p.m., Central time. *This number should not be given to Participants*. Participants can reach Wespath by calling **1-800-851-2201**. The Interactive Voice Response (IVR) Telephone System at Wespath is available 24 hours a day, seven days a week.

Explanation of Terms

You will find terms starting with capital letters throughout this Manual. To help you understand the rules that govern the Plan, these terms are defined in the Glossary section.

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. Wespath reserves the right to amend this Manual or any of the rules, policies and interpretations of the Plan at any time without prior notification.

[1] Plan Documents include, but are not limited to, the *HealthFlex Plan Document* (Plan Document), the *HealthFlex Summary Plan Description* (SPD), the *HealthFlex Benefit Booklets*, any certificate of insurance that may govern portions of the Plan, and the Rules for Risk Pools.

Your Duties as a Plan Sponsor

It is incumbent upon you as Plan Sponsor to fulfill your duties and obligations under HealthFlex or the Plan. You have executed an Adoption Agreement with Wespath in which you represent that you will abide by the terms of the Plan and the documents and policies that govern it.

One of the most important obligations you have as Plan Sponsor is providing accurate and up-to-date eligibility and enrollment data to Wespath regarding Eligible Persons and Participants through the Benefits Access Portal and Benefitsolver systems. The Plan is subject to many time-sensitive provisions of the Internal Revenue Code of 1986 (Code), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Patient Protection and Affordable Care Act of 2010 (ACA) and other laws. In addition, the Plan is under certain time-sensitive obligations to its Claims Administrators through service agreements, contracts and policies. As such, it is very important that you as Plan Sponsor abide by the time limits set out in this Manual and the Plan Documents. In some cases, because of the limits set out in the laws mentioned in the preceding sentence, the Plan cannot correct errors resulting from missed deadlines or may be limited to correcting such errors only on a prospective basis.

Wespath and the Claims Administrators rely on information provided by Eligible Persons, Participants and Plan Sponsors when evaluating coverage and benefits under the Plan. All such information, 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.

About the Plan

Wespath maintains the Plan for the benefit of clergy and lay Employees (and their Dependents) of The United Methodist Church. The Plan is a “Church Plan” as defined in Section 414(e) of the Code and Section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Plan’s status as a Church Plan has a significant legal meaning; you can read more about it in the section entitled *Legal Status of the Plan*.

CLAIMS ADMINISTRATORS

The Claims Administrators for the Plan—engaged through administrative services 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 Claim 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 govern the Plan, Wespath has also delegated certain fiduciary responsibilities and duties to the Claims Administrators. Also, see the section entitled *Legal Status of the Plan*.

Moreover, certain Contracts with the Claims Administrators, notably the insurance contracts and policies with the vision and mental health benefit providers, are contracts of insurance. As such, the terms of those contracts with respect to the Participants covered under them may supersede the terms of this *Plan Sponsor Manual*. Contact Wespath if you have questions regarding the manner in which the Claims Administrators and Wespath share duties under the Plan.

HIPAA

The privacy of the health records of Plan Participants and their Dependents is protected by specific security and privacy regulations under HIPAA. Under HIPAA, Wespath employees and Plan representatives and agents (such as Claims Administrators) generally may not release Protected Health Information (PHI), to a Participant's Plan Sponsor or Spouse (or any other party unless required by law) unless the Participant authorizes such release. HIPAA also applies when a Participant wants PHI to be shared among health plans and Providers for reasons other than payment or treatment. Wespath's Notice of Privacy Practices describes the Plan's privacy practices and Participant rights to access their records. The notice is available on the Wespath website at **wespath.org/benefits/plans/healthflex/announcements**.

Wespath will require a Participant's written authorization before disclosing his or her PHI to anyone other than the Participant or his or her personal representative (that is, his or her guardian or named representative in a power of attorney) unless an exception under HIPAA allows the disclosure without written authorization. Participants may be asked to complete and return authorization forms and to provide verification of information. Please remember that these and other actions are taken to safeguard the privacy of Participants and their families. Also, keep in mind that from time to time employees and agents of Wespath, such as the Claims Administrator, may access PHI, subject to the rules of HIPAA and the privacy policies of Wespath, as part of their day-to-day function of administering the Plan.

Risk Pool Rules

The HealthFlex Plan implemented the Rules for Risk Pools (Risk Pool Rules) January 1, 2004. Effective January 1, 2015, the HealthFlex Plan modified the Risk Pool Rules to remove the Standard Risk Pool.

- **Risk Pool:** Conference and denominational Plan Sponsors are all part of the risk pool and must enroll 100% of Eligible Persons in the mandatory categories, subject to certain limited exceptions explained in Appendix E, and at least 75% of all Eligible Persons[2] appointed to or employed at a Conference-responsible organization for any optional categories indicated in Exhibit A to the Adoption Agreement (Exhibit A). With respect to Employees of a non-Conference-responsible organization or a local church, that organization or local church must execute a Sub-adoption Agreement and enroll at least 75% of its Eligible Persons.
- **Employer Plan Sponsors:** Employer Plan Sponsors are all part of the Risk Pool and must enroll 75% of their Employees, who are Eligible Persons, in the Plan.

The Risk Pool Rules establish certain other standards and criteria for participation and for payment of Required Contributions. See Rules for the Risk Pool, reproduced in Appendix D, for additional information. Individuals who waive coverage using the Mandatory Waiver Form are not subject to the Risk Pool Rules.

Adoption Agreements

Conferences and Affiliated Organizations that wish to adopt HealthFlex must execute an Adoption Agreement with Wespath to become a Plan Sponsor. An Adoption Agreement is a contract wherein the Plan Sponsor promises to abide by the terms of the Plan and to assume certain duties and obligations under the Plan. Wespath will accept both original, e-mailed and faxed copies of Adoption Agreements and related exhibits. Emailed documents will only be accepted if sent from the work address email of the individual authorized to sign adoptions agreements.

[2] For purposes of the Risk Pool rules, deacons are treated as lay employees.

HealthFlex sets forth basic (i.e., required or mandatory) and optional (i.e., discretionary) categories of participation by clergy Employees, deacons (also clergy Employees) and lay Employees. A Plan Sponsor must specify on *Exhibit A to the Adoption Agreement* (Exhibit A) the optional categories of individuals who should be considered eligible under the Plan.

Exhibit A also defines eligibility as it pertains to Surviving Spouses, Surviving Dependents, Retired Participants, continuation coverage and leaves of absence under certain paragraphs of *The Book of Discipline*. Some Plan Sponsors have certain age and service requirements that must be met by lay Employees before they can participate in the Benefit Options offered by the Plan Sponsor. The Plan Sponsor must offer HealthFlex participation to all Eligible Persons who fall into those categories indicated on Exhibit A and must provide certain notices and materials at the time the Eligible Person becomes eligible. Failure by a Plan Sponsor to do so could result in penalties and possible termination from the Plan. Please refer to Appendix D for an illustrative list of Plan Sponsor duties and requirements.

The respective medical, dental and vision Benefit Options within the Plan that a Plan Sponsor adopts on *Exhibit B to the Adoption Agreement* (Exhibit B) are those available to the Eligible Persons indicated in the Plan Sponsor's elections on Exhibit A. On Exhibit B, a Plan Sponsor also indicates its election to participate on the Small Employer Exception to the Medicare Secondary Payer rules, if applicable.

Plan Sponsors must complete Exhibits A and B and submit such Exhibits to Wespath annually by June 30 preceding the Plan Year. Upon adopting the Plan, a Plan Sponsor must execute a *HealthFlex Plan Sponsor HIPAA Certification Form*, and from time to time may be requested by Wespath to execute an amendment to or a restatement of the Privacy Addendum. A Plan Sponsor cannot make any changes to the elections it has made with respect to optional categories of coverage or Benefit Option selections after the beginning of the Plan Year to which the elections apply. Wespath, in its discretion, can consider requests to add certain new extension ministry appointments during appointment change season. Any other amendments must be effective the first of the month and cannot be earlier than the first day of the then-current year.

COVERAGE LEVELS

The level of coverage (based upon the Plan's coverage tiers and the number of Dependents covered) with respect to a Participant for medical, dental and vision Benefit Options are not required to be the same. Participants must be enrolled in the Benefit Option in order for any dependents to also be covered, unless the Participant is eligible for a Plan Sponsor's Medicare Benefit Option and Dependents are eligible for the HealthFlex Benefit Options. However, different dependents can be covered under different HealthFlex Benefit Options.

The level of coverage with respect to the Participant determines the Required Contributions for such coverage that the Plan Sponsor must pay to Wespath as the HealthFlex Plan Administrator and trustee. Plan Sponsors may make separate arrangements with Participants to allocate Required Contributions among them.

The information that follows provides details regarding eligibility and administrative policies governing HealthFlex, including elections of Benefit Options, effective dates of coverage and billing.

The Plan, Its Components and Its Benefit Options

The Plan is made up of two components: the group health plan and the cafeteria plan.

The group health plan contains several Benefit Options that cover Participants for: 1) medical and hospitalization expenses, 2) prescription drug expenses, 3) mental and behavioral health expenses, 4) dental expenses, 5) vision expenses, 6) a health reimbursement account (HRA), and (7) well-being programs and incentives.

The cafeteria plan contains several sub-components: 1) a premium conversion plan, 2) a flexible spending account for health care expenses, 3) a flexible spending account (FSA) for dependent day care expenses, and 4) a health savings account (HSA), if applicable.

Only current common-law employees may be Participants in the cafeteria plan. Although self-employed individuals are not permitted to be Participants in the cafeteria plan, United Methodist clergy can participate in the cafeteria plan.[3] The Benefit Options under the group health plan and the rules of the cafeteria plan are explained below.

BENEFIT OPTIONS

Through the Benefit Options under its group health plan component, the Plan provides comprehensive health and medical benefits designed to help its Participants meet their health care needs. HealthFlex provides Plan Sponsors with a choice of medical, prescription drug, dental and vision Benefit Options to offer their Eligible Persons. A Participant must be covered under a Benefit Option in order for Dependents to also 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. Participants do not need to be enrolled in the medical Benefit Option in order to be eligible for the other Benefit Options (i.e., dental, vision); however, Plan Sponsors may elect to require Participants to be enrolled in medical in order to enroll in dental and/or vision.

Wespath, in its sole discretion, can add, eliminate or discontinue new Benefit Options at any time; however, Wespath will provide reasonable notice to Plan Sponsors and Participants in such case, barring extraordinary circumstances.

For more information about the Benefit Options offered under the Plan and the specific terms and conditions of the Benefit Options and the benefits offered under each, please review the *HealthFlex Benefit Booklet* or certificate of insurance applicable to each Benefit Option.

MEDICAL BENEFIT OPTIONS FOR ACTIVE PARTICIPANTS AND RETIRED PARTICIPANTS UNDER AGE 65

There are four types of medical Benefit Options, administered by the Plan's Claims Administrators, available to Participants and their Dependents:

- Preferred Provider Organization (PPO)
- Health Reimbursement Account (HRA) Plan
- Health Savings Account (HSA) Plan

[3] The U.S. Tax Court held, in the *Weber* case, that a United Methodist clergyperson is treated as an employee for Federal income tax purposes.

Within each of the types of Benefit Options above, multiple plan designs may be available. Differences among these Benefit Options are primarily the deductibles, co-payments, co-insurance amounts and out-of-pocket maximums.

HEALTH REIMBURSEMENT ACCOUNT (HRA) PLAN

An HRA plan is a type of account-based health insurance plan that allows a Participant to use a health reimbursement arrangement (also called an HRA) to pay certain eligible health care expenses directly, while a high-deductible health coverage plan (i.e., a PPO-type plan with a higher Deductible) protects the Participant from large medical expenses. Services are typically subject to deductible/co-insurance instead of copayments, but the deductible does not apply to pharmacy.

An HRA is used to offset eligible unreimbursed expenses incurred by the Participant or covered Dependents on a nontaxable basis (the contributions to the HRA generally are not taxable). If HRA funds are not used during a Plan Year, the remaining amount will roll over to the following Plan Year, with no maximum on accumulated rolled-over funds as long as the Participant continues participation in the HRA Plan and subject to rules outlined below. Some plan sponsors may offer an HRA with the B1000 plan, in which case the rules below regarding HRAs apply.

HRA balances remaining at retirement may be used to the extent allowed under the law for eligible health care-related expenses, including health coverage in retirement through Medicare and Medicare supplement plans outside of HealthFlex. To be eligible, a Participant must satisfy the retiree eligibility rules of both HealthFlex and the Plan Sponsor. The HRA balance will be available to a Participant even if the Plan Sponsor does not sponsor health coverage for retired Participants through the Plan.

HRA Funding

A health reimbursement account (HRA) will be established for each eligible Participant and used for the sole purpose for reimbursement of eligible medical expenses. Each year the plan sponsor or Wespath will determine the amount that will be contributed to the HRA for the Plan Year based on the Plan adopted/ elected. In addition, Plan Sponsors may contribute additional funds to an HRA. Contributions will be funded and available at the beginning of each Plan Year. Participants may not contribute their own funds to the HRA.

HRA Tax Reporting

HRAs are funded solely by the plan sponsor; employees may not make contributions to their HRA. Contributions to an HRA are not included in the employee's income and are not reported on the IRS Form W-2. Employees do not pay federal income taxes or employment taxes on the contributions made to their HRA.

HRA Reimbursements

The HRA allows reimbursement only for eligible medical expenses. To be an eligible expense, a Participant cannot otherwise be reimbursed for the expense by the Plan or through other insurance or similar group health coverage; and he or she cannot claim the expense as an itemized deduction on an individual income tax return. In other words, the expense must be out-of-pocket to the Participant, and he or she cannot "double dip." Many out-of-pocket health care expenses, such as Co-payments, Co-insurance amounts, Deductibles and out-of-network charges, are reimbursable. In addition, medical expenses described in §213(d) of the Code are eligible for reimbursement from the HRA. Also, the costs of some over-the-counter medications are reimbursable.

In addition, if a Participant has a Retiree HRA as described below, he or she may request reimbursements for long-term care insurance, or any premiums for health and dental insurance or Medicare Part B.

Expenses Not Eligible
Importantly, a Participant *cannot use* an HRA to pay for HealthFlex Required Contributions, while he or she is an active Employee.

Expenses incurred by a Spouse or Dependent who is not covered by the Plan are not eligible for reimbursement. The Participant must certify with HealthEquity that expenses are for an eligible Dependent. Participants may contact Wespath or the Claims Administrator (HealthEquity for the HRA) for a list of permissible HRA expenses.

Carryover of Accounts
If any balance remains in the HRA for a Plan Year after all reimbursements have been made for the Plan Year, such balance shall be carried over to reimburse the Participant for eligible medical expenses incurred during a subsequent Plan Year, if he or she maintains participation in HealthFlex.

HRA Balances When a Participant Elects an HSA Plan
Participants who elect an HSA plan and have an existing HRA balance will have their HRA balance converted to an HSA-compatible HRA (i.e., a health reimbursement account that is compatible with a health savings account), which is limited to vision and dental expenses until the participant reports to the account administrator that the IRS-defined deductible has been met. This also applies if the Participant's Spouse has his or her own HRA; the Spouse's HRA must also be an HSA-compatible HRA.

Opting Out of HRA
Having an HRA balance with the Plan causes a Participant or former Participant to have "minimum essential coverage" under the Affordable Care Act, which renders him or her ineligible for federal assistance (i.e., a premium tax credit) toward the purchase of a Marketplace plan *(instead of a HealthFlex plan)*, if he or she is otherwise eligible. Therefore, if a Participant wants to have medical coverage through the Health Insurance Marketplace (also known as an exchange) under the Affordable Care Act and to be eligible for a premium tax credit, he or she can request to opt out of the HRA (i.e., forfeit the remaining balance) or convert the HRA to a limited-use HRA which can only be used for eligible vision and dental expenses.

UMC Couples

Generally, under the Affordable Care Act (ACA), HRAs cannot be stand-alone; they must be integrated with a major medical plan such as a group health plan and the employee must be offered health coverage. HealthFlex does not permit a HealthFlex stand-alone HRA to be integrated with a major medical plan other than HealthFlex.

For a clergy couples whose primary participant becomes the covered dependent (e.g., at Annual Enrollment), the HRA of the participant who was primary will not be terminated and the HRA will not be subject to the 90-day rule. The HRA will not be treated as a stand-alone HRA since under the ACA, it can still be considered integrated with the spouse's HealthFlex plan. Because the HRA will be treated as integrated with the spouse's HealthFlex plan, the HRA of the clergyperson who was the primary can be used to pay eligible expenses of dependents; the HRA is not just limited to the individual who was the primary participant.

If the clergyperson who was the primary participant loses HealthFlex coverage for a reason other than retirement, the HRA can then only be used for the clergyperson and cannot be used to pay eligible expenses of his or her dependents. If the clergyperson who was the primary participant retires, the HRA is converted to a retiree HRA, and the clergyperson who was the primary participant is able to use the retiree HRA for retiree premiums of the participant and spouse if applicable.

Termination of HRA Participation

If a Participant is no longer eligible to participate in an HRA plan, as described below, and a balance remains in his or her HRA, the funds will be handled in the subsequent Plan Year in the following way:

Change in Participant Status	Impact on HRA
Participant leaves HealthFlex voluntarily without continuation coverage (including waiver of coverage, if permitted by plan sponsor)	HRA is available for 90 days following termination of coverage or until it is exhausted, whichever is earlier.
Participant leaves HealthFlex by termination of employment and is not on continuation coverage	HRA is forfeited 90 days following termination or until it is exhausted, whichever is earlier.
Participant who left HealthFlex voluntarily who is on continuation coverage	HRA is forfeited 90 days following termination of continuation coverage or until it is exhausted—whichever is earlier.
Participant leaves HealthFlex by termination of employment and is on continuation coverage	HRA is available for 90 days following termination of continuation coverage or until it is exhausted, whichever is earlier.
Plan sponsor ceases to sponsor HealthFlex	HRA remains intact through retirement until it is exhausted or participant dies. HRA is available for 90 days following termination of coverage or until it is exhausted, whichever is earlier.
Clergyperson appointment change causes them to lose HF eligibility	HRA remains intact through retirement until it is exhausted or participant dies. If participant terminates employment from a sponsoring denomination, the HRA is available for 90 days following this termination or until it is exhausted—whichever is earlier.
Lay employee goes from full-time to part-time and loses HF eligibility	HRA is available for 90 days following the loss of eligibility.
Participant enrolls in HealthFlex with another plan sponsor	HRA balance rolls over and remains available until it is exhausted or participant dies. If participant terminates employment from any sponsoring denomination, the HRA is available for 90 days following this termination or until it is exhausted—whichever is earlier.

Change in Participant Status	Impact on HRA
Clergyperson of a clergy couple switches from being the primary participant to a dependent	HRA remains intact through retirement until it is exhausted or participant dies. HRA is available for 90 days following termination of coverage or until it is exhausted, whichever is earlier.
Participant selects different benefit option with same plan sponsor	HRA balance rolls over and remains available until it is exhausted or participant dies. If participant terminates employment from the UMC, the HRA is available for 90 days following this termination or until it is exhausted—whichever is earlier.
Participant moves to Via Benefits	HealthFlex HRA balance remains with the health system vendor and remains available until it is exhausted or participant dies. HRA is not combined with Via Benefits HRA. If retired, HRA becomes a Retiree HRA
Participant retires[4]	HRA balance becomes a Retiree HRA and remains available (does not require retiree health coverage through HealthFlex) until it is exhausted or participant dies. If eligible for Via Benefits, HRA is not combined with Via Benefits HRA.
Retired clergy employed as lay	Retiree HRA converted to active HRA and follows active HRA rules.
Retired clergy returns to active relationship with the Plan Sponsor	Retiree HRA converted to active HRA and follows active HRA rules.
Participant or spouse becomes eligible for Retiree HRA while the other remains in the active plan	Entire active HRA balance becomes retiree HRA, but separate active HRA in the name of the active participant/spouse may be created and receive new contributions. If a separate HRA is opened for the spouse or other primary lead dependent and that dependent subsequently leaves HF, their HRA remains available for 90-days or until exhausted-whichever is earlier.
Participant with no covered dependents dies	HRA is forfeited after a 180-day claims spend-down period. Only claims incurred prior to the Participant's date of death are eligible.
Participant with covered dependents dies	If lead dependent is in HealthFlex, the HRA remains available to all covered dependents. Otherwise the HRA is forfeited after a 180-day claims spend-down period.

[4] Participants who retire as Ministers of Other Denominations are not treated as retired from HealthFlex Plan Sponsors for HRA purposes. They are treated as terminated and their HRA is available for 90 days following termination of continuation coverage or until it is exhausted, whichever is earlier.

Change in Participant Status	Impact on HRA
Participant moves back to the active plan from MSPSEE through Via Benefits.	HRA with Via Benefits is available to use for up to six months. Any remaining balance after six months is returned to the Plan Sponsor.
Participant moves to 'No Record of Appointment' status	HRA is available for 90 days following termination of coverage or until it is exhausted, whichever is earlier.
Participant moves to a Special Appointment outside the US	HRA remains intact through retirement until it is exhausted or participant dies. If participant terminates employment from the UMC, the HRA is available for 90 days following this termination or until it is exhausted—whichever is earlier.
Participant loses HealthFlex eligibility with a UMC Plan Sponsor and subsequently enrolls in HealthFlex through another denomination or entity.	HRA balances remains available while the participant is enrolled in HealthFlex through another denomination or entity so long as the enrollment with the new entity becomes effective no later than 90 days after the loss of UMC coverage (including continuation coverage if applicable). HRA balance remains intact through retirement from the new entity as long as active enrollment in HealthFlex with the new entity occurred within 90 days of termination from the UMC annual conference. If transition takes more than 90 days, HRA is available for 90 days following UMC termination of continuation coverage or until it is exhausted, whichever is earlier.

If a Participant terminates for any reason and then is rehired after the 90-day period following which the HRA is terminated, he or she will be considered a new HRA Participant. However, if he or she goes on a qualifying leave under the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, Wespath will continue to maintain his or her benefits on the same terms and conditions as if he or she was still an active Employee. If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, he or she will be treated as having terminated participation.

Small Balances

Notwithstanding the foregoing, if a Participant has an HRA balance but is no longer a Participant in HealthFlex and the HRA balance is $100 or less, Wespath reserves the right to forfeit this remaining small balance and terminate the HRA completely with 90 days' notice. For current Participants not receiving a new HRA contribution and with an HRA balance $100 or less, Wespath reserves the right to forfeit the remaining small balance with 90 days' notice.

Surviving Spouse HRAs

Surviving spouses (regardless of age) who inherit an HRA from a deceased participant can use the HRA to pay for active health premiums.[5]

[5] Regulatory guidance does not address surviving spouses who inherit an HRA and who are not Medicare-eligible. Specifically, the regulations do not address if the surviving spouse can use the HRA for health care premiums if he or she is not yet Medicare-eligible but also not actively employed by the HRA provider. This is a plan design business decision.

Health Savings Account (HSA) Plans and HSAs

A HealthFlex HSA plan is an IRS-qualified high-deductible health plan. It is a type of account-based health insurance plan that protects the Participant from large medical expenses and also allows a Participant to use a Health Savings Account (HSA) to pay eligible health care expenses directly. In order to participate in the HSA offered through HealthFlex (including employer or personal contributions), participants must accept the terms and conditions of the HSA.

An HSA is used to offset eligible unreimbursed medical expenses incurred by the Participant or covered Dependents on a nontaxable basis (both Plan/employer and Participant contributions to the HSA generally are not taxable). HSAs can also be used for non-eligible medical expenses; however, any amount used for non-eligible expenses will be treated as taxable income and subject to a tax penalty if under age 65.

If HSA funds are not used during a Plan Year, the remaining amount will roll over to the following Plan Year, with no maximum on accumulated rolled-over funds. HSA balances remaining at retirement may be used to the extent allowed under the law for eligible health care-related expenses, including health coverage in retirement through Medicare plans outside of HealthFlex.

HSA Funding

An HSA will be established for each eligible Participant in the HSA plan who does not opt out of the HSA and does accept the terms and conditions of the HSA. HSAs may be funded by the Plan Sponsor. In addition, the Participant can elect to make his or her own pre-tax contributions into the HSA. Participants who are on a leave of absence will receive the Plan Sponsor Contribution. If Participants on a leave of absence want to make personal contributions to the HSA, they must do so on an after-tax basis directly with the custodial bank. Plan Sponsor Contributions will be funded and available in full at the beginning of each Plan Year. Participant Contributions will be available monthly as they are made to the HSA.

Participants who are currently enrolled in an HSA plan and transfer to a Plan Sponsor who offers the same HSA plan will not be eligible for an additional HSA contribution from the new Plan Sponsor.

Participants who lose eligibility and become eligible again mid-year are not eligible for an additional Plan Sponsor Contribution into the HSA until the following Plan Year. Dependents who become Surviving Dependents or Divorced Spouses are not eligible for an additional HSA Plan Sponsor Contribution until the following Plan Year.

HSA Contributions Limit

HSAs are subject to an annual contribution limit established by the Internal Revenue Service (IRS). The contribution limit is based on single or family coverage. For 2024, the contribution limit is $4,150 for single coverage and $8,300 for family coverage. Participants age 55 and older can contribute an additional $1,000 annually.

Participants who enroll in the HSA mid-year can either contribute under the IRS “Last Month Rule” or contribute a prorated amount based on the actual number of months in the HSA Plan and eligible for the HSA. Under the Last Month Rule, the Participant can contribute the full HSA amount for the current year, provided the Participant is eligible on December 1 of the current year and remains eligible and enrolled through December 31 of the following year. If eligibility is lost prior to December 31 of the following year,

the excess contributions must be returned (upon participant request) by the tax-filing deadline (April 15) to avoid being treated as income and also have a penalty applied.

Participants whose spouse also has his or her own HSA can contribute up to the family limit as long as one of them has family coverage. The limit is split between the Participant and Spouse. If however, the Participant and Spouse are each enrolled in single coverage, they are each limited to the contribution limit for single coverage.

Participants are responsible for complying with IRS contribution limits and all other applicable IRS regulations associated with an HSA.

HSA Reimbursements

The HSA allows reimbursement for eligible medical expenses. To be an eligible expense, a Participant cannot otherwise be reimbursed for the expense by the Plan or through other insurance or similar group health coverage; and he or she cannot claim the expense as an itemized deduction on an individual income tax return. In other words, the expense must be out-of-pocket to the Participant, and he or she cannot "double dip." Many out-of-pocket health care expenses, such as Co-payments, Co-insurance amounts, Deductibles and out-of-network charges, are reimbursable through an HSA. In addition, medical expenses described in §213(d) of the Code are eligible for reimbursement from the HSA.

HSAs may also be used for non-eligible expenses; however, the amount used is treated as taxable income and subject to a penalty (20% in 2024) if the Participant is under age 65.

Carryover of Accounts

If any balance remains in the HSA for a Plan Year after all reimbursements have been made for the Plan Year, such balance shall be carried over to reimburse the Participant for eligible medical expenses incurred during a subsequent Plan Year.

Termination of HSA Participation

If a Participant is no longer eligible to participate in an HSA plan (e.g., elected a non-HSA plan, retired, terminated or enrolled in Medicare) and a balance remains in his or her HSA, the funds are available for use until exhausted. The HSA balance is never lost or forfeited; it remains with the Participant.

The Custodial Bank may charge an administration fee directly to the participant for account balances below a certain threshold. Investment options may also be available through the Custodial Bank for individuals with account balances above a certain threshold.

RESTRICTIONS ON CHANGES TO HSA FUNDING

Final funding files are sent to HealthEquity on December 5. Wespath is unable to accept any changes to HSA or FSA personal contribution amounts for the current year after December 4. This includes individuals who become eligible for benefits after December 4.

MEDICAL BENEFIT OPTIONS FOR MEDICARE-ELIGIBLE PARTICIPANTS

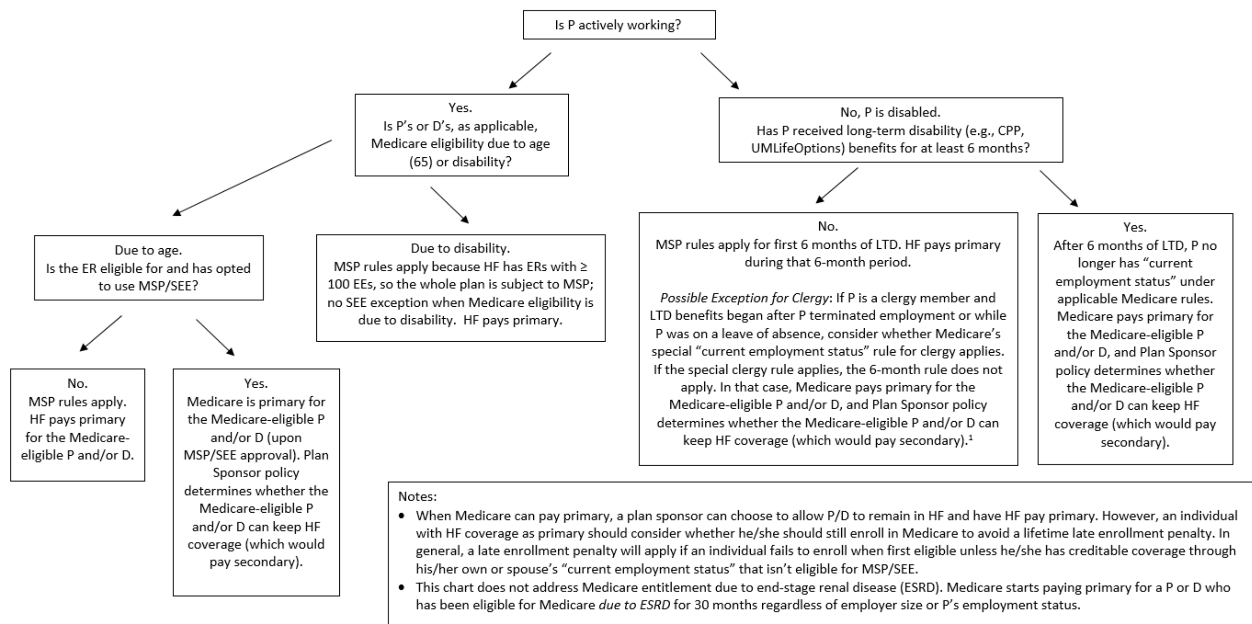
For Participants or Dependents who are age 65 and over (i.e., eligible for Medicare), or under age 65 but eligible for Medicare, the Plan Sponsor's policies and rules will determine whether those individuals remain eligible for coverage under HealthFlex, transition to Via Benefits (an organization that assists Medicare-eligible individuals in choosing individual Medicare supplement plan coverage from a variety of

health insurance carriers), or some other approach. In addition to the Plan Sponsor's policies and rules, HealthFlex requires the following categories of Medicare-eligible individuals to have Medicare pay primary: (1) individuals who are retired and over age 65 (not eligible for HealthFlex), (2) over-age 65 spouses of retired individuals (pre and post 65 retirees) (spouse not eligible for HealthFlex), (3) individuals who are working over age 65 and whose Plan Sponsor has elected the Small Employer Exception (may be eligible for HealthFlex depending on the Plan Sponsor's rules, but Medicare is primary), and (4) certain categories of individuals who are Medicare-eligible due to disability, as illustrated in the chart at the end of this section (Medicare pays primary for certain categories).
Please note: Participants who are enrolled in Medicare [e.g., enrolled in Medicare due to disability or enrolled through the Medicare Secondary Payer Small Employer Exception (MSPSEE)] are not eligible to contribute to an HSA in their name and therefore should consider not electing an HSA plan. Wespath provides a document detailing considerations for HSA contributions when approaching Medicare eligibility (click here).

If a Participant who should be Medicare primary remains covered in HealthFlex but does not enroll in Medicare Part B, the Active Plan will not cover the cost of Claims (or the portion thereof) that would otherwise be covered under Medicare Part B. Therefore, a Participant should enroll in Medicare Part B to ensure maximum coverage. If a Participant elected to opt out of the Social Security program but purchases Medicare coverage at age 65, he or she will participate in the Medicare Option as elected by the Plan Sponsor.

In order to participate under Via Benefits, a Participant must be enrolled in Medicare Part B. If a Participant elected to opt out of the Social Security program but purchases Medicare coverage at age 65, he or she may opt for coverage using Via Benefits, if elected by the Plan Sponsor. If the Participant does not purchase Medicare coverage, he or she will remain in the Benefit Option for Active Participants, if permitted by the Plan Sponsor. *However, the Active Plan will not cover the cost of Claims (or the portion thereof) that would otherwise be covered under Medicare Part B*.

A Participant and his or her Dependents generally must be covered under the same Benefit Options, even if they live in different geographic areas. In certain circumstances a Participant and his or her Dependent can be covered under different Benefit Options due to factors such as age and Medicare eligibility. Such circumstances involve Retired Participants who have not yet attained age 65, Medicare-eligible disabled Participants and the working aged under the MSPSEE Rules (when the Plan Sponsor has elected the Small Employer Exception). For example, a Retired Participant who is over age 65 may be covered in a Medicare supplement plan such as through Via Benefits, while his or her Spouse or Dependent who is under age 65 will remain enrolled in a medical Benefit Option for Active Participants.



Waiving HealthFlex Coverage When Medicare-Eligible

An active participant or spouse of an active participant who is eligible for Medicare coverage can choose to waive HealthFlex active coverage. If the participant and/or spouse waives HealthFlex coverage, the waiver applies to all: medical, dental and vision coverage. However, employers and health plans must not incentivize (or appear to incentivize) Medicare-eligible participants to drop active coverage. Therefore, the following steps must be taken to protect the plan and plan sponsor if a request is received to drop active coverage for someone who is Medicare-eligible and HealthFlex would otherwise be primary:

- The request to drop active coverage should be requested by completing the appropriate form (i.e., the HealthFlex Enrollment/Change form or the HealthFlex Mandatory Premium and Coverage Waiver form).
  - Medicare coverage will be considered "Other Coverage" and a legitimate reason for waiving coverage without triggering an employer penalty under the Risk Pool Rules if a valid Mandatory Premium and Coverage Waiver form is submitted.
- The participant and/or spouse should submit a signed statement certifying no one provided them an incentive to waive HealthFlex coverage. Wespath will provide a template for this purpose.
- If the participant and/or spouse wishes to use Via Benefits' services to enroll in Medicare supplemental coverage, they should contact Via Benefits independently and should not enroll through Wespath or the plan sponsor.
- The plan sponsor should not provide an HRA for the person or any other incentive to waive coverage. Any incentive is prohibited if the waiver of coverage results in Medicare paying primary for a person who would otherwise have a group health plan pay primary.

DENTAL BENEFIT OPTIONS

Plan Sponsors offer up to three dental Benefit Options for Active and Retired Participants and their Dependents:

- Passive PPO 2000
- PPO
- Dental HMO (based on ZIP code availability)

Plan Sponsors can choose to offer dental Benefit Options to Active Participants without necessarily offering dental Benefit Options to Retired Participants.

A Plan Sponsor can only offer the dental Benefit Option when it offers medical Benefit Options. A Participant does not have to be covered under a medical Benefit Option in order to elect the dental Benefit Option; however, Plan Sponsors may choose to require Participants to elect medical Benefit Option in order to elect the dental Benefit Option. A Participant must be covered under the dental Benefit Option in order for Dependents to be covered under the dental Benefit Option. Participants may opt out of dental coverage for themselves and all Dependents covered by the medical Benefit Option. Retired participants age 65 and older are not eligible for dental Benefit Options through HealthFlex.

VISION BENEFIT OPTIONS

An "exam only" vision Benefit Option is included with all medical Benefit Options; because it is an excepted benefit, individuals may choose to opt out of the "exam only" vision (but with no cost savings). Plan Sponsors also offer the "Full Service" and Premier" buy-up vision plans, which the Participants may select.

Plan Sponsors may choose to offer the vision Benefit Option to Active Participants without necessarily offering the vision Benefit Option to Retired Participants.

A Plan Sponsor can only offer the vision Benefit Option when it offers medical Benefits Options. A Participant does not have to be covered under a medical Benefit Option in order to be covered under the vision Benefit Option; however, Plan Sponsors may choose to require Participants to elect medical Benefit Option in order to elect vision Benefit Option. A Participant must be covered under the vision Benefit Option in order for Dependents to be covered under the vision Benefit Option. Participants may opt out of vision coverage for themselves and all Dependents covered by the medical Benefit Option. Retired participants age 65 and older are not eligible for vision Benefit Options through HealthFlex.

MEDICARE SECONDARY PAYER SMALL EMPLOYER EXCEPTION (MSPSEE)

When a multiple employer group health plan (Multiple Employer Plan), like HealthFlex, has at least one participating employer with fewer than 20 employees, Medicare's secondary payer requirements allow a Multiple Employer Plan to exempt aged individuals from the Working Aged Rules that would otherwise require the plan to pay primary to Medicare, provided that their coverage is by virtue of current employment status. This is called the Small Employer Exception, i.e., the Medicare Secondary Payer Small Employer Exception (MSPSEE). The HealthFlex Plan has elected to support the Small Employer Exception for certain employers offering coverage through HealthFlex, if elected by the Plan Sponsor. Additional requirements are needed to participate in MSPSEE and are detailed in Appendix E.

A Participant must be actively working, enrolled in active coverage, and employed by an employer with fewer than 20 employees for the Participant (and/or his/her Dependent) to qualify for the Small Employer Exception. In addition, the Participant or Dependent, as applicable, must be entitled to Medicare Part A and B due to age, and will thereby have the option to enroll in Via Benefits or have Medicare pay primary in the active plan.

The Small Employer Exception does not apply with respect to the Medicare coverage of a Participant or Dependent who is eligible for Medicare due to disability.

If you have questions regarding the Small Employer Exception, please contact your Client Relationship Manager or Client Service Manager. They will work with the HealthFlex benefits team to address your questions. For additional information, see the Medicare Secondary Payer Administrative Guidelines, which are reproduced in Appendix E.

If Participants or Plan Sponsors encounter difficulties with the Centers for Medicare and Medicaid Services (CMS) or the Medicare Coordinator of Benefits regarding the order of payment (i.e., whether the Plan or Medicare should be the primary payer), the matter should be promptly referred to the Wespath Health Team for assistance.

Pre-Tax Contributions (Cafeteria Plan)

Under Internal Revenue Code §125, Participants in the Plan can choose to pay the Required Contributions, also called premiums, for Benefit Options on a pre-tax basis. This is known as the "premium conversion" aspect of the cafeteria plan. An Active Participant who is actively at work (i.e., who is not on a leave or assigned any non-salaried status) can elect to pay for benefits on a pre-tax basis. Alternatively, Active Participants can elect to forego the benefits of the premium conversion plan, paying all Required Contributions on an after-tax basis. Regardless of whether a Participant opts to participate in the cafeteria plan component of the Plan, Wespath administers the Plan as a cafeteria plan under §125 of the Code. As such, the ability of Participants to change their elected Benefit Options is strictly limited to Annual Election Periods and certain Change of Status Events. Please refer to the section of this Manual entitled *Change of Status Events* and Appendix A for more information.

A cafeteria plan must offer Participants a choice between cash and qualified benefits. The Plan satisfies this requirement by offering Employees a choice to receive their full salary in cash (i.e., the full, unreduced salary as the cash option) or a reduced salary with the reduction amounts used to purchase some, or all, of the qualified benefits of the Plan (i.e., the Benefit Options and deferrals to flexible spending accounts).

Participant contributions (elective deferrals) to health care or dependent care flexible spending accounts (FSAs) are also pre-tax (through salary reduction arrangements).

Premium Credit

The Premium Credit is a component of HealthFlex. The premium credit is a fixed amount that the Plan Sponsor allocates to each HealthFlex Participant depending on eligibility status. Each Plan Sponsor determines the premium credit amount(s) for the applicable subgroups of its population. A Participant must be covered under the medical Benefit Option in order to be eligible for the premium credit. The premium credit functions as a "credit" toward the overall premium cost of the plan(s) elected. Participant's Required Contribution is the remainder of the plan cost after the premium credit has been applied.

If a Participant elects a Benefit Option that costs less than the premium credit, the excess premium credit will be deposited into a HRA if the B1000 or an HRA Plan Benefit Option is elected or into an HSA if an HSA Plan Benefit Option is elected. If the Participant elects a Benefit Option that costs more than the premium credit, the remaining Required Contribution should be deducted on a pre-tax basis from the Participant's paycheck. The Salary-Paying Unit is responsible for implementing the deduction of the remaining Required Contribution and remitting the collected amount to the Plan Sponsor. The Required Contribution deducted from the Participant's paycheck is eligible for the premium conversion portion of

the Plan's cafeteria plan. HealthFlex will bill the Plan Sponsor for the premium credit plus any remaining Required Contribution.

After-Tax Contributions

Participants who are not actively employed and receiving compensation must pay the Required Contributions (premiums) for their medical, dental and vision coverage on an after-tax basis. Such Participants cannot take advantage of the cafeteria plan's premium conversion aspect to pay Required Contributions, or underpayment of these contributions, on a pre-tax basis. Upon a Participant's request, Wespath will deduct Required Contributions directly from pension or welfare plan benefits administered by Wespath. In other cases, the Plan Sponsor must bill and collect Required Contributions directly from these Participants. 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 aspect and flexible spending accounts of the cafeteria plan as long as they remain actively working.

Flexible Spending Accounts (FSA)

Active Participants, with the exception of actively working Participants who are on the MSPSEE, who are actively at work, i.e., who are not on a leave of absence or assigned any non-salaried status, can choose to defer compensation to a flexible spending account. HealthFlex offers a flexible spending account for health care expenses and one for dependent day care expenses. An Employee can elect to reduce his or her salary for a coverage period (usually, a Plan Year) through a salary-reduction agreement where the employer deducts the contribution amount pro rata each month or payroll period. These salary deductions are applied to fund the Participant's flexible spending account(s).

Flexible spending accounts, as defined and governed by §§ 105, 106 and 129 of the Code and included as part of a cafeteria plan, can only provide reimbursement for eligible health care expenses or dependent day care expenses. The Plan maintains its flexible spending accounts as bookkeeping accounts, with the "account balance" representing the amount of the Employee's salary reduction contributions, less any amounts already reimbursed or the amount that the Plan can pay, subject to the flexible spending account rules and regulations, to reimburse an Employee's eligible expenses.

To participate in the HealthFlex FSAs, a Participant must be covered by a HealthFlex medical Benefit Option offered by the Plan Sponsor. For each year in which a Participant desires to maintain FSAs, the Participant must make an affirmative election to defer part of his or her salary to the FSAs (i.e., the Participant must make FSA elections each year—typically during the Annual Election Period, in order to maintain an FSA for the coming Plan Year). If a Participant does not elect an amount for the FSAs each Plan Year, the Participant is presumed to have made an election to defer zero dollars ($0) to each such FSA and will therefore not have access to such accounts for that Plan Year. Amounts remaining in a dependent care FSA at the end of a Plan Year do not carry over to the following Plan Year. Amounts remaining in a health care FSA at the end of a Plan Year carry over only to the extent permitted by the plan's carry-over rules.

Health care FSA

The health care FSA allows reimbursement for any eligible medical expense, as defined by §213 of the Code, that is not otherwise reimbursed by the Plan, through its Benefit Options, insurance or similar group health coverage, and that is not claimed as an itemized deduction on an individual tax return. Most important, Participants cannot use a health care FSA to pay for HealthFlex Required Contributions (plan premiums), long-term care expenses, insurance or similar health coverage premiums. A list of permissible

and non-permissible medical expenses with respect to a health care FSA can be found on the Benefits Access website.

Participants who elect an HSA plan Benefit Option can elect an HSA-compatible FSA which is limited to vision and dental expenses. The health care FSA will remain a limited-use FSA until the participant notifies HealthEquity that he/she has met the applicable IRS-defined deductible and provides appropriate documentation; then the FSA can be used for all eligible health care expenses. (2024 IRS-defined deductible: $1,600 individual, $3,200 family). This also applies if the Participant's Spouse has his or her own health care FSA. The Spouse's FSA must also be an HSA-compatible FSA. If a participant in HealthFlex is covered also by a spouse's full-use FSA, the HealthFlex Participant is ineligible for contributions to the HSA.[6] Even if the Participant is covered but does not use the spouse's full-use FSA, the Participant is ineligible for contributions to the HSA. The Participant is responsible for adhering to these IRS requirements.

The Participant may submit claims for reimbursement of expenses incurred during the coverage period up to the amount elected for the coverage period. Under the health care FSA, the amount elected for the entire Plan Year is available to the Participant for reimbursement of eligible medical expenses incurred during the applicable Plan Year beginning with the first day of the coverage period. This requirement is called the "uniform coverage rule."

Generally, a Participant must incur eligible expenses for reimbursement under the health care FSA during the applicable Plan Year. Expenses are incurred when the service or care is provided, and not necessarily when the Participant is billed or pays for the care.

Unused health care FSA funds will be forfeited if the Participant does not incur enough expenses during the Plan Year to exhaust that Plan Year's FSA balance. In addition, Participants must remember to submit these expenses for reimbursement by the last day of the run-out period, which is April 30 of the year following the applicable Plan Year.

However, HealthFlex will permit a participant to carry forward up to $640 remaining in his or her health care FSA at the end of a Plan Year to the following Plan Year. For this purpose, the amount remaining unused as of the end of the Plan Year is the amount unused after medical expenses have been reimbursed at the end of the plan's run-out period for the plan year. The carryover of up to $640 does not count against or otherwise impact the maximum permitted election for the health care FSA (i.e., $3,200). The Participant will have until December 31 of the following year to apply eligible expenses against the $640 carry-over balance, if applicable (i.e., until December 31, 2025 for the 2024 Plan Year). If a Participant carries over up to $640 into the following year health care FSA but does not elect any new health care FSA funds in the second year, the participant is not eligible to carryover any funds into a third year. Remaining funds will be forfeited after the full second year. The carryover and maximum election amounts noted in this paragraph are for the 2024 Plan Year. The IRS typically announces limits for the coming year each October or November.

Example:
Participant must spend all but $640 of their health care FSA by December 31 of the 2024 plan year or it will be lost. After December 31, 2024, participant can carry over up to $640 remaining in their health care FSA account into 2025.

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[6] IRS Notice 2005-86.

- If participant elects to contribute to a health care FSA in 2025: They will be able to carry over up to the IRS 2025 carryover limit into the 2026 plan year.
- If participant does not elect to contribute to a health care FSA in 2025: They will not be able to carry over any FSA funds into 2026.

Dependent Care FSA

Unlike the health care FSA, the amount of dependent care FSA reimbursement available at any time during the Plan Year is limited to the amount credited to a Participant's dependent care FSA at the time of the reimbursement request (reduced by the amount of prior dependent care FSA reimbursements paid to the Participant to date in the Plan Year). Furthermore, the dependent care FSA does not have a carry-over provision for unspent amounts.

Participants who elected an HSA plan may also elect a full-use dependent care FSA.

FSA—Unclaimed Amounts

Unclaimed amounts in an FSA are forfeited by the Employee if not reimbursed by the end of the Run-Out Period. This requirement is the "use-it-or-lose-it" rule and it is mandated by the Code. Such forfeitures accrue to the Plan and are used to offset administrative expenses.

Note: A special, temporary change was made to the "use it or lose it" rule for 2021 and 2022 that applies to both health and dependent care FSAs. **Click here** to learn more about the change.

UMC COUPLES

If both Spouses of a married couple are eligible for HealthFlex benefits because of their clergy, deacon, or lay Employee statuses within The United Methodist Church, they are considered a "UMC Couple" and the following provisions shall apply.

- Each individual in the UMC Couple can be enrolled as a Participant or as a Dependent, but no person can be enrolled both as a Participant and as a Dependent. This rule applies even if the two individuals are associated with two different Plan Sponsors.
- The two individuals may each enroll as a Participant and cover Eligible Dependent Children. An Eligible Dependent Child, however, cannot be covered twice (i.e., cannot be covered under one parent's coverage and also under the other parent's coverage.)
- When both individuals are enrolled in the Plan (one as a Participant and one as a Dependent) and the member of the UMC Couple who is listed as the Participant loses eligibility, the Dependent Spouse then becomes the covered Participant and maintains the existing coverage for any covered Dependents. This is a manual process and may require completion of a separate *HealthFlex or Via Benefits Enrollment/Change Form* for each individual or an election for each individual in Benefitsolver.
- When both individuals are enrolled in the Plan, one as a Participant and one as a Dependent, the Dependent does not need to submit the *HealthFlex Mandatory Coverage Waiver Form*. This is a manual process and may require notifying the Health Team of the circumstances under which the *Waiver Form* is not required.
- Whichever member of the UMC Couple enrolls as the Participant may elect a health care FSA up to the maximum amount permitted. If both members of the UMC Couple enroll as Participants, each may elect a separate health care FSA; each Participant may elect up to the IRS-established maximum

contribution amount. In the latter case, a health care FSA can be used to pay eligible expenses of either person, but a specific expense can be reimbursed only once from one FSA account.

- Whichever member of the UMC Couple enrolls as the Participant may elect a dependent care FSA up to the IRS-established maximum contribution amount. If both members of the UMC Couple enroll as Participants, each may elect a separate dependent care FSA, but the maximum amount permitted is applied across both Participants.
- Participants and Plan Sponsors can find additional information regarding FSA benefits on the HealthFlex website.

Eligibility and Enrollment

It is very important that a Participant or Eligible Person inform his or her Plan Sponsor of any Change of Status Events within 31 days of the occurrence of such events, and that the Plan Sponsor also inform Wespath of such event within 31 days of the event. Failure of Plan Sponsors to inform Wespath in a timely manner of such events and notices can jeopardize the ability of Participants to make election changes and can have adverse tax consequences for the individuals or cause individuals to lose coverage.

For a Special Enrollment of an Eligible Person, the Plan Sponsor will send the affected Eligible Person a *HealthFlex or Via Benefits Enrollment/Change Form*. The Eligible Person must complete the *HealthFlex or Via Benefits Enrollment/Change Form* and return it to the Plan Sponsor in a timely manner such that the Plan Sponsor can submit the form to Wespath within 31 calendar days of the Special Enrollment Event.

The Plan Sponsor may notify Wespath about a Participant's Change of Status or Special Enrollment Event by completing the *HealthFlex or Via Benefits Enrollment/Change Form* on behalf of the requesting Participant, indicating "signature on file" in the form's signature block, and submitting the form to Wespath. HealthFlex Exchange participants may be able to complete some enrollments online without completion of a form.

When Other Health Coverage is lost or the Eligible Person encounters any of the other Special Enrollment Events listed above, the 31-day count starts with the first day that follows the Special Enrollment Event (the first day without coverage under the Other Health Coverage plan).

31-Day Signature Requirement

HealthFlex maintains a rule that requires a Participant's or Eligible Person's Plan Sponsor to sign and submit any *HealthFlex or Via Benefits Enrollment/Change Form* with respect to the Participant or Eligible Person to Wespath within 31 days of the qualifying event. If the qualifying event is adding a newborn to coverage, the *HealthFlex or Via Benefits Enrollment/Change Form* must be submitted within 60 days of the qualifying event.

If an enrollment or change request does not meet this 31-day requirement, Wespath will apply a non-compliance rule to determine which enrollment and coverage requests and changes the Plan will allow. Generally, because of the time limits set forth in HIPAA and the Code, Wespath will deny requests from Participants and Eligible Persons to add or delete coverage when the 31-day requirement is not satisfied, unless there are extenuating circumstances.

Non-Compliant Enrollments

If the Eligible Person's request does not meet the 31-day requirement for Plan Sponsor signature, the Eligible Person is unable to enroll for coverage under the Plan until the next Open Enrollment Period (typically called the Annual Election Period). The Eligible Person may enroll outside of the Annual Election Period if he or she subsequently experiences a Change of Status Event, including a Special Enrollment Event as defined under HIPAA.

If a Participant's request does not meet the 31-day requirement for Plan Sponsor signature, the Participant may not elect to drop medical, dental or vision Benefit Options for himself or herself or his or her Dependents. The Participant also may not change his or her elected deferral to an FSA during the course of a Plan Year without encountering a Change of Status Event that allows such change. Exceptions to this are for extenuating circumstances only and require review by the Plan Manager and the Compliance/Legal department(s).

See *Change of Status Events* and *Open Enrollment* for more information.

Active Participant—Enrollment

The date a person first enters a covered category is considered to be his or her eligibility date.

The Plan Sponsor must notify an Eligible Person of his or her eligibility and provide the Eligible Person with a HealthFlex enrollment packet, which includes either a *HealthFlex or Via Benefits Enrollment/Change Form*. On the *HealthFlex or Via Benefits Enrollment/Change Form*, the Eligible Person must indicate whether coverage is being accepted or declined for himself or herself and any Dependents. If the Eligible Person declines coverage, he or she must indicate whether he or she has Other Health Coverage. The Eligible Person must complete and return the *HealthFlex or Via Benefits Enrollment/Change Form* to the Plan Sponsor in a timely manner in order to allow the Plan Sponsor to review and sign it within 31 days after his or her eligibility date. The Plan Sponsor then faxes or mails the completed *HealthFlex or Via Benefits Enrollment/Change Form* to Wespath.

The enrollment packet also contains important information for the Eligible Person regarding: 1) his or her HIPAA rights, 2) rights to continuation coverage in the event of termination of coverage, and 3) other Plan rules. Plan Sponsors must provide the enrollment packet to newly hired Eligible Persons and anyone else who becomes eligible.

Wespath maintains a record of all enrolled Participants and enrolled Dependents for administrative, communication and compliance purposes. It is important to send the *HealthFlex or Via Benefits Enrollment/Change Form* as soon as possible after eligibility to avoid limitations on coverage.

> **Example:** Eva is hired on April 1 and is eligible to participate in HealthFlex. Her Plan Sponsor provides the enrollment packet and *HealthFlex or Via Benefits Enrollment/Change Form*. Eva reviews the information, completes the form, and returns it to the Plan Sponsor. The Plan Sponsor reviews the form and signs it. The Plan Sponsor then forwards the completed form to Wespath. The entire process must be completed by the end of day May 1.

Please note: Eligible Persons whose Plan Sponsor offers HealthFlex coverage through HealthFlex Exchange will not complete the *HealthFlex or Via Benefits Enrollment/Change Form*. Instead, such Eligible Persons would enroll in HealthFlex or make plan election changes online through the Benefitsolver web portal.

Participants who become eligible to enroll in HealthFlex for the first time on or after April 1 are not required to take the Health Check during their first year of participation in HealthFlex to avoid paying a higher deductible.

DEPENDENT (INCLUDING SPOUSE)—ENROLLMENT

To cover an eligible Dependent (including a Spouse) under HealthFlex, the Participant must enroll the Dependent in the Plan. The Participant must indicate on the *HealthFlex or Via Benefits Enrollment/ Change Form* that coverage for such Dependent is desired, and then submit the form to his or her Plan Sponsor for signature within 31 calendar days of the new Dependent's eligibility date. The Plan Sponsor then faxes or mails the form to Wespath. A Dependent's eligibility date is the date he or she first meets the definition of an Eligible Dependent.

> **Example:** A newborn child's eligibility date is his or her birth date. A newborn child of a covered Participant is covered under HealthFlex for 31 calendar days from the date of such child's birth regardless of whether he or she is ultimately enrolled for coverage under HealthFlex. If the Participant wishes to cover the child beyond the 31 days following birth, the Participant must add the child to coverage by submitting the *HealthFlex or Via Benefits Enrollment/Change Form* to the Plan Sponsor within 60 days of the birth.

In certain circumstances, civil union partners and domestic partners of Employees may be covered, depending upon (1) the law of the State in which the Employee resides and Plan Sponsor is located, and (2) the elections of the Plan Sponsor.

Participants are responsible for notifying their Plan Sponsor and Wespath of any changes that affect a covered Dependent's eligibility or coverage. Any such notifications that a Participant does not submit in a timely manner will be subject to the *Retroactive Enrollments and Terminations* provisions described later in this Manual. Exceptions to this are for extenuating circumstances only and require review by the Plan Manager and the Compliance/Legal department(s).

DOMESTIC PARTNER COVERAGE

A Plan Sponsor may elect, through its Exhibit D, Civil Partner Coverage, to offer coverage for the same-sex partner (Civil Partner) of an Employee who has entered a civil union or domestic partnership, which, under the law of the state[7] in which the Employee 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 are 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 or SECA for clergy) 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.

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[7] Some localities and municipalities have established domestic partner registries. HealthFlex does not permit plan sponsors covering jurisdictions that are subunits of states recognizing limited domestic partnerships to adopt coverage of domestic partners.

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, i.e., 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 Book of Discipline is not entirely clear on how to treat same-sex partners for health benefits purposes. HealthFlex plan sponsors may want to consider the following paragraphs when making decisions related to such benefits: *Discipline* ¶¶162J, 162V, 161F, and 162B, as well as ¶¶341.6 and 304.3 with respect to clergy.

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 ¶806.9 or ¶613.19 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 UMC 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.

NON-SALARIED PARTICIPANT COVERAGE

A Participant appointed to a status related to medical leave, family leave, voluntary leave, involuntary leave, transitional leave, military leave or maternity/paternity leave, as defined by *The Book of Discipline*, must be covered under the Plan at the time of such appointment or status change in order to continue to have access to coverage under HealthFlex. The Participant will remain in his or her then-currently elected Benefit Options. However, any FSA the Participant has will be immediately discontinued (see *Medical Leaves* below for the exception for medical, family and maternity/paternity leaves).

Required Contributions for non-salaried Active Participants are paid on an after-tax basis. Non-salaried Active Participants are not included in the mandatory group of covered individuals under the Risk Pool Rules.

Clergy Employees appointed as students or to "attend school" are also considered non-salaried Active Participants. A Plan Sponsor must indicate on its Adoption Agreement whether these types of non-salaried statuses are eligible for coverage under HealthFlex.

If a Participant returns to active salaried status from an eligible non-salaried status during the course of a Plan Year, for the balance of that Plan Year he or she must remain in those Benefit Options under which he or she was covered while in the non-salaried status. Flexible Spending Account elections are made available to the Participant.

Generally, eligibility under the Plan for individuals on leaves other than medical leave (which is limited by a Plan Sponsor's own policies) is limited to 12 months of regular coverage, after which the individual is eligible for continuation coverage under the Plan. A Participant is not eligible for more than 12 months of regular coverage if he or she takes consecutive leaves of absence. An individual would become eligible for regular coverage again in the Plan if he or she is appointed to an active service appointment or employed as a lay Employee pursuant to the Plan Sponsor's Adoption Agreement Exhibit A.

Medical Leaves

The following rules generally will apply when a lay Employee of a Plan Sponsor that is subject to the terms of the Family and Medical Leave Act (FMLA) takes an FMLA leave, or a clergy Participant takes a medical leave, a family leave or a maternity/paternity leave as defined in *The Book of Discipline*, subject to the requirements of §125 of the Code and any other applicable laws and regulations:

- The Participant may maintain his or her medical, pharmacy, dental and vision benefits, provided that the Plan Sponsor continues coverage under its policies and rules. Covered clergy granted maternity/ paternity leave will remain covered for the duration of the leave. The Participant may maintain his or her health care or dependent care FSA as if he or she has been a salaried Active Participant for three (3) calendar months from the end of the month in which the Participant first went from salaried to medical leave status (i.e., began the FMLA leave). A Participant can pay the premium conversion and salary-reduction amounts due for that period: 1) in full on a pre-tax basis either before the medical leave or upon return from medical leave (if within the three-month period), or 2) on an after-tax basis during the medical leave.
- If the Participant continues to receive salary, Required Contributions and salary-reduction amounts may be deducted on a pre-tax basis during the leave.
- At the end of the three-month period described above, Wespath will terminate any health care or dependent care FSA the Participant might have. The Participant has 90 days from the later of (1) the last day on which he or she received salary or (2) the last day of the 3-month period described above if he or she maintained the FSA when the medical leave began, in which to submit claims for reimbursement from his or her FSA for claims incurred on or before the last day on which the Participant received salary. Claims submitted after this 90-day run-out period will not be paid, and any amounts remaining in FSA accounts after such period are forfeited to the Plan.

Disability

A Participant approved for the Comprehensive Protection Plan (CPP), *UMLifeOptions* or other employer/ Plan Sponsor-provided long-term disability benefits may remain in his or her then-currently elected HealthFlex Benefit Options, provided that the Plan Sponsor continues coverage under its policies and rules. If a Participant receiving long-term disability benefits (e.g., from the Comprehensive Protection Plan or UMLifeOptions), remains in HealthFlex under a Plan Sponsor's policy, and the Participant or a covered Dependent become eligible for Medicare for any reason, Medicare will begin paying primary to HealthFlex for the Participant or Dependent, as applicable, once the Participant has received disability benefits for six

months[8]. 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 when upon later enrollment.

If the Participant is not covered by a long-term disability plan, Wespath will determine the disabled status of the Participant for the purposes of this Plan. Any FSA the Participant has will be discontinued immediately. The Participant has 90 days from the last day on which he or she received salary in which to submit claims for reimbursement from his or her FSA for claims incurred on or before the last day on which the Participant received salary. Claims submitted after this 90-day run-out period will not be paid, and any amounts remaining in FSA accounts after such period are forfeited to the Plan.

A Participant who is receiving disability benefit payments under a welfare benefit plan administered by Wespath (such as CPP or *UMLifeOptions*) can request that his or her Required Contributions be paid from his or her disability benefit under such plan.

Disabled Participants and Dependents who meet the requirements for Medicare to act as primary payer for medical claims (i.e., they have been receiving Social Security Disability Income (SSDI) benefits for 24 months) can elect to enroll in the Medicare supplement option through Via Benefits if elected by the Plan Sponsor, unless the Disabled Participant or disabled Dependent has coverage under HealthFlex on account of the "current employment status" of himself or herself or that of his or her Spouse, in which case the Disabled Participant or Dependent must remain in a Benefit Option for Active Participants to comply with the Medicare Secondary Payer rules.

To maximize coverage under Medicare, or if applicable to be eligible for a Medicare supplement plan through Via Benefits, Participants should enroll in Medicare Part B (Medical Insurance). Allsup, Inc. (Allsup) can answer any questions or concerns participants may have regarding coordination of benefits with Medicare or assistance with enrolling in Medicare Part B. Participants should contact Allsup at **1-800-854-1418**.

HealthFlex will continue to pay secondary to Medicare as permitted by law.

You as Plan Sponsor should provide each affected individual with cost information (i.e., Required Contribution or premium rates) and Benefit Summaries for their current HealthFlex Benefit Option. For Disabled Participants and Dependents who elect to remain in the Plan, , HealthFlex will continue to pay Claims secondary to Medicare, as permitted by law, and Participants will remain subject to the network requirements and limitations that are established by the Plan. These network restrictions mean that the Participant or Dependent must continue to seek care from network providers within the Blue Cross Blue Shield of Illinois) network who are also Medicare providers, in order to maximize benefits under the Plan.

Participants and Dependents who are not eligible for Medicare shall remain covered under a medical Benefit Option for Active Participants as permitted by their Plan Sponsor.

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[8] 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.

If a Retired Participant or his or her Dependent who is under age 65 becomes entitled to Medicare due to a disability, the medical Benefit Options available to him or her are the same as those described above. If the Dependent and the Retired Participant through whom the Dependent is covered are both eligible for Medicare, the Dependent will be placed in the same medical Benefit Option as the Retired Participant. If the Retired Participant through whom the Dependent is covered is not eligible for Medicare, the Dependent will make an election from available Benefit Options as described above.

Neither the Plan nor the Plan Sponsor shall provide incentives, monetary or otherwise, to Participants to choose coverage that would pay secondary to Medicare in violation of the Medicare Secondary Payer (MSP) Rules. Although the Participants affected by these rules are eligible for and enrolled in Medicare, and Medicare will be their primary payer irrespective of the Benefit Option under the Plan through which they are covered, the election permitted under these rules is solely in the discretion of each affected Participant.

USERRA

When a Participant covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) takes a qualified military leave, the following rules will apply:

- A person eligible under USERRA will receive the same HealthFlex benefit coverage as any other person serving on a leave.
- If an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.
- A person eligible under USERRA must provide advance written or verbal notice of military service leave and the duration of all military leaves while employed with his or her current Employer may not exceed 5 years, unless provided otherwise under USERRA.
- A person eligible under USERRA will receive HealthFlex participation credit for any service period covered under USERRA as though he or she was not called to military service. For the purposes of HealthFlex participation for retiree eligibility, his or her record will appear as though he or she were participating in HealthFlex as an Active Participant due to the military service.
- A person who is called to military service and who participated in HealthFlex immediately prior to such military service is eligible to elect to continue HealthFlex participation for a period beginning on the date of the military leave and ending on the earlier of:
  — 24 months of military leave or
  — the date he or she does not return, as determined by USERRA
- A person can retroactively elect continuation of coverage back to the date of departure while on a qualified military leave provided he or she pays all unpaid Required Contribution amounts.
- A person who elects coverage while serving the military is not required to pay more than 102% of the full HealthFlex premium for Participants who are not on continuation of coverage.

Retired Participants

Whether health benefits coverage through Wespath is available for Retired Participants depends upon the selection the Plan Sponsor has made on Exhibit B to its Adoption Agreement. A Participant must meet the criteria set out in the retirement policies of his or her Plan Sponsor.

A Spouse or Dependent is eligible for coverage through the Retired Participant if the retiring Participant is eligible for coverage. The Spouse or Dependent is not required to be covered at the time of Participant's

retirement. However, Dependents will be subject to any additional eligibility requirements of the Plan Sponsor. In addition, a Spouse or Dependent can be eligible for pre-65 HealthFlex coverage through the Retired Participant, even if the Retired Participant is enrolling in the Plan Sponsor's retiree plan (even if not with Wespath) and was not in HealthFlex at the time of retirement because he or she had Other Health Coverage.

Three (3) months before the anticipated retirement date, the Plan Sponsor should notify the eligible Participant of his or her eligibility to continue participation in HealthFlex as a Retired Participant (i.e., Participants who retire prior to age 65) or eligibility to participate in Via Benefits (i.e., Participants who retire on or after age 65) by providing the Retired Participant a *HealthFlex Retiree Enrollment Packet* and applicable forms. On the *HealthFlex or Via Benefits Enrollment/Change Form*, the Retired Participant indicates whether:

- He or she accepts or declines coverage for himself or herself and any Dependents.
- The Retired Participant must indicate on the *HealthFlex or Via Benefits Enrollment/Change Form* his or her legal residence as of the anticipated retirement date.
- If applicable, the Retired Participant should indicate whether he or she authorizes the withholding of Required Contributions from his or her retirement plan benefit payment by using the *Health Plan Deduction from Benefit Check Form*. This is not available to Participants in Via Benefits. However, if the spouse or dependents remain in the employer's active HealthFlex plan, premiums can be deducted from the Participant's benefit check.

The Retired Participant should return the *HealthFlex or Via Benefits Enrollment/Change Form* and *Health Plan Deduction from Benefit Check Form* to his or her Plan Sponsor at least two (2) months prior to the Participant's anticipated retirement date but no later than 31 days after the date of his or her retirement.

Upon receipt of the completed forms, the Plan Sponsor should review, sign and fax, e-mail or mail them to Wespath. It is important for Wespath to receive the forms as soon as possible in order to assure timely and accurate administration.

If the retiring Participant or eligible Dependent has Other Coverage at the time of retirement (e.g., through a subsequent employer or through a Spouse's employer), he or she may decline HealthFlex coverage and retain the ability to enroll for such coverage at a future date. The Eligible Person can exercise this enrollment option during any HealthFlex Open Enrollment Period or upon loss of his or her Other Health Coverage. See *Open Enrollment and Change of Status* for more details.

If the Eligible Person loses his or her Other Health Coverage and wishes to exercise his or her option to enroll in HealthFlex coverage, the Eligible Person must notify the Plan Sponsor within 31 calendar days from the loss of Other Health Coverage. If the Eligible Person does not meet this 31-day requirement, the Eligible Person will be eligible to enroll for coverage under HealthFlex during any HealthFlex Open Enrollment Period

A Retired Participant and his or her covered Spouse and Dependents will be covered under the same Benefit Options unless age restrictions apply (i.e., Medicare entitlement). See *Benefit Options* for additional information.

Generally, when a Retired Participant gains a new Dependent child through court-ordered legal guardianship, Wespath may consider the child eligible for coverage.

Retired Participants Who Resume Employment

In order to comply with certain requirements of HIPAA and the Medicare Secondary Payer Rules that apply to retirees and the working aged, Wespath will treat a Retired Participant as an Active Participant for HealthFlex coverage if the Retired Participant:

- resumes compensated employment within the connectional structure of the Church with a Plan Sponsor or through an Episcopal appointment; and
- is in an eligible category under the applicable Adoption Agreement.

The Medicare Secondary Payer Rules (MSP Rules) require that Plan Sponsors and the Plan offer such working aged individuals the same Benefit Options under the group health plan that are available to active employees under age 65. See also *Small Employer Exception*.

Surviving Dependent

A Dependent of a Participant (including the Participant's Spouse) who is covered under the Plan at the time of the Participant's death may continue to be eligible for medical, dental and vision material Benefit Option coverage under the Plan as a "Surviving Dependent." Whether coverage is available for Surviving Dependents depends upon the selection the Plan Sponsor has made on its Adoption Agreement Exhibit A and the policies of the Plan Sponsor.

At the time of the Participant's death, a Surviving Dependent will remain in his or her then-currently elected Benefit Options for the balance of the Plan Year in which the death occurred. FSA accounts are discontinued as of the end of the last day of the month in which the Participant's death occurs. Surviving Dependents have 90 days from the date of the Participant's death in which to submit eligible claims for reimbursement from the FSA account, after which remaining accounts balances will be forfeited to the Plan.

The Plan Sponsor must notify eligible Surviving Dependents of their eligibility to continue coverage under HealthFlex as a Surviving Dependent on a timely basis, generally, within 31 calendar days of the Participant's death or the Plan Sponsor's notice of such death.

If a Surviving Dependent wishes to decline coverage, the Surviving Dependent must complete a *HealthFlex or Via Benefits Enrollment/Change Form* indicating he or she is declining coverage. The Plan Sponsor must sign and date the *HealthFlex or Via Benefits Enrollment/Change Form* within 31 calendar days following the Participant's death and submit it to Wespath by fax or mail. (The date of death is included in the 31-day count.) If a Surviving Dependent declines HealthFlex Surviving Dependent coverage when he or she is first eligible for such coverage, the Surviving Dependent will be eligible to enroll for such coverage under HealthFlex at a future date (i.e., upon loss of his or her Other Health Coverage or at any HealthFlex Open Enrollment).

Surviving Dependent Spouses covered under the Plan may opt to: 1) cover their minor children or adult Dependent children in a state plan (State Plan)[9]; 2) decline HealthFlex coverage for those Dependents; and 3) retain the option to re-enroll those Dependents should they lose coverage under the State Plan on account of: i) bankruptcy/termination of the State plan; ii) loss of eligibility under the State Plan due to

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[9] A State Plan for purposes of this policy shall be: I) an S-CHIP as defined under federal law, such as PeachCare, TennCare, Illinois AllKids, among others; (II) Medicaid; (III) the Indian Health Services Program; or (IV) another governmental health plan or program that is intended to aid low income minor children and is, in the view of Wespath, substantially similar to the programs in I, II and III.

income changes; or iii) other loss of eligibility for the State Plan that is not on account of reaching age of majority. The Dependents must satisfy all other eligibility criteria in the Plan in order to re-enroll including, but not limited to, limiting ages and payment of Required Contributions. In addition, to re-enroll, the Surviving Dependent Spouse who is the parent or guardian of the Dependents who are to be covered must be covered under the Plan. The Dependents should be enrolled within 60 days of loss of State Plan coverage.

Nothing in this policy should be construed to prohibit a Dependent from being covered in the Plan concurrently with a State Plan, unless state or federal law prohibits simultaneous coverage.
The Surviving Dependent must notify the Plan Sponsor no later than 31 calendar days following the date the Other Health Coverage was lost so that the Plan Sponsor can send the Surviving Dependent a *HealthFlex or Via Benefits Enrollment/Change Form* and other applicable information. The Surviving Dependent must complete and return the *HealthFlex or Via Benefits Enrollment/Change Form* and any other necessary forms to the Plan Sponsor for signature within 31 calendar days from the date of notification of the loss of Other Health Coverage. If the Surviving Dependent fails to meet this 31-day requirement, the Surviving Dependent will be eligible to enroll for such coverage under HealthFlex at a future date (i.e., upon loss of his or her Other Health Coverage or at any HealthFlex Open Enrollment).

Upon turning age 65, a Surviving Dependent will be covered in HealthFlex through the medical and dental Benefit Options available to Medicare-eligible Retired Participants until his or her death, as long as he or she pays the Required Contributions.

If a Surviving Dependent Spouse remarries, he or she may maintain HealthFlex coverage as a Surviving Dependent; however, the Surviving Dependent may not enroll new Dependents he or she acquires after the Participant's date of death (i.e., those Dependents acquired by a Surviving Dependent after the Participant's death 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 medical, dental and vision Benefit Options available to Non-Salaried Participants until he or she no longer meets the Plan's definition of an Eligible Dependent Child.

Surviving Dependents may opt to pay Required Contributions from pension benefits administered by Wespath by completing a *Health Plan Deduction from Benefit Check Form*.

Divorced Spouses

The Spouse (Divorced Spouse) of a Participant who has divorced or legally separated from the Participant is eligible to participate in the Plan's medical, dental and vision Benefit Options if the Participant is responsible through a court order for:

- The majority of financial support of the Divorced Spouse,
- The medical or other health care expenses of the Divorced Spouse.

The Participant must notify the Plan Sponsor in a timely manner when there is an eligible Divorced Spouse who meets the conditions indicated above and for whom the Participant wishes to obtain HealthFlex coverage.

In the event that the Participant is not required to cover the Divorced Spouse by court order, the Divorced Spouse will be eligible for up to 24 months of continuation coverage. See *Continuation Coverage* for additional information.

The Plan Sponsor must provide the Divorced Spouse a *HealthFlex or Via Benefits Enrollment/Change Form*. The Divorced Spouse must complete and return the *HealthFlex or Via Benefits Enrollment/Change Form* to the Plan Sponsor within 31 calendar days of the date of entry of the court order. If the Divorced Spouse fails to meet this 31-day requirement, the Divorced Spouse forfeits the option to enroll in the Plan at a future date.

On the *HealthFlex or Via Benefits Enrollment/Change Form*, the Divorced Spouse must indicate whether he or she accepts coverage. The Divorced Spouse also must indicate his or her legal residence. The only level of coverage available to a Divorced Spouse is Participant Only. If the Divorced Spouse declines coverage, the Divorced Spouse forfeits the option to enroll for coverage under HealthFlex at a future date.

At the time of divorce or legal separation from a Participant, a Divorced Spouse will remain in his or her then-currently elected Benefit Options for the balance of the Plan Year in which the divorce or legal separation occurred (or the legal order or decree was issued). If a divorced spouse wants to opt out of dental coverage at the time of the divorce, the Plan will permit the divorced spouse to do so. The FSAs are not available to a Divorced Spouse.

Upon turning age 65 the Divorced Spouse may be covered in HealthFlex through the medical and dental Benefit Options available to Medicare-eligible Retired Participants, based on the elections of the Plan Sponsor, until his or her death. However, in no event will coverage extend beyond the time the earliest of the following events occurs:

- The period specified in the legal order or decree has expired.
- The death of the Participant (if the legal order or decree provides for the termination of the Participant's responsibility at that time, or if the legal order or decree is silent as to termination upon the Participant's death).
- The Divorced Spouse fails to pay Required Contributions in a timely manner as required by the Plan and Plan Sponsor.

If a Divorced Spouse remarries, he or she remains eligible for coverage through the Plan, unless otherwise provided for in the legal order or decree that gave rise to the Divorced Spouse's HealthFlex eligibility. Newly acquired Dependents of a Divorced Spouse are not eligible for coverage under the Plan.

The Plan Sponsor will be responsible for notifying Wespath of the above information regarding changes in eligibility. If the Plan Sponsor fails to submit such information in a timely manner, the change in eligibility will be subject to the Retroactive Termination and Enrollment provisions.

A Divorced Spouse of a deceased Participant is not eligible for coverage as a Surviving Dependent; however, depending upon the terms of the divorce decree or other related judicial order, such Spouse might be eligible for continued coverage pursuant to the terms of the order.

If a Divorced Spouse declines HealthFlex coverage after having become eligible for coverage as a Divorced Spouse, the Divorced Spouse forfeits the option to enroll in the Plan at a future date. However, if the Divorced Spouse is not covered under HealthFlex because he or she declined coverage as a Dependent of a Retired Participant at the time of the Participant's retirement because he or she had Other Health

Coverage, the Divorced Spouse may also decline coverage under the Plan as a Divorced Spouse at the time of the legal separation or divorce and retain the option to enroll for coverage at a future time. The Divorced Spouse can exercise this enrollment option during any HealthFlex Open Enrollment Period or upon the loss of his or her Other Health Coverage.

The Divorced Spouse, or the Participant on his or her behalf, must pay his or her portion of the Required Contribution on an after-tax basis.

CONTINUATION COVERAGE—ACTIVE PARTICIPANTS AND THEIR DEPENDENTS, SURVIVING DEPENDENTS, DIVORCED SPOUSES AND DEPENDENTS OF RETIRED PARTICIPANTS

Generally, when a Participant or covered Dependent loses eligibility under the Plan, coverage terminates at midnight on the last day of the month of the individual's last day of eligibility.

Continuation coverage is not available to a Participant or their Dependents if their coverage is ending due to failure to timely pay Required Contributions by the Plan Sponsor or Participant as determined by Wespath.

Participants should contact their Plan Sponsor or Wespath if they have questions about eligibility for continuation coverage.

If a Participant is eligible for Continuation Coverage under the Plan, the Plan Sponsor will be billed the Required Contribution; Wespath will not directly bill Participants who are on continuation coverage. Plan Sponsors must bill and collect Required Contributions for Continuation Coverage directly from the individuals who are so covered. Individuals covered through Continuation Coverage must pay their Required Contributions on an after-tax basis.

Wespath will treat the death of a Participant as a Change of Status event. Therefore, any covered Dependents will be offered 24 months of continuation coverage from the date of the Participant's death if the Plan Sponsor does not elect to cover surviving Dependents on their Adoption Agreement.

The affected Participant or Dependent must notify the Plan Sponsor when a Dependent ceases to be eligible for coverage, i.e., when a limiting age is reached within 30 calendar days of the event causing the loss of eligibility. This 30-day count begins on the day after the event causing the loss of eligibility occurs.

In addition, the Plan Sponsor ***must*** notify Wespath of the Participant's or Dependent's loss of eligibility within 60 calendar days of the event causing the loss of eligibility. Within 10 business days of being so notified, Wespath will send the Participant, and the Divorced Spouse in cases of divorce, a notice explaining continuation coverage. The Participant also must forward this notice to the affected Dependent, if applicable.

The individual who has lost coverage has 60 calendar days from the date coverage is terminated in which to notify the Plan Sponsor or Wespath of his or her desire (or his or her Dependent's desire) to elect continuation coverage. In the same 60-day period, the Participant (or Dependent) must complete a *HealthFlex or Via Benefits Enrollment/Change Form* and submit it to his or her Plan Sponsor. The Participant or Dependent must return the *HealthFlex or Via Benefits Enrollment/Change Form* to the Plan Sponsor such that the Plan Sponsor can sign and send the form to Wespath on or before the end of the 60th calendar day after the event.

If the Participant or Dependent does not accept continuation coverage or if the *HealthFlex or Via Benefits Enrollment/Change Form* is not returned in such time that the Plan Sponsor can forward the completed form to Wespath within the 60-day period, the affected Participant or Dependent forfeits the option to elect continuation coverage. If a Participant and/or Dependent accept continuation coverage, they may at any point during the continuation coverage drop Continuation Coverage by notifying their Plan Sponsor and Wespath.

A Participant or Dependent who reaches age 65 and is Medicare-eligible generally cannot be eligible for continuation coverage. Refer to HealthFlex SPD “Continuation Coverage” section for any additional information regarding continuation coverage for Medicare-eligible individuals.

Important to note is that continuation coverage does not count as a Special Enrollment Period (SEP). This means that in order to avoid any Medicare enrollment penalties, the participant should not delay getting Medicare Part B. The Special Enrollment Period begins when active HealthFlex coverage ends, not when continuation coverage ends.

HealthFlex is not covered by federal COBRA law and some states have “mini-COBRA” laws that can apply to plans that aren’t covered by the federal law. Wespath believes that no state “mini-COBRA” law applies to HealthFlex as a whole/at the plan level, therefore, Wespath does not monitor all of them closely. However, it might be possible that a particular state’s law applies to the Plan Sponsors and participants in that state. If a Plan Sponsor wants to impose a 2% surcharge on the continuation premium, Wespath recommends that the Plan Sponsor work with their chancellor or other legal counsel to confirm whether any “mini-COBRA” state law applicable to the Plan Sponsor allows it. It would be the Plan Sponsor’s responsibility to monitor state laws for changes and create a policy or other documentation to support the 2% surcharge.

There may be other coverage options for the Participant and his or her Dependents. Under the Affordable Care Act, as of January 1, 2014, they are able to buy coverage through the online Health Insurance Marketplace (**healthcare.gov**). In the Marketplace, they could be eligible for an income-based tax credit (“premium tax credit”) that lowers their monthly premiums right away, and they can see what their premium, deductibles and out-of-pocket costs will be before they make a decision to enroll. Being eligible for Continuation Coverage does not limit eligibility for coverage or for a premium tax credit through the Marketplace. Additionally, the Participant and his or her Dependents may qualify for a special enrollment opportunity for another group health plan for which they are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if they request enrollment within 30 days.

Refer to HealthFlex SPD for any additional information regarding continuation coverage.

UPON REGAINING ELIGIBILITY IN THE SAME PLAN YEAR

When an individual regains eligibility under the Plan during the same Plan Year in which he or she lost eligibility, there are certain rules that apply to the Benefit Options available to him or her. This situation occurs when a person is rehired in the same Plan Year as his or her previous employment terminated with the same Plan Sponsor, or when a person loses HealthFlex eligibility due to a status change and gains eligibility again in the same Plan Year due to another status change. An example of this is when a person begins an ineligible part-time appointment status but returns to an eligible full-time active service appointment in the same Plan Year.

When the individual returns to an eligible category within 90 days from losing eligibility, Benefit Options are reinstated to what the participant had prior to losing coverage.

When the individual returns to an eligible category after 90 days from losing eligibility, he or she must indicate on the *HealthFlex or Via Benefits Enrollment/Change Form* whether he or she accepts or declines coverage. The process and 31-day Plan Sponsor signature requirement apply just as they do for a newly-eligible Eligible Person. If the affected individual elects coverage, Wespath automatically places the individual in the same medical, dental and vision Benefit Options he or she was last covered under when previously eligible, if available. If the individual has had a change of residence that affects network coverage, he or she might be covered under a different Benefit Option.

The Participant is given the option to re-enroll (or enroll if they did not have an FSA prior) in the health care or dependent care FSA.

GRANDFATHERING GROUPS FOR ELIGIBILITY PURPOSES

Wespath will consider requests by the Plan Sponsor and, in its sole discretion, may permit the following groups or individuals to be eligible for coverage under the Plan in alignment with this policy and the associated rules. The Plan Sponsor must execute an amendment or addendum to its HealthFlex Adoption Agreement. The "transition amendment" will be based upon agreed terms between Wespath and the Plan Sponsor.

The intent of this policy is to limit risk to the Plan while allowing flexibility for Plan Sponsors—especially when determining clergy appointments. The Plan recognizes the Church continuously evolves, and this policy is not intended to impede the business activities of the Church. Examples of situations in which a participant's coverage in HealthFlex may be grandfathered include (but are not limited to) the following:

- New HealthFlex Plan Sponsors (including those resulting from a conference merger or realignment), upon entering HealthFlex, may request that a group of similarly situated individuals be eligible to enroll in HealthFlex where, under then-current eligibility provisions of HealthFlex, such group would be ineligible to be covered under HealthFlex. Such group of individuals must have been eligible for coverage under the Plan Sponsor's group health plan at the time the Plan Sponsor adopts HealthFlex.
- New HealthFlex Plan Sponsors (including those resulting from a conference merger or realignment) may also request that an individual covered by the previous group health plan be eligible to enroll in HealthFlex even though the Plan Sponsor did not elect to cover the category to which the individual belongs. The individual must be clergy serving full or ¾ time and covered as of August 1 of the last year in the previous group health plan to continue coverage after the transition to HealthFlex. In this case, the individual(s) would maintain coverage until the individual experiences a change in appointment. The individual(s) would be dropped from coverage when the appointment change occurs unless the plan sponsor amends the adoption agreement to cover all individuals in the applicable category. If coverage is terminated, these individuals may be eligible for continuation of coverage for an additional 18 months, pursuant to the continuation of coverage rules.
- Existing HealthFlex Plan Sponsors may also request that a group of individuals previously covered by HealthFlex remain covered even though the Plan Sponsor did not continue to elect to continue coverage for the category to which the individual belongs. In this case, the individual(s) would maintain coverage until the individual experiences a change in appointment. The individual(s) would be dropped from coverage when the appointment change occurs unless the plan sponsor amends the Adoption Agreement to cover all individuals in the applicable category. If coverage is terminated,

these individuals may be eligible for continuation of coverage for an additional 18 months, pursuant to the continuation of coverage rules.

In limited circumstances, current HealthFlex Plan Sponsors may request that a group of individuals be eligible to enroll in HealthFlex where, under then-current eligibility provisions of HealthFlex, such group would not be eligible for coverage, if such group is created through a newly created type of appointment that occurs during the appointment change season. For example, if a clergyperson is appointed mid-year during appointment change season to an employer within the Plan Sponsor that previously was not listed on the Plan Sponsor's Adoption Agreement, then the Plan Sponsor may amend (subject to Wespath's approval) its Adoption Agreement to update the listed employers and add the new employer. The Plan Sponsor may not amend the Adoption Agreement mid-year to add a new category of appointment under a paragraph of *The Book of Discipline* that was not covered in the Adoption Agreement at the beginning of the year.

HealthFlex Plan Sponsors may also request that certain individuals be eligible to enroll in HealthFlex as a result of an arrangement between the Plan Sponsor and the individual, such as to settle litigation, as part of a severance package, etc. Wespath will consider such requests if the matter is fully disclosed in advance to Wespath, the individual in considered in underwriting, and the individual cannot be covered under a category available on the adoption agreement. The individual would remain covered as long as premiums are paid.

- The Plan Sponsor must provide the classification of individuals it wishes to cover;
- The Plan Sponsor must provide the reasons and justification for the request;
- The Plan Sponsor must provide the Plan Sponsor's general eligibility rules and retirement policy under the transition amendment;
- The Plan Sponsor must agree that, going forward, individuals appointed to or otherwise becoming a part of the affected group of individuals (i.e., with the same employment status as those under the transition amendment) will be subject to the then-current HealthFlex eligibility rules and retirement provisions;
- The Plan Sponsor will evaluate each request for coverage based on the terms of the transition amendment and will submit *HealthFlex or Via Benefits Enrollment/Change Forms* for each affected individual.

When a Participant’s Plan Sponsor Changes

In the event a Participant’s employment, membership or appointment changes from one HealthFlex Plan Sponsor to another, the Participant is treated as a “new hire” for eligibility, enrollment and election purposes. He or she will have experienced a Change of Status Event. See *Change of Status Events*.

If the Participant made an FSA election for the current plan year and the Participant has received reimbursements that exceed the amount contributed to date, the Participant will be required to continue the FSA election and payroll deductions. If the Participant’s year-to-date contributions exceed the amount reimbursed for the plan year, the Participant will be required to make a new FSA election (taking into account what has already been contributed) if they want to continue with the FSA.

- When moving to the exact same benefit option under a new Plan Sponsor, the participant will not receive any new plan sponsor funding [health reimbursement account (HRA) or health savings account (HSA)] if the funding is included in the plan design. Progress toward the deductible and OOP limits will automatically transfer. If the member moves from single to 2-person or family coverage in the same Benefit Option, the participant will get the incremental funding so their total funding equals the family funding. Progress toward the deductible and OOP limits for the individual previously covered will automatically transfer.
- When moving to a different benefit option, the participant will receive any new plan sponsor funding (HRA or HSA) if the funding is included in the plan design. Progress toward the deductible and OOP limits will not transfer.

Any additional funding provided by the plan sponsor will be awarded based on plan sponsor criteria. If the participant does not enroll in the same benefit option and it is available, the participant is ineligible to have the accumulated deductible and out-of-pocket amounts transferred.

If the participant moves due to a mid-year conference merger/realignment, any accumulated deductible or out-of-pocket amounts will be transferred in accordance with the rules of the merger/realignment.

Retroactive Enrollments and Terminations

If Wespath receives a *HealthFlex or Via Benefits Enrollment/Change Form* with respect to an Eligible Person, Participant, or Dependent more than 31 days after the date of the related event (e.g., date of hire, marriage, etc.), Wespath will consider the request for enrollment to be in non-compliance with Plan rules. Depending on the nature of the event, the date of the event itself may or may not be included in the 31-day count (see *Change of Status Events* for more information). The Eligible Person’s, Participant’s or Dependent’s *HealthFlex or Via Benefits Enrollment/Change Form* will be processed by the Wespath for record-keeping purposes, but Wespath will make an indication of “No Coverage” or “No Change” in coverage for that Eligible Person, Participant or Dependent until otherwise provided for under the terms of the Plan.

If the delay in submission of the *Enrollment Form* is not the fault of the Eligible Person or Participant, and the Plan Sponsor accepts full responsibility for the delay, Wespath, in its discretion, may affect coverage of such individual retroactively. In no event, however, will coverage be retroactive more than 30 calendar days from the date Wespath receives the *HealthFlex or Via Benefits Enrollment/Change Form*. In all cases, monthly Required Contributions are due for full calendar months of coverage.

Please note: Any retroactive enrollments are limited by the cafeteria plan rules under §125 of the Code. Cafeteria plan elections, including premium conversion amounts and flexible spending account (FSA) contributions cannot be made on a retroactive basis; they can only be made prospectively. As such, Participants cannot pay any Required Contributions due from time periods already past related to retroactive enrollments on a pre-tax basis, nor can they make any retroactive flexible spending account elections or contributions on account of retroactive enrollments.

In the event a Participant or Dependent loses eligibility (i.e., ceases to be eligible under the terms of the Plan), the Plan Sponsor or the individual must notify Wespath of the loss of eligibility within 31 calendar days of the end of the month in which the Participant or Dependent became ineligible. If the Plan Sponsor or affected individual does not notify Wespath within this time period, Wespath will apply the termination of coverage retroactively to the date coverage was lost; however, billing will only be adjusted back 60 calendar days from the date the termination of coverage is processed.

Wespath may also make limited exceptions to this general rule in the case of the death of a Participant or Dependent. In such a case, termination of coverage (for administrative purposes) is effective the first day of the month coincident with or next following the date of death. However, the Plan will reimburse premiums back to the date of death, or the January 1 of the current year if the death occurred in a prior year. However, if the date of the death notification of a prior year death is in the first quarter of the current year, the Plan may reimburse premiums back to January 1 of the prior year.

Declining Coverage

A Participant or Eligible Person must indicate on the *HealthFlex or Via Benefits Enrollment/Change Form* whether he or she declines coverage with respect to himself or herself and any Dependents. If the Participant or Eligible Person is declining coverage for any individual, the Participant or Eligible Person should indicate whether that individual has Other Health Coverage. Other Health Coverage has the same meaning as defined under HIPAA. Medicare does not qualify as Other Health Coverage for this purpose.

Termination of coverage and the related billing change are effective the first day of the month following the date of the event that served as the basis for the end of coverage.

Individuals who decline coverage but do not submit the Mandatory Waiver form may be subject to a Risk Pool penalty.

Losing Eligibility

Loss of coverage due to ineligibility and the related billing change are effective the first day of the month following the date of the event that served as the basis for the involuntary loss of coverage.

Wespath or a Claims Administrator will notify the affected Participant or Dependent of his or her option to elect Continuation Coverage.

Late Entrant Provisions

A Late Entrant is an Eligible Person who does not enroll for coverage within 31 calendar days of the date he or she is first eligible. Late Entrants are subject to a number of Plan provisions.

A Late Entrant cannot be enrolled for coverage until a subsequent Open Enrollment period for coverage. This would begin the first day of the Plan Year that follows such Open Enrollment Period or until the Late Entrant experiences a Special Enrollment Event.

Open Enrollment

If a non-covered Eligible Person wants to elect coverage or a Participant wants to decline or add coverage for himself or herself or his or her Dependents for the following Plan Year, he or she must notify his or her Plan Sponsor and complete a *HealthFlex or Via Benefits Enrollment/Change Form* indicating such change in coverage. The Plan Sponsor must sign the *HealthFlex or Via Benefits Enrollment/Change Form* and submit it to Wespath before the annual cutoff date for the Open Enrollment Period (i.e., the Annual Election Period).

Change of Status Events

There are events that can occur during a Plan Year following which a Participant may make certain limited changes in his or her elections for the remainder of the Plan Year. These events, called "Change of Status Events," are described in Appendix A to this Manual. These Change of Status rules apply to all Participants, including Retired Participants, Surviving Dependents, Divorced Spouses and individuals on Continuation Coverage. Although the cafeteria plan portion of the Plan applies only to Active Participants and certain former Participants, under §125 of the Code, the rules for making benefit choices, or elections, under the Plan are set by Wespath, for consistency, ease of administration and non-discrimination, such that the Open Enrollment Period, Annual Election Period and Change of Status Event rules apply to all Participants.

Because the Plan is designed to provide tax-advantaged benefits under §125 of the Code as a cafeteria plan, once a Participant makes benefit elections for a Plan Year, he or she generally cannot change them. The limited circumstances under which a Participant can change benefit elections are called Change of Status Events as described in §125 of the Code, and they include rights stemming from Special Enrollment Events, as defined in HIPAA. HealthFlex is permitted by law to be more restrictive than the regulations require but cannot be more permissive.

Changes allowed under these provisions must be consistent with the event experienced. FSA changes are permitted only where the Change of Status Event affects the eligibility for Plan coverage as a whole (not just the Benefit Option). In no event can an FSA election be changed solely on account of a change in cost or coverage under another plan.

When changes are permitted under the Change of State Event rules, a Participant can initiate or discontinue FSA accounts. Increases and decreases to existing FSA elected amounts generally are not allowed during the Plan Year. See Appendix A for additional information.

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

UMC COUPLES

When a clergy person is married to another clergy person and they are both eligible for HealthFlex, the Plan Sponsor along with the clergy couple determine how the couple is enrolled: (i) two single coverages or (ii) family coverage where one person is the primary participant and the other is a dependent of the primary participant.

In the case of a clergy couple with family coverage (or participant plus one) where the dependent was not eligible for HealthFlex and then becomes eligible (i.e., experiences a change of status event), the newly eligible individual may choose to enroll in HealthFlex under single coverage.

If the newly eligible individual elects the same benefit options that he or she was covered under as a dependent of the primary participant, upon request by the plan sponsor and the participant, HealthFlex may transfer amounts the newly eligible individual had accumulated toward the deductible and out-of-pocket limits (OOP) to his or her newly elected benefit option.

If the person enrolling in HealthFlex does not elect the same benefit option, amounts he or she accumulated towards the deductible and OOP will not be transferred with them to their newly elected benefit option.

In the case of a clergy couple where each person had single coverage and one member loses eligibility for HealthFlex, the individual losing coverage may enroll as a dependent of the other individual. If the individual losing eligibility was in the same benefit option that he or she is transferring to as a dependent, upon request by the plan sponsor and the participant, HealthFlex may transfer amounts the individual had accumulated toward the deductible and OOP limits to his or her benefit option as a dependent.

If the dependent enrolling in HealthFlex was not in the same benefit option to which he or she is moving to as a dependent, amounts he or she accumulated towards the deductible and OOP will not be transferred with them to their new benefit options as a dependent.

If the dependent had an FSA when he or she was a primary HealthFlex participant, the dependent will have 90 days from the date of termination to submit claims for eligible expenses incurred prior to the date of termination.

Contact the Compliance Department via the Special Request process to determine any impact to HRA or HSA funding.

Elections of Options, Effective Dates of Coverage and Billing

ACTIVE PARTICIPANTS AND RETIRED PARTICIPANTS UNDER AGE 65

The Participant has 30 calendar days from their eligibility date to make any changes to his or her elections. Once the Eligible Person or Participant has made his or her elections on the HealthFlex website or through paper acknowledgement to the Plan Sponsor, no changes are permitted until the next Annual Election Period, unless the Eligible Person or Participant encounters a Change of Status Event, including a Special Enrollment Event.

Elections of medical, dental or vision Benefit Options are effective as of the Participant's eligibility date. If the effective date of coverage is on or before the 15th of the month, the effective date for billing of Required Contributions for such coverage will be the first day of the month in which the eligibility date

occurs. If the effective date of coverage is after the 15th of the month, the effective date for billing of Required Contributions for such coverage will be the first day of the month coincident with or next following the eligibility date. Elections to defer compensation to a Flexible Spending Account are effective for both coverage and billing purposes on the 1st day of the month coincident with or next following the election date; however, elections made prior to the 5th of the month will be effective on the 1st day of that month. Election changes to Flexible Spending Accounts cannot be made on a retroactive basis. In any case, the Participant will receive a confirmation statement showing the elections under which he or she will be covered for the Plan Year.

If Participant is eligible for coverage in a given month under two plan sponsors, the plan sponsor responsible for billing for that month would be the one where participant was eligible for a longer period of time.

Retired Participants and Dependents who are under age 65 cannot make elections on the Benefits Access website.

When the covered Dependent of a Retired Participant or the Retired Participant who is under age 65 attains age 65, he or she must then elect to be covered under the same Benefit Option as the older individual. When such a situation occurs, both the Retired Participant and his or her Dependent may have an election opportunity. In this scenario, a Retired Participant or his or her Dependent may elect to change Benefit Options if available during the Plan Year. The Plan Sponsor must notify Wespath of such change for the affected covered persons. In such cases, the covered persons must then remain in the selected Benefit Option for the remainder of the Plan Year.

Under the terms of the Plan, Retired Participants and their Dependents are subject to the same Change of Status Event rules.

Annual Elections

All covered Participants may make annual elections with respect to coverage for the following Plan Year during the Annual Election Period set by Wespath (also called the Open Enrollment Period in this Manual). This includes salaried and non-salaried Active Participants, Surviving Dependents, Retired Participants, Divorced Spouses, individuals on Continuation Coverage, and all other Participants. Although the cafeteria plan portion of the Plan applies only to salaried Active Participants, under §125 of the Code, the rules for making benefit choices, or elections, under the Plan are set by Wespath such that the Annual Election Period, Special Enrollment Event and Change of Status rules apply to all Participants.

A Participant receives an annual notification indicating that the Participant must log into the Benefitsolver Portal via Benefits Access to view all Benefit Options available to him or her based on the Plan's provisions, his or her Plan Sponsor's Adoption Agreement, and his or her residential zip code. Benefitsolver also indicates the Benefit Option coverage the Participant will have if he or she makes no election during the Annual Election Period, i.e., the default Benefit Options. The Participant must make his or her elections during the specified Annual Election Period.

The Participant can continue to make changes during the specified Annual Election Period. At midnight on the last day of the specified Annual Election Period, the Annual Election Period will close. No additional changes can be made until the next Annual Election Period or upon the occurrence of a Change of Status or Special Enrollment Event.

A confirmation statement can be printed immediately after the Participant makes his or her elections reflecting the Benefit Options the Participant will have for the following Plan Year. A Participant may make changes in his or her annual elections only during the Annual Election Period, or in the event he or she encounters a Change of Status Event, including a Special Enrollment Event, during the Plan Year.

If a Participant does not have access to a computer, he or she must contact his or her Plan Sponsor or the Wespath Health Team to make elections; however, in the case of HealthFlex Exchange participants, a Participant who does not have access to a computer should contact the Businessolver customer service team to make elections. If the Plan Sponsor receives elections prior to the Annual Election Period deadline but is unable to process the elections prior to the deadline, the Plan Sponsor must submit the elections to the Health Team at Wespath for proper processing.

Non-Payment of Premiums and Salary Reductions

If a Participant fails to make the Required Contributions for the Participant and/or Dependents within 30 calendar days of the due date, or the Participant's Salary-Paying Unit or employer fails to make Required Contributions on the Participant's behalf, the Plan Sponsor may notify Wespath and ask that Wespath apply the HealthFlex Termination Policy to the delinquent Participant and/or Dependents. Under the HealthFlex Termination Policy, Wespath will notify the delinquent Participant and Dependents of his or her delinquency, and demand payment of delinquent Required Contributions. If the Participant, and/or his or her Salary-Paying Unit or employer, does not remedy the delinquency within 15 days of notice, Wespath will terminate the Participant's coverage (along with the coverage of any of the Participant's Dependents).

Notice to the Participant must be made by certified mail with return receipt or by commercial overnight courier service. In instances where the Participant does not accept the mailing and provide signature, after 15 days of the initial notice, Wespath will follow up with a second mailing. The second mailing will provide a receipt to the sender (Wespath) that the letter was delivered, but will not require Participant signature. If the delinquency is not remedied within 15 days of this second mailing, Wespath will terminate the coverage as described above.

The HealthFlex Termination Policy may apply to a Participant's and/or Dependent's medical, dental and vision Benefit Options and Flexible Spending Accounts, separately or as a group, depending on the specifics of billing and delinquency in each case. For example, since dental and vision premium amounts are billed separately in the HealthFlex Exchange, dental and/or vision benefits can be terminated due to nonpayment without terminating medical benefits (assuming medical premiums were paid). However, a Participant will not be eligible for any other benefits, including an FSA, if his or her medical Benefit Option is terminated. The health care FSA, HRA and Plan Sponsor HSA contributions are funded on the first day of the Plan Year and therefore these contributions cannot be stopped. However, Participant contributions into the dependent care FSA and HSA will no longer be accepted when the medical coverage is terminated. If the health care FSA is terminated for non-payment, the Participant will have 30 days to submit request for reimbursement for claims incurred prior to the date the FSA is terminated. In addition, the Participant cannot make up these contributions if medical coverage is reinstated upon payment of delinquent Required Contributions.

Termination of the health care FSA, HRA and HSA due to non-payment of premiums and salary reductions follow the same termination rules as outlined in the *Termination of HRA Participation, Termination of HSA Participation and Flexible Spending Account* sections above.

If coverage is terminated for nonpayment, the risk pool penalty will be applied because non-payment of premiums is not a valid waiver reason.

The Plan Sponsor must request in writing that Wespath terminate coverage pursuant to the terms of the Plan and the HealthFlex Termination Policy. If a Participant and/or Dependent is terminated under the HealthFlex Termination Policy and later wants to re-enroll in the Plan, he or she must wait until the next Open Enrollment Period, provided all Required Contributions have been received. If the Participant has made elections for the next Open Enrollment Period but has not paid all Required Contributions, coverage for the next plan year will not be implemented.

Conversion Rights

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

Appeals

The general terms of the appeals processes for Claims under HealthFlex are outlined in this section. Appendix C describes the specific appeals procedures for certain Claims Administrators under the Plan.

Delegated Appeals Procedures

The Plan Document grants Wespath the power to delegate fiduciary and non-fiduciary duties and obligations to its agents. Wespath has delegated, through the terms of the administrative services agreements and contracts and policies of insurance, the fiduciary duty of adjudicating medical and behavioral health Claims to Blue Cross Blue Shield of Illinois and adjudicating appeals of denied medical and behavioral health Claims to Quantum Health. Wespath has also delegated per above both Claim adjudication and appeals to OptumRx (prescription drugs), Cigna (dental) and VSP (vision). Claimants must submit ***all Claims and appeals*** of denied Claims for benefits to these Claims Administrators as noted above.

The appeals procedures of the Plan's Claims Administrators will comply with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act (ACA); Interim Final Rule issued by the Department of Health and Human Services (45 CFR Part 147) implementing Section 2719 PHSA.

The final determination—the binding appeal—with respect to: 1) medical, 2) prescription drug, 3) mental and behavioral health, 4) dental and 5) vision benefits rests with these Claims Administrators. **Wespath has delegated these administrative and fiduciary duties to the Claims Administrators and does not have the authority to review or overturn the determinations**.

Refer to the Summary Plan Description and HealthFlex Benefits Booklets for Appeals information.

Termination of Participation of a Plan Sponsor

Wespath has established rules for terminating Plan Sponsor participation in the Plan for failing to make Required Contributions on a timely basis.

Payments for HealthFlex premiums are due on the last business day of each month.

If Wespath, as the plan administrator, is not aware of circumstances that should require the immediate use of the procedures outlined in 3.06(f) of the HealthFlex Plan Document, then as an alternative, Wespath may use the following policy to collect outstanding payments to the plan.

If a plan sponsor has not made payments within 5 days of the end of the month (i.e., the grace period), then a notification of non-payment will be sent to the respective plan sponsor with a request for immediate payment. This request will be sent by a member of the Plan Sponsor Relations team to the Conference Benefits Officer / Treasurer for Conferences or the equivalent of the Human Resource Manager or Chief Financial Officer for non-Conference plan sponsors.

If payment is not received by the 15th of the month after such notification, then a 2nd notification will be sent by a member of the Plan Sponsor Relations team to the Chair of the Board of Pensions and Bishop for a Conference Plan Sponsor or again to the CFO and President / CEO of a non-Conference Plan Sponsor. Wespath's General Secretary, CFO, and COO, along with other members of Wespath's management team, will be informed of this delay in payment.

If, after this second notice, payment is not received by the end of the then-current month, Wespath will begin assessing a late fee retroactive to the original due date. The late fee shall be calculated based on the then-prevailing IRS-published underpayment rate plus 5% applied to the balance past due and will continue for the period the balance remains outstanding. Failure to pay the late fee could result in plan termination.

If payment is not received by the 5th day of month 3 (35 days past due) a member of the Plan Sponsor Relations team will reach out to the sponsor and obtain an explanation for the lack of payment. This explanation will be distributed to the General Secretary, CFO, and COO. If amounts remain outstanding from this date it will be at the discretion of the General Secretary, CFO and COO (requires 2 of the 3) if the termination provisions detailed in the HealthFlex Plan Document should be initiated.

The table below shows the tasks to be performed in the collection process for any month not paid by its due date:

DAY	TASK	DAYS PAST DUE
	Month 1 (assumes all months are 30 days)	
15	**Invoice Sent Month 1**	
30	Invoice Month 1 Due	
	Month 2	
35	Grace Period Expires Invoice 1 / 1st notice sent to CBO / HR Director	**5**
45	2nd notice sent to CBO, CFO, Bishop/President and Wespath General Secretary, CFO and COO	**15**

60	Late Fee Assessment - Begin assessing a late fee for any amounts past due greater than 30 days.	30
	Month 3	
65	Plan Sponsor Relations team obtains an explanation for non-payment from the Plan Sponsor.	35
65+	at the discretion of the General Secretary, CFO, and COO.	

If Wespath terminates a Plan Sponsor's participation in the Plan for delinquent payments, the Plan Sponsor is not eligible to re-adopt the Plan for three years after the date of such termination. Wespath may establish policies for late payment that include late fees, service charges or other provisions to support the collection of amounts due from Plan Sponsors.

Wespath can also terminate the participation of Plan Sponsors for breach of their Adoption Agreements, non-compliance with provisions of the Plan, and violations of state and federal law.

Legal Status of the Plan

NOT INSURANCE

Use of the terms co-insurance, co-payment, deductible and premium in reference to the Plan does not imply that any of the Claims Administrators or other agents insure the Plan. Similarly, use of such terms does not imply that the Plan provides insurance or that the Plan and Wespath are 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, associated with organizations affiliated with Wespath through The United Methodist Church. Blue Cross and Blue Shield of Illinois, Quantum Health, CIGNA, and OptumRx are merely third-party administrators in a contractual relationship with the Plan and Wespath, but are not financially responsible for any benefits paid under the Plan.

Although Church Plans are considered employee welfare benefit plans under §3(1) of ERISA, as indicated by §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, under the Church Plan Parity and Entanglement Prevention Act of 1999 (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 the Plan Document, *any HealthFlex Summary Plan Description (SPD)*, and the *HealthFlex Benefit Booklets* and any Amendments to such documents; and
- Make factual determinations related to the Plan and the benefits provided thereunder.

Wespath, in its discretion, has delegated some of its 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 in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Wespath and Claims Administrators may, in their sole discretion, offer benefits for services that would otherwise not be covered services under the Plan. The fact that Wespath or 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.

METHOD OF FUNDING BENEFITS

Medical, prescription drug and dental benefits are self-funded or self-insured from accumulated assets and are provided directly from Wespath. Wespath may purchase excess risk insurance coverage, often called stop-loss coverage, which is intended to reimburse Wespath for certain losses incurred and paid under the Plan by Wespath. Such excess risk coverage, if any, is not part of the Plan; it does not imply that Wespath is in the business of insurance nor does it render the Plan subject to state insurance regulations. Payments out of the Plan to health care providers on behalf of the Participants will be based on the provisions of the Plan. In addition, certain benefits under the Plan, such as vision benefits and mental and behavioral health benefits, may be funded through insurance contracts.

FIDUCIARY AND ADMINISTRATIVE DUTIES

As the Plan Administrator, Wespath has an obligation to follow the terms of the Plan Document. The Plan Document names Wespath as both the administrator and fiduciary of the Plan. An administrator must perform its duties in a manner consistent with the terms of the Plan. A fiduciary must maintain and administer the Plan in the interest of the Plan and its Participants. The fiduciary must perform its duties in a reasonable and prudent manner.

The Plan Document grants Wespath the power to delegate fiduciary and non-fiduciary duties and obligations to agents and others.

RIGHT TO AMEND OR TERMINATE PLAN

Wespath reserves the right to amend, modify, or terminate the Plan in any manner, for any reason not prohibited by law, at any time and without prior notification.

Glossary

The following are important definitions for your information.

ACTIVE PARTICIPANT

Active Participant means any Employee who:

- participates in the Plan while he or she remains an Employee, and
- is not a Terminated Participant or a Retired Participant.

ADOPTION AGREEMENT

An agreement, executed by each Plan Sponsor and if accepted by Wespath, that becomes part of the Plan. An Adoption Agreement is the means by which a Plan Sponsor adopts the Plan and specifies any optional provisions, such as Benefit Options, that are a part of any Plan 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 and that is a participating organization in the Plan.

AFFORDABLE CARE ACT (ACA)
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 Eligible Persons may elect Benefit Options for the following Plan Year for themselves and Dependents, by making elections through the Benefits Access website. Wespath as the Plan Administrator, in its discretion, will determine the period of time that is the Annual Election Period.

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 an indemnity option, an HMO option, or a PPO option). In other words, under the Plan, generally, the PPO and Mental Health PPO plans for medical benefits with their corresponding prescription drug plans are considered separate Benefit Options, as are the Indemnity, PPO and HMO dental plans, and the incentive materials and full-service vision plans.

THE BOOK OF DISCIPLINE
The term *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. References in this Manual are to the 2012 *Book of Discipline*.

CHANGE OF STATUS EVENT
An event described in Appendix A.

CHURCH
The Church as referred to in this Manual means The United Methodist Church.
CHURCH PLAN
An employee benefit plan established and maintained for its employees by a church or by a convention or association of churches as established in Section 414(e) of the Code and Section 3(33) of ERISA.

CLAIM
The term Claim means: 1) with respect to claims for medical, prescription drug, dental, vision, and mental and behavioral health benefits or FSA reimbursements, notification in a form acceptable to the Claims Administrator and the Plan that a service has been rendered or furnished to a Participant. This notification must include full details of the service received, including the Participant's name, age, sex, 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 the Participant; and 2) with respect to eligibility and elections, notification in a form acceptable to Wespath that the Participant or Eligible Person has a *bona fide* dispute about Wespath's interpretation or application of a provision of the Plan related to eligibility or elections.

CLAIMANT

The term Claimant means a person who makes a Claim for benefits under the Plan or who appeals the denial of such a Claim, or such person's representative.

CLAIMS ADMINISTRATOR

For medical, behavioral health, and hospitalization services provided under the terms of the Plan, 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 VSP, Inc. 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.

CMS

The term CMS means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

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

A child who meets the definition of Eligible Dependent Child, below, a spouse who meets the definition of Spouse, below, or other dependent permitted to be covered under the Plan pursuant to its terms. Under the Medical Reimbursement and Dependent Care Accounts, the definition of "dependent" is determined by §§125, 152, 105 and 129 of the Code. *For example, this could include dependent parents or grandparents.*

EARLY RETIREMENT DATE

Early Retirement Date means the first day of the month coinciding with or next following:

- In the case of a clergy Employee, the later of:
  - The date specified in the clergy Employee's Plan Sponsor's Adoption Agreement that complies with ¶715.3 of *The Book of Discipline* with respect to policies on elective retirement.
  - The age or service completion date specified:
    1. In ¶357.2b of *The Book of Discipline*; or
    2. For a clergy Employee who retires in accordance with ¶357.2a or ¶357.3 of *The Book of Discipline* or who is a Terminated Participant, age 62; or

- In the case of a lay Employee who is employed by:
  - A General Agency, the date specified in the lay Employee's Plan Sponsor's Adoption Agreement (which must be consistent with ¶715.3 of *The Book of Discipline* with respect to policies on elective retirement).
  - Any employer other than a General Agency, the date specified in the lay Employee's Plan Sponsor's Adoption Agreement (which may not be earlier than the lay Employee's 55th birthday nor later than his or her normal retirement date).

If a Plan Sponsor's Adoption Agreement does not specify an Early Retirement Date, it will be deemed to be the first day of the month coinciding with or next following the lay Employee's 62nd birthday.

ELIGIBLE DEPENDENT CHILD

The Plan definition of an "eligible dependent child" is:

- Any child of an eligible Participant from birth through the last day of the month the child attains age 26.
- Any unmarried child, without regard to the child's age, who is not self-supporting due to mental or physical impairment as determined by the Plan Administrator. A child who is not self-supporting must be mainly dependent upon the Participant for care and support. This child must have become incapable of self-support either before reaching age 19 or while covered as a Dependent under this Plan or any other health insurance plan.

The Participant must give Wespath, BCBSIL, or Quantum Health proof, when requested, that the child meets these conditions. The request may come from Wespath, a Claims Administrator or an HMO. When proof is requested, a form will be provided to the Participant along with instructions for handling of the form. An attending physician statement is required as part of the form.

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

The following are *not* considered Eligible Dependent Children:

- A grandchild or foster child who has not been legally adopted by the Participant or over whom the Participant has been accorded legal guardianship.
- A natural, legally adopted, or stepchild of a spouse of an eligible Participant who is not living with the Participant or for whom another party is legally responsible for the majority of financial support of the child, or specifically for the medical health care expenses of the child.

Eligible Person

The term Eligible Person means an employee of a Plan Sponsor, or other person eligible under the terms of the Plan to become a Participant of the Plan maintained by Wespath who meets the eligibility requirements for this health care coverage, in accordance with the terms of the Plan as described in the Plan Document.

Employee

For purposes of this *Plan Sponsor Manual*, 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 who is a common law employee of Wespath or an Affiliated Organization, including a former Employee who has retired.

ERISA

The term ERISA means the Employee Retirement Income Security Act of 1974, as amended.

General Board

The term General Board means the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois, in its role as Plan Administrator. As of July 2016, the General Board is doing business as Wespath Benefits and Investments (Wespath).

HealthFlex or Via Benefits Enrollment/Change Forms

The two forms prescribed and created by Wespath for effecting enrollment in, termination from and changes to eligibility under the HealthFlex Plan or the Via Benefits program.

HealthFlex Exchange

HealthFlex Exchange is a plan selection model that permits participants to choose from all HealthFlex Benefit Options, each coupled with a pharmacy plan, offset by a premium credit from the Plan Sponsor. HealthFlex Exchange retains the HealthFlex plan framework, including the same national networks, carriers and wellness programs.

Health Reimbursement Account (HRA)

Health Reimbursement Accounts are health reimbursement arrangements as described in *IRS Notice 2002-45*. HRAs are employer (i.e., Plan Sponsor and Plan)-funded accounts that help Participants covered in the HRA Plan Benefit Option (or other HealthFlex plan designs as designated by the Plan Sponsor) satisfy higher deductibles and pay for out-of-pocket expenses by reimbursing certain eligible medical expenses. HRAs do not include any Participant contributions.

Health Savings Account (HSA)

Health Savings Accounts are employer (i.e., Plan Sponsor and Plan)-funded and if elected, participant-funded accounts for participants covered in an HSA Plan. 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 pay for out-of-pocket expenses by reimbursing certain eligible medical expenses.

HSA Plan

HSA Plan refers to a Benefit Option under the Plan that is an IRS-qualified high-deductible health plan. The HSA 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 HSA plan is accompanied by a health savings account (HSA), which provides Plan Sponsor- and Plan-provided financial assistance toward satisfying those higher deductibles. Participants with an HSA plan 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.

HSA-Compatible HRA

An HSA-Compatible HRA ("limited-use HRA") is a tax savings account that may be provided by a Plan Sponsor to a Participant in the HSA plan. An HSA-Compatible HRA can only be used for dental and vision expenses until the participant reports to the account administrator (HealthEquity) that the IRS-defined statutory deductible has been met and provides appropriate documentation; then the HRA can be used for all eligible health care expenses.

HSA-Compatible FSA

An HSA-Compatible FSA ("limited-use FSA") is a health care Flexible Spending Account that is elected by a Participant in an HSA plan. An HSA-Compatible FSA can only be used for dental and vision expenses until the participant reports to the account administrator that the IRS-defined statutory deductible has been met and provides appropriate documentation; then the FSA can be used for all eligible health care expenses.

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.

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 Eligible

The term Medicare Eligible means a person who has met all of the eligibility requirements for Medicare.

Medicare Secondary Payer or MSP

The term Medicare Secondary Payer (MSP) means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 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. See Appendix B for more information about the MSP Rules.

Open Enrollment Period

The term Open Enrollment Period means a period of time during which Eligible Persons may enroll themselves and Dependents under the Plan. Wespath as the Plan Administrator, in its discretion, will determine an annual period of time that is the Open Enrollment Period. In addition, for newly eligible individuals, the Open Enrollment Period is the 30 days immediately following their date of hire or appointment to the Plan Sponsor.

Other Health Coverage

Under HealthFlex, Other Health Coverage includes a self-insured group health plan; an individual 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 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 Primary Participant or an enrolled Dependent, but this term applies only while such person is enrolled under the Plan.

Plan

The term Plan means the Hospitalization and Medical Expense Program, commonly called HealthFlex, maintained by Wespath on behalf of its employees and the employees and other Participants of the organizations and corporations affiliated with Wespath through The United Methodist Church. The Plan is an employee welfare benefit plan as defined in §3(1) of ERISA and a church plan as defined in §3(33) of ERISA and §414(e) of the Code. The Plan may also be referred to as the Program from time to time.

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).

Plan Administrator

The General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois (Wespath). The terms General Board, Wespath and Plan Administrator are used interchangeably throughout this Manual.

Plan Sponsor

- 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 Plan Year is the 12-month period beginning January 1 and ending December 31.

PRIMARY PARTICIPANT
The term Primary Participant means a full-time Employee of Wespath, a full-time Employee of an Affiliated Organization and any other person eligible under the terms of the Plan who is currently in active service and enrolled in the Plan (including retired Employees age 65 and over who are considered working aged Employees under the MSP Rules and do not work for an employer that has elected the Small Employer Exception under the MSP Rules). The term also includes retired employees of Wespath and Affiliated Organizations who are under the age of 65.

REQUIRED CONTRIBUTION
Required Contributions include, but are not limited to, amounts due under Section 4.05 of the Plan, 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.

RETIRED PARTICIPANT
Retired Participant means, in the case of:

- A clergy Employee, either:
  - Being placed in the retired relation in accordance with ¶357 of *The Book of Discipline*.
  - Incurring, on or after his or her early retirement date a termination of employment and either: 1) termination of Conference or denominational relationship, or 2) a five-year no record of appointment.

- A lay Employee, the earliest of:
  - The date such lay Employee incurs a termination of Employment on or after his or her early retirement date.
  - In the case of a long-term disability plan disabled or short-term disability plan disabled lay Employee, the date on or after his or her early retirement date that he or she elects to begin his or her benefits under any retirement plan administered by Wespath.
  - In the case of a lay Employee on an approved leave of absence who does not return to work at the scheduled end of the leave of absence, the date the leave of absence was scheduled to end if such date is on or after his or her early retirement date.

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

- General Conference
- A General Agency
- A Jurisdictional Conference
- A Conference
- A Conference board, agency, or commission
- A local church located in a Conference
- Any other entity to which a clergyperson under Episcopal appointment is appointed
- Any other employer of lay Employees who are eligible to participate in a Church Plan.

SPECIAL ENROLLMENT EVENTS

Changes in coverage of an Eligible Person, or the Spouse or Dependent of a Participant or Eligible Person under another employer's group health plan. An Eligible Person may make certain coverage election changes in the following circumstances:

- The Eligible Person declined coverage under HealthFlex because he or she (or his or her spouse or dependent) had Other Health Coverage, then the Eligible Person (or his or her Spouse or Dependent) lost the Other Health Coverage because he or she is 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 he or she exhausted the COBRA or other continuation coverage period.
- The Eligible Person becomes eligible for a premium subsidy for coverage under HealthFlex through Medicaid or a state Children's Health Insurance Program (S-CHIP).
- The Eligible Person becomes ineligible for a Premium Tax Credit in the Affordable Care Act's Health Insurance Marketplace (Exchange).
- The Eligible Person declined coverage under HealthFlex for his or her Spouse or Dependent, because his or her Spouse or Dependent had Other Health Coverage, COBRA or other continuation coverage, then his or her 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.
- The Eligible Person gains a new Dependent due to marriage, birth, adoption, placement for adoption or legal guardianship.
- The Plan or the Other Health Coverage (or the plan of the Eligible Person's Spouse or Dependent) no longer offers a Benefit Option to an entire class of similarly situated individuals that includes the Eligible Person.
- The Eligible Person is assigned "No Coverage" under HealthFlex because of non-compliance with the time requirements for Change of Status Events and then one of the above events occurs.

In order to enroll in the Plan as a result of a Special Enrollment Event, an Eligible Person, or the Spouse or Dependent involved, must be otherwise eligible for coverage under the terms of the Plan.

SPOUSE

The term Spouse, for purposes of the Plan, means a person who is in a marital relationship with a Participant (or with 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 shall not be a Spouse for purposes of the Plan. A person who is a Spouse shall 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.

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

TERMINATED PARTICIPANT

Terminated Participant means a person who has been a Participant under the Plan as sponsored by a Plan Sponsor, but who:

- is a lay Employee and has incurred a termination of employment with such Plan Sponsor, or
- is a clergy Employee and has incurred a termination of Conference relationship.

WESPATH

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

Appendix A

CHANGE OF STATUS EVENTS

A covered Participant in HealthFlex who experiences certain changes in his or her family's status might be permitted to make limited changes in his or her HealthFlex elections for the current Plan Year. The Plan is administered as a cafeteria plan under the rules and regulations of §125 of the Code. Because the Plan is a cafeteria plan, circumstances in which a Participant can make a change to his or her elections outside of the Open Enrollment Period and Annual Election Period under the Plan are limited to those Change of Status Events described in §125 of the Code that the Plan has incorporated in its election change rules. These Changes of Status Events include:

- Marital status changes (e.g., marriage, divorce, legal separation[10]).
- 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, i.e., becomes ineligible, or regains eligibility (e.g., reaches a limiting age).
- Change in employment[11] status of a Participant or Dependent that affects eligibility for the underlying benefit 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).
- Change in residence[12] that affects eligibility (e.g., moving out of the coverage area for a managed care option).
- Participant would like to cease coverage under HealthFlex in order to purchase coverage through a competitive Marketplace established under the Affordable Care Act.[13]

Any changes in elections based upon a Change of Status Event must be **on account of** and **consistent with** such Change in Status as determined under applicable IRS rules. For example, when a Participant acquires a new Dependent, the election change for that Change of Status Event would be to add coverage for that Dependent, not to drop coverage for other Dependents.[14]

In certain other limited circumstances a Participant may make changes to his or her elections; these additional Change in Status Events are:

- Judgment, decree or order (i.e., a qualified medical child support order).
- Medicare or Medicaid Entitlement[15] (or loss of such entitlement).

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[10] In the case of legal separation, the Participant must provide documentation showing he/she is living separately from his/her spouse. To prove separation, a Participant may use documents like rental agreements for separate properties, separate utility bills, bank accounts, etc.

[11] Appointment changes within a conference, other than appointment to non-salaried statuses, and compensation changes alone are not considered Change of Status Events.

[12] Changes in residence that affect eligibility for certain coverage 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.

[13] 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 Risk Pool. Participants must contact their Plan Sponsor before waiving the plan.

[14] In accordance with IRS guidance, however, Dependents in addition to the newly acquired Dependent can be added to coverage under what is known as the "tag-along" rule.

[15] Treasury Regulations define Medicare or Medicaid Entitlement as Enrollment in Medicare or Medicaid, as applicable (i.e., when participant becomes enrolled).

- Mid-year Plan changes (e.g., significant changes in the cost of coverage or significant curtailment of coverage during a Plan Year).
- Certain required circumstances under the Family and Medical Leave Act where applicable to your employer.

HIPAA Special Enrollment Events

If an Eligible Person declines coverage under the Plan, in certain situations he or she may be able to enroll for coverage under the Plan at the time he or she loses Other Health Coverage. This rule would also apply if the Eligible Person were assigned "No Coverage" by the Plan due to noncompliance with the 31-day Plan Sponsor signature requirement for enrollment.

The situations in which an Eligible Person may be able to enroll for HealthFlex coverage upon the loss of Other Health Coverage or in which Participants may make changes to certain elections are called Special Enrollment Events and are as follows:

- The Eligible Person declined coverage under HealthFlex because he or she (or his or her spouse or dependent) had Other Health Coverage, then the Eligible Person (or his or her Spouse or Dependent) lost the Other Health Coverage because he or she is 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 he or she exhausted the COBRA or other continuation coverage period.
- The Eligible Person becomes eligible for a premium subsidy for coverage under HealthFlex through Medicaid or a state Children's Health Insurance Program (S-CHIP).
- The Eligible Person becomes ineligible for a Premium Tax Credit in the Affordable Care Act's Health Insurance Marketplace (Exchange).
- The Eligible Person declined coverage under HealthFlex for his or her Spouse or Dependent, because his or her Spouse or Dependent had Other Health Coverage, COBRA or other continuation coverage, then his or her 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.
- The Eligible Person gains a new Dependent due to marriage, birth, adoption, placement for adoption or legal guardianship.
- The Plan or the Other Health Coverage (or the plan of the Eligible Person's Spouse or Dependent) no longer offers a Benefit Option to an entire class of similarly situated individuals that includes the Eligible Person.
- The Eligible Person is assigned "No Coverage" under HealthFlex because of non-compliance with the time requirements for Change of Status Events and then one of the above events occurs.

In order to enroll in the Plan as a result of a Special Enrollment Event, you, or the Spouse or Dependent involved, must be otherwise eligible for coverage under the Plan.

If a Participant or Eligible Person does not experience a Change of Status Event, he or she is not permitted to change his or her elections for the given Plan Year at any time during the Plan Year. In such cases, election changes may only be made during the Open Enrollment (i.e., Annual Election Period) for the subsequent Plan Year.

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

When an Eligible Person accepts HealthFlex coverage due to a Special Enrollment Event or makes an election change due to a Change of Status Event, the effective date of medical, dental and vision Benefit Option coverage is as follows:

- **Special Enrollment Event—loss of Other Health Coverage:** HealthFlex coverage will be effective as of the first day the Eligible Person is 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 the Eligible Person is without the COBRA coverage or other continuation coverage.
- **Special Enrollment Event or Change of Status Event wherein a new Dependent is added to the Eligible Person's family:** HealthFlex coverage will be effective as of the date of the marriage, birth, adoption, placement for adoption, or legal guardianship.
- **Change of Status Event wherein a Dependent regains eligibility:** HealthFlex coverage will be effective as of the date the Dependent first meets the eligibility requirements.

If the addition of a health care or dependent care FSA is permitted under HealthFlex Change of Status provisions, the effective date of that benefit election is the effective date of HealthFlex coverage.

When an Eligible Person loses or declines HealthFlex coverage due to a Change of Status Event, the effective date of the loss of medical, dental and vision Benefit Option coverage and the termination of FSA participation is the last day of the month in which the date of the Change of Status Event occurred.

Example 1:
John has declined HealthFlex coverage because he has coverage through his spouse's employer. John's wife 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 or Via Benefits Enrollment/Change Form*. He completes and returns the form to his Plan Sponsor's office. All of this must be done such that the Plan Sponsor can sign the *HealthFlex or Via Benefits Enrollment/Change Form* by 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 1 Susan gives birth to her daughter, Alicia. Susan notifies her Plan Sponsor of the birth and receives a *HealthFlex or Via Benefits Enrollment/Change Form*. She completes the form adding Alicia as a covered dependent and returns it to her Plan Sponsor's office. All of this must be done such that the Plan Sponsor can sign the Enrollment/Change Form by end of the business day on July 31. Coverage is effective May 1.

If a Participant or Eligible Person fails to meet this time requirement, the Participant or Eligible Person cannot make coverage or election changes due to the Change of Status Event (Special Enrollment Event or otherwise), and he or she will have to wait until the next Open Enrollment Period for coverage effective the following Plan Year. See *HealthFlex Life Event Chart* (next pages) for additional information.

HealthFlex Life Event Chart

Special Enrollment Event for Eligible Persons Who Have Declined HealthFlex Coverage	Enrollment/Coverage Category Changes	Health care FSA (Elect/Terminate)	Dependent care FSA (Elect/Terminate)	Medical/Dental Option Change at Time of Event
Newly eligible Dependent; Spouse loses other coverage; individual loses other coverage (e.g., due to divorce or death of Spouse)	May enroll for coverage of self and eligible dependents	May elect	May elect	Yes, full elections
Become eligible for state-based premium assistance for HealthFlex coverage under Medicaid or a state Children's Health Insurance Program (CHIP).	May enroll for coverage of self and eligible dependent	May elect	May elect	Yes, full elections
Become ineligible for a Premium Tax Credit in Affordable Care Act's Health Insurance Marketplace (Exchange).	May enroll for coverage of self and eligible dependent	May elect	May elect	Yes, full elections

HEALTHFLEX LIFE EVENT CHART (CONTINUED)

Family Status Change of Participant with Coverage	Enrollment/Coverage Category Changes	Health care FSA (Changes)	Dependent Care FSA (Changes)	Medical/Dental Option Change at Time of Event
Gain new Dependent child (birth, adoption, placement for adoption or legal guardianship)	May enroll and cover new dependent and (because of the tag-along rule) other eligible Dependents	May elect, increase or terminate	May elect, terminate, increase or decrease	No
New Spouse (marriage)	May enroll and cover new Dependent (and because of the tag-along rule, other eligible Dependents); may decline coverage of self* and Dependents (if other health coverage is available through Spouse)	May elect, terminate, increase or decrease	May elect, terminate, increase or decrease	No
Dependent regains health coverage eligibility	May enroll affected Dependent	No	No	No
Spouse loses other health coverage	May cover Spouse and other eligible Dependents	May elect; may increase	May elect, terminate, increase or decrease	No

* **Note:** If *HealthFlex* coverage is required by a Participant's Plan Sponsor, the Participant will not be able to decline coverage for him or herself.

HEALTHFLEX LIFE EVENT CHART (CONTINUED)

Family Status Change of Participant with Coverage	Enrollment/Coverage Category Changes	Health care FSA (Changes)	Dependent care FSA (Changes)	Medical/Dental Option Change at Time of Event
Divorce or legal separation	Must decline coverage of Spouse and any other ineligible Dependents; may enroll eligible Dependents; may drop Dependents enrolled in Spouse's plan	May terminate; may decrease	May elect, terminate, increase or decrease	No
Participant loses health coverage eligibility	Must be terminated; Participant eligible for Continuation Coverage	N/A	N/A	No
Participant dies	Covered Dependents eligible for Surviving Dependent coverage	N/A	N/A	No
Child dies	Drop coverage of deceased individual only	May terminate; may decrease	May terminate; may decrease	No
Spouse dies	Drop coverage of Spouse or add eligible Dependents, if other Dependents lose coverage through deceased Spouse	May elect; may increase; may decrease	May elect; may increase	No
Loss of Benefit Option due to ZIP code change through a change in residence	May decline coverage of self* and Dependents	No	No	Only the medical and dental option(s) being lost or gained
Spouse gains Other Health Coverage	May decline coverage of self* and Dependents	May terminate or decrease	May elect, terminate, increase or decrease	No

* **Note:** If *HealthFlex* coverage is required by a Participant's Plan Sponsor, the Participant will not be able to decline coverage for him or herself.

HEALTHFLEX LIFE EVENT CHART (CONTINUED)

Family Status Change of Participant with Coverage	Enrollment/Coverage Category Changes	Health care FSA (Changes)	Dependent care FSA (Changes)	Medical/Dental Option Change at Time of Event
Medicare entitlement (i.e., enrollment in Medicare)	Change to the medical plan available to participants age 65 and over	N/A	N/A	Yes
Medicaid entitlement (i.e., enrollment in Medicaid)	Change to the medical plan available to participants who enroll in Medicaid)	N/A	N/A	Yes
Judgment, order or decree	Add or drop Dependent in accordance with the judgment, order or decree	May elect, may terminate, may increase, may decrease	May elect, terminate, increase or decrease	No
Salaried to non-salaried status (leave of absence)	Participant can drop or change coverage	Terminated	Terminated	No
The Participant's hours of service are reduced so that he or she is expected to average less than 30 hours of service per week, but remains eligible for coverage under HealthFlex	Participant can drop or change coverage	Terminated	Terminated	No

* **Note:** If *HealthFlex* coverage is required by a Participant's Plan Sponsor, the Participant will not be able to decline coverage for him or herself.

OTHER LIFE EVENTS

In addition to the events described above, certain events, like certain changes of appointment status, can trigger coverage and elections changes.

- **Disability and Medicare Entitlement:** Upon Medicare Entitlement (i.e., enrollment in Medicare), a Participant may elect to change coverage, dropping HealthFlex and opting into the plan sponsor's Medicare plan (e.g., Via Benefits) where available. **Medicare Secondary Payer Small Employer Exception (MSP):** A Medicare-eligible participant actively working for small employer in the MSP (MSPSEE) program will be covered by Via Benefits if available. There is no reduced rate option for individuals in the active HealthFlex plan who have Medicare paying primary.

Appendix B

MEDICARE SECONDARY PAYER RULES

The Center for Medicare Services (CMS) has specific rules for deciding when Medicare should pay health care claims second (i.e., when it should be the secondary payer), after another type of insurance or health coverage.

When Medicare Pays Secondary

The statutory rules for Medicare Secondary Payer (MSP) coverage vary depending on: 1) the basis for Medicare coverage and employer group health plan (GHP) coverage, and 2) the size of the employers participating in the GHP.

In general, Medicare pays secondary to the following:

- A GHP covering an individual with end-stage renal disease during the first 30 months of Medicare eligibility or entitlement.
- A GHP covering an individual age 65 or over who works or whose spouse works for an employer with 20 or more employees, if that individual or the individual's Spouse (of any age) holds "current employment status."
- A multi-employer or multiple employer GHP in which at least one participating employer employs 20 or more employees. Medicare will pay secondary to the GHP even with respect to employers with fewer than 20 employees, ***unless*** the plan elects the Small Employer Exception (MSPSEE) under the statute.
- A GHP covering disabled individuals under age 65, if the coverage is provided due to the participant's "current employment status."

Current Employment Status

An individual is covered by virtue of current employment status, if the individual meets these criteria:

- Actively working as an employee, or
- Not actively working and is receiving disability benefits from an employer for the first 6 months of such disability benefits, or
- An individual who:
  - retains employment rights in the industry (i.e., through a union contract);
  - has not had his or her employment terminated by the employer;
  - is not receiving disability benefits from an employer for more than six months;
  - is not receiving Social Security disability benefits; and
  - has ongoing GHP coverage that is not COBRA (continuation) coverage.

Special Rule for Clergy

A special rule may apply to clergy in certain circumstances. Under that special rule, a clergy member may lose "current employment status" prior to receiving disability benefits for 6 months if the clergy member 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 clergy member 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. When the special rule applies, Medicare may start paying primary earlier that would occur if the general 6-month rule described above applied.

Appendix C

DUTIES AND RESPONSIBILITIES UNDER HEALTHFLEX

Powers and Duties of the Administrator
Wespath shall have the power to take all actions required to carry out the provisions of the Plan and shall further have the following powers and duties, which shall be exercised in a manner consistent with the provisions of the Plan:

- To construe and interpret the provisions of the Plan, and make rules and regulations under the Plan to the extent deemed advisable by Wespath;
- To file or cause to be filed all such annual reports, returns, schedules, descriptions, financial statements and other statements as may be required by any federal or state statute, agency, or authority;
- To obtain from the Plan Sponsors and Employees such information as shall be necessary to the proper administration of the Plan;
- To determine the amount, manner, and time of payment of benefits hereunder;
- To contract with such insurance carriers, Claims Administrators or other service providers as may be necessary to provide for benefits;
- To communicate to any insurer, Claims Administrator or other contract service provider of benefits under this Plan in writing all information required to carry out the provisions of the Plan;
- To notify the Participants of the Plan in writing of any amendment or termination of the Plan, or of changes in benefits available under the Plan;
- To prescribe such forms as may be required for Employees to make elections under this Plan;
- To settle, compromise, or submit to arbitration any claims, debts, or damages due or owing to or from the Plan, to commence or defend suits or legal or administrative proceedings, and to represent the Plan in all suits and legal and administrative proceedings, and to comply with judicial and administrative orders, decrees, judgments, summons, subpoenas, levies and other writs or instruments of judicial or administrative process, without regard to their potential vulnerability to challenge on jurisdictional or other legal grounds, all within the sole discretion of Wespath; and
- To do such other acts as it deems reasonably required to administer the Plan in accordance with its provisions, or as may be provided for or required by law.

Duties of the Plan Sponsor

The Plan Sponsor shall assume the following duties with respect to the Plan:

- To accurately and in a timely manner enroll clergy Employees and lay Employees, as applicable;
- To maintain records of Participants' compensation, enrollment and elections;
- To remit Required Contributions to Wespath;
- To provide the Administrator with statistical data and other information satisfactory in form and accuracy within a reasonable time after a request by Wespath sufficient to enable Wespath to discharge its duties under the Plan as Plan Administrator;
- To register with and report to government agencies, as appropriate;
- To comply with applicable federal and state laws and regulations;
- To properly notify clergy Employees and lay Employees of their rights and obligations under the Plan; and
- To comply with the terms of HIPAA.

The Plan Sponsor must discharge these duties with the reasonable skill, care and prudence expected of employers with respect to the welfare benefits of their employees. Plan Sponsors indemnify HealthFlex and Wespath against claims from Participants related to errors arising from the duties of the Plan Sponsor.

Appendix D

RULES FOR RISK POOL

This document outlines the rules that apply to the risk pool.

Wespath will review these rules annually and modify them in its sole discretion. If a Plan Sponsor fails to meet the rules of the Risk Pool, Wespath will notify the Plan Sponsor of such failure and provide the Plan Sponsor a limited opportunity to rectify the matter. If the Plan Sponsor does not rectify the situation in a timely manner, Wespath, in its discretion, can terminate the Plan Sponsor from the Plan at the end of the applicable Plan Year.

The Risk Pool is designed to maximize the distribution of the risk of large claims. The mandatory rules do not mean that "participation" or "coverage" of eligible individuals is mandatory but rather all churches and Salary-paying Units with appointed eligible clergy share in the cost and the risk of providing a group health plan for clergy. This is part of the connectional philosophy of The United Methodist Church.

Thus, the Risk Pool requires the payment of Required Contributions for 100% of eligible clergy (elders) whether or not the clergyperson has elected coverage in the HealthFlex Plan. Eligible clergy includes both "Basic Coverage" and "Optional Coverage" categories selected on *HealthFlex Adoption Agreement Exhibit A – Conference Plan Sponsor Eligible Categories of Coverage* (Exhibit A). (Please note the Exclusions paragraph for the categories for which these rules do not apply.)

If a Plan Sponsor selects any elder extension ministries eligibility categories on Exhibit A, the Plan Sponsor must provide the names of the locations, i.e., Salary-paying Units, to Wespath. The Plan will bill the Conference for every elder position in the selected extension ministries eligibility categories at the named Salary-paying Units.

For deacon eligibility categories, the conference Plan Sponsor can choose to have the risk pool rules apply at the Conference level or at the Salary-paying Unit level. If "Conference Level" is selected in Part 2, Section 3 of Exhibit A, the Plan will invoice the Conference for Required Contributions for every deacon position in the selected eligibility categories (100%). If the Plan Sponsor selects any deacon extension ministries eligibility categories, the Plan Sponsor must provide the names of the locations, i.e., Salary-paying Units, to Wespath. The Plan bills the Conference for every deacon position in the selected eligibility categories at the named Salary-paying Units. If the Plan Sponsor selects "Salary-paying Unit Level" on Exhibit A, then the Salary-paying Unit must determine whether the deacon coverage is under the Conference health plan or another health plan offered by the Salary-paying Unit. If the Salary-paying Unit completes a HealthFlex Sub-Adoption Agreement and selects deacon coverage, then the Plan bills the Conference for all enrolled deacon positions in the selected categories in Exhibit A at that participating Salary-paying Unit. A Salary-paying Unit can elect to cover deacons but not lay employees under HealthFlex.

For Plan Sponsors that elect to cover lay or other optional employees at certain Salary Paying Units, 75% of all eligible lay or deacon Employees, as selected on Exhibit A, must be covered in the HealthFlex Plan. The Plan applies the 75% requirement to each selected category separately, not all selected categories aggregately. (Note the Exclusions paragraph for the categories for which these rules do not apply.) The Plan applies the 75% coverage rule to each participating Salary-paying Unit. When a Salary-paying Unit has fewer than 12 lay or deacon Employees, the Salary-paying Unit satisfies the percentage requirements if the number of covered lay or deacon Employees corresponds to the number in the chart as follows:

Required Number of Covered Lay/Deacon Employees	Total Number of Eligible Lay/Deacon Employees
1	1
1	2
2	3
3	4
3	5
4	6
5	7
6	8
6	9
7	10
8	11
75%	12 or more

If the Salary-paying Unit does not meet the 75% coverage rule, the Plan will notify the Salary-paying Unit of the situation and give it an opportunity to correct the situation. If the Salary-paying Unit does not correct the matter within the time frame set by the Plan, the Plan, in its discretion, can terminate the Salary-paying Unit from the Plan at the end of the then current Plan Year.

Employer Plan Sponsors must cover 85% of all eligible Employees, as selected on Exhibit A – *Employer Plan Sponsor Eligible Categories of Coverage*, in the HealthFlex Plan.

If the Employer Plan Sponsor does not meet the 85% coverage rule, the Plan will notify the employer Plan Sponsor of the problem and give the employer Plan Sponsor an opportunity to correct the situation. If the employer Plan Sponsor does not correct the situation, Wespath, in its discretion, can terminate the employer Plan Sponsor from the Plan at the end of the Plan Year.

Note: The rules of the risk pool also apply to clergy and lay Employees who have health coverage through the Indian Health Service, or the health plan of a former employer.

Exclusions: The rules of the risk pools do not apply to the categories for retirees and surviving Spouses, i.e., persons in those categories are not included in the count for compliance. Medical/disability, maternity/paternity and family leaves are not categories for selection. Only individuals covered at the time they become disabled or take maternity/paternity or family leave may remain covered. For clergy appointed to the following categories: sabbatical leave, voluntary leave of absence and involuntary leave of absence, a covered individual may remain covered for up to one year. Subsequent eligibility depends upon the new appointment being to an eligible category. Individuals who have completed a *Mandatory Waiver Form* do not count toward Risk Pool Rules.

The risk pool rules apply only to the primary individual and not to Dependents. In the case of clergy couples where both individuals meet the eligibility rules and are actively employed, the Plan Sponsor along with the clergy couple determines how the couple is enrolled. Wespath bills the Conference Plan Sponsor as follows:

Covered as two singles	Billed as two singles
One clergy Participant waives coverage as Participant to be covered as Dependent under clergy Spouse's family coverage	Billed as family
One clergy Participant waives coverage as Participant to be covered as Dependent under clergy Spouse's coverage	Billed as participant plus one

In the situation of a "clergy and lay Employee couple" both eligible persons must meet the eligibility rules of the Conference and employer.

Certain eligible participants (clergy and lay Employees) may decline HealthFlex coverage by submitting a completed *HealthFlex Mandatory Coverage Waiver Form*, and the Plan will not assess a Risk Pool penalty (equivalent to a single premium in the Plan Sponsor's lowest-cost plan) to the Plan Sponsor.

The Risk Pool penalty will not be applied with respect to participants who decline coverage due to the following reasons:

- Individuals enrolling in Medicaid
- Individuals enrolling in TRICARE or CHAMPUS
- Individuals enrolling in employer-provided coverage through another employer, including a former employer
- Individuals enrolling in employer-provided coverage through a spouse's plan
- Individuals declining HealthFlex coverage *because their offer of coverage is not "affordable"* as defined in the Affordable Care Act (ACA). Under the ACA, an individual does not have "affordable" coverage if his or her personal contribution for individual (self-only) coverage costs more than 9.5% of one's modified adjusted gross income (MAGI)
- Individuals who *qualify for a premium tax credit* through the ACA's Health Insurance Marketplace because 1) their MAGI is between 100% and 400% of the federal poverty level based on household size, **and** 2) the Salary-Paying Unit (i.e., local church) has been permitted to opt out of the annual Conference's plan (provided through HealthFlex) by Conference rules, has so opted-out and is therefore not offering Employer-provided coverage
- Individuals have no offer of employer-provided coverage under HealthFlex

Clergy couples do not need to submit a *HealthFlex Mandatory Coverage Waiver Form* to decline primary coverage for an individual if he or she will be covered as a dependent under the other individual's coverage. This is a manual process and may require notifying the Health Team of the circumstances under which the *Waiver Form* is not required.

At churches or employers where none of the conditions above is met, the Plan Sponsor will continue to be billed an amount equivalent to a single (individual) coverage premium as a Risk Pool penalty for each eligible full-time appointed clergyperson's coverage, even if the Employee declines HealthFlex enrollment or the Employee or local church refuses to pay.

Members of the annual conference can covenant through legislation that all eligible clergy are expected to be covered in the Conference health plan; or that the churches and Salary-paying Units with appointed eligible clergy are expected to share in the cost of providing that plan; or that covered clergy are expected to contribute toward the cost of that plan. In addition to *The Book of Discipline*, conferences should consider secular laws, both federal and state level, before taking such actions. For example, depending on

applicable laws, it may or may not be permissible to mandate participation or coverage as a condition of employment or appointment. Therefore, Wespath recommends that a Conference consult its chancellor or legal counsel before taking any actions.

If a Conference becomes a HealthFlex Plan Sponsor, the Conference is subject to the terms and conditions of HealthFlex (e.g., see sections 1a. and 1b. of the Plan Sponsor Adoption Agreement). The HealthFlex Plan includes a cafeteria plan component and a group health plan component. The group health plan component only requires participant contributions (i.e., contributions from the individual) if that individual actually receives group health plan coverage (i.e., has not waived coverage and can receive benefits) under the HealthFlex Plan. Further, the cafeteria plan allows certain individuals to elect group health plan coverage and to pay for their share of the cost for such coverage, if any, with pre-tax salary reductions. This means that, if an individual does not elect coverage under the group health plan component, the individual may not make pre-tax salary reduction contributions under the cafeteria plan. For the reasons stated above, Wespath believes that the terms and conditions of the HealthFlex Plan do not provide for or authorize the mandating of contributions from individuals who have waived or not elected group health plan coverage.

Administration of the Risk Pool—For each Conference Plan Sponsor, Wespath will conduct an initial review of the designated eligible population prior to the first year of participation in the Risk Pool. The initial review will ensure that all eligible clergy, as described above, are counted in the Risk Pool whether coverage has been elected or waived by the individual clergy. After this initial review, the Conference Plan Sponsor must submit an enrollment form, for either enrollment purposes or for risk pool census purposes, for every eligible clergy at the time each clergy becomes eligible even if the individual waives coverage. Individuals in a mandatory category will automatically be enrolled in individual coverage in the default plan unless an Enrollment/Change or Waiver form is submitted. The Conference HealthFlex invoice will have charges for both covered and non-covered eligible clergy, as described above. The charges for non-covered clergy are considered surcharges for risk and the Conference must pay them. Wespath has the right to conduct subsequent reviews of the population every two years.

Using Exhibit A, each Conference Plan Sponsor selects the eligible categories for its own lay Employees (Part 5) and the parameters within which participating Salary-Paying Units can select the eligible categories for their lay Employees (Part 6). Each participating Salary-Paying Unit must complete a Salary-Paying Unit Sub-Adoption Agreement selecting its eligible categories as allowed by Part 6 of Exhibit A. Along with the sub-Adoption Agreement, the Salary-paying Unit must submit an enrollment form for each eligible lay Employee whether coverage has been elected or waived by the lay Employee, either for enrollment purposes or for risk pool census purposes. Thereafter, the Salary-paying Unit must submit an enrollment form for every eligible lay Employee at the time they become eligible, even if the individual waives coverage for the same purposes. The Conference Plan Sponsor is responsible for ensuring that each Salary-paying Unit meets the 75% coverage rule.

For each employer Plan Sponsor, Wespath will conduct an initial audit to ensure that 85% of all eligible Employees are covered, excluding retirees and surviving Spouses. Thereafter, the employer Plan Sponsor must submit an enrollment form for every eligible Employee at the time the Employee becomes eligible even if the Employee waives coverage either for enrollment purposes of for risk pool census purposes. Wespath has the right to conduct subsequent audits every two years.

Appendix E

MEDICARE SECONDARY PAYER/SMALL EMPLOYER EXCEPTION (MSPSEE) ADMINISTRATIVE GUIDELINES

Procedures for Implementing the Small Employer Exception
For a Plan Sponsor applying for the Small Employer Exception for the first time, the following steps must be taken:

Note: Participants must be in HealthFlex active coverage prior to moving to the MSPSEE with Via Benefits. If the participant is not enrolled in active coverage, he/she will not be able to transition to MSPSEE.

Step #1: Plan Sponsor Makes Adoption Agreement Election
Plan sponsor must adopt the Small Employer Exception in Part 8 of Exhibit B to the HealthFlex Adoption Agreement. The plan sponsor should return the completed *HealthFlex Plan Options – Exhibit B* (along with a completed Adoption Agreement) by **June 30** of any given year. (Plan sponsors adopting HealthFlex Exchange should use the *HealthFlex Exchange Plan Options – Exhibit B* form.)

Step #2: Plan Sponsor Facilitates Completion of *Employer Certification Form*
Wespath will provide an electronic copy of the *Employer Certification Form* to a plan sponsor after receiving a signed Adoption Agreement and Exhibit B indicating its intent to participate in the Small Employer Exception. This form indicates whether or not an Employer is eligible for the Small Employer Exception and must be completed for *each Employer* that has working participants age 65 or older in an active plan. For information regarding how to identify Employers, see "How to Identify Individual Employers." To help facilitate this process, the Wespath Health Team will also provide the plan sponsor a current list of all participants and/or spouses age 65 or older in an active plan and all participants and/or spouses in an active plan within four months of turning 65. Plan sponsors/Salary Paying Units are then required to:

- Send the Employer Certification Form to the identified Employers.
- Ask that the Employer complete, sign and promptly return the *Employer Certification Form* to the Plan Sponsor. The form may be completed and signed by the Conference Benefits Officer or Treasurer as the employer's authorized representative.
- Retain a copy of the completed document and send the original to Wespath.

Step #3: Wespath Applies for Small Employer Exception with CMS
Upon receipt of the completed Employer Certification Form from the Plan Sponsor or Salary-Paying Unit, Wespath will forward the Form to CMS, along with the Participant's indicative data (e.g., name, effective date of coverage, Social Security Number, etc.) with a request to apply the Small Employer Exception. In addition, the Health Team will send a letter to the participant explaining the process, which includes enrolling in Medicare Parts A and B.

Step #4: Wespath Informs Active Plan Carrier that with Medicare Pays Primary or Notifies Via Benefits of Eligibility

- Once Wespath receives CMS approval of the request for the Small Employer Exception, Wespath will enroll the Participant in the Active Plan with Medicare Primary and inform the Participant and Plan Sponsor of the approval and subsequent enrollment change.
- If the Plan Sponsor uses Via Benefits instead of the Active Plan with Medicare Primary, the participant's eligibility will be forwarded to Via Benefits. Once the participant has completed the Via Benefits enrollment process and is covered by a Medicare supplement plan, the participant's coverage in the active plan will end.
- This change of enrollment will only occur upon the approval of CMS, even if the participant is otherwise eligible to participate in the Active Plan with Medicare Primary or through Via Benefits due to attaining age 65.

Procedures for Ongoing Administration
For a Plan Sponsor currently participating in the Small Employer Exception, the following actions must be taken (as needed or required):

Step #1: Plan Sponsor completes an annual review of the list of current employers in the MSPSEE provided by Wespath and notifies Wespath of changes (i.e., removal of an employer/employee/spouse or addition of a newly eligible employer/employee/spouse). Although Wespath will provide a list for an annual review, plan sponsors should inform Wespath anytime an employer, employee or spouse is no longer eligible or becomes eligible for MSPSEE.

Step #2: Wespath Contacts Plan Sponsor for Information (if necessary)
Four (4) months before a Participant attains age 65, Wespath will send a request for an *Employer Certification Form* to the Plan Sponsor in order to determine if the Small Employer Exception applies. However, if a certification form has been submitted to Wespath within the last year, a new form will not be required. If a form is needed, a Plan Sponsor must collaborate with the Participant's Employer to gather and submit the requested information to Wespath. For information regarding how to identify Employers, see "*How to Identify Individual Employers*." Wespath will also send a letter to the Participant explaining the application process.

Step #3: Plan Sponsor Facilitates Completion of Employer Certification Form (if necessary)
Upon request, a Plan Sponsor must:

- Send the Employer Certification Form to the Employer identified through Step #1.
- Ask that the Employer complete, sign and promptly return the Employer Certification Form to the Plan Sponsor. The form may be completed and signed by the Conference Benefits Officer or Treasurer as the employer's authorized representative.
- Retain a copy of the completed document and send the original to Wespath.
- These steps should be completed as soon as possible, but no later than 60 days before the Participant's Medicare enrollment date (typically the date the Individual turns 65).

Step #4: Wespath Applies for Small Employer Exception with CMS
Upon receipt of the completed Employer Certification Form from the Plan Sponsor, Wespath will forward the Form to CMS along with the Participant's indicative data (e.g., name, effective date of coverage, Social Security Number, etc.) with a request to apply the Small Employer Exception. In addition, the Health Team will send a letter to the participant explaining the process.

Step #5 Wespath Changes Participant's Coverage to the Active Plan with Medicare Primary or Notifies Via Benefits of Eligibility

Once Wespath receives CMS approval of the request for the Small Employer Exception, Wespath will inform the Plan Sponsor and Participant and terminate participant's active HealthFlex coverage.

If the Plan Sponsor uses Via Benefits, the participant's eligibility will be forwarded to Via Benefits. Once the participant has completed the Via Benefits enrollment process and is covered by a Medicare supplement plan, the participant's coverage in the active plan will end.

This change of enrollment will only occur upon the approval of CMS, even if the participant is otherwise eligible to participate in the Active Plan with an Active Rate Benefit Option or Via Benefits.

In addition, the following items must be considered by the Plan Sponsor or Salary Paying Unit during the ongoing administration of the Small Employer Exception:

> **Monitor and Report Changes—**When an employer no longer has fewer than 20 employees, that employer is no longer eligible for the MSPSEE. When a Participant transfers from a plan sponsor that has elected the MSPSEE to a plan sponsor that has not elected or is not eligible for the MSPSEE, the Participant is no longer eligible for MSPSEE. Therefore, a Plan Sponsor should require that an Employer promptly complete an *Employer Certification Form* (if the employer is no longer a small employer) or complete a *HealthFlex Enrollment/Change Form* (when an individual's status changes).

Step #1: Plan Sponsor Notifies Wespath of Change:
The Plan Sponsor will send to Wespath the *Employer Certification Form* to notify that the Small Employer Exception no longer applies to the Employer or a *HealthFlex or Via Benefits Enrollment/Change Form* if an individual is no longer eligible for MSPSEE.

Step #2: Wespath Notifies CMS that the Small Employer Exception no Longer Applies
Upon receipt of the completed form from the Plan Sponsor, Wespath will forward the form to CMS along with the Participant's indicative data (e.g., name, effective date of coverage, Social Security Number, etc.) with a request to remove the individual from the Small Employer Exception. In addition, the Health Team will send a letter of explanation to the participant.

Step #3 Wespath Informs Active Plan Carrier that with Medicare Pays Secondary Wespath will immediately inform the plan carrier that Medicare will pay secondary for the Participant or spouse in the Active Plan and inform the Participant and Plan Sponsor.

- **New Employers**—During a calendar year, an Employer may offer coverage through HealthFlex that it did not previously. In such instances and when possible/known, at least 90 days before a Participant attains age 65 or before a Participant already age 65 becomes employed at or appointed to an Employer in the Plan Sponsor's jurisdiction that might be a Small Employer, Wespath will:

  - send an Employer Certification Form the Plan Sponsor in order to determine if the Small Employer Exception applies;
  - ask that the Plan Sponsor or Employer promptly complete, sign and return the Employer Certification Form to the Wespath Health Team; and
  - retain a copy of the completed document.

  If a completed Employer Certification Form indicates that the Employer is a Small Employer, the Health Team will:

  - forward the letter to CMS for consideration; and
  - enroll the Participant in the Active Plan with Medicare Primary (or pass eligibility to Via Benefits) once CMS approval of the request for the Small Employer Exception is received and inform the Participant and Plan Sponsor of the enrollment.

- **New Individuals or Spouses**—During a calendar year, an Individual or Spouse of a Small Employer who was not previously covered by HealthFlex may enroll for such coverage. Or a retired Participant covered under the Active Plan with Medicare Primary or Via Benefits eligibility may return to work at a Small Employer. If the Individual or Spouse will be newly eligible for the Small Employer Exception, the Health Team will:

  - forward information to CMS for consideration; and
  - enroll the Participant in the Active Plan with Medicare Primary (or pass eligibility to Via Benefits) once CMS approval of the request for the Small Employer Exception is received and inform the Participant and Plan Sponsor of the enrollment.

- **Employers who provide HealthFlex to active employees but not Retiree coverage**—Wespath will administer the MSPSEE program as provided above. Active coverage for an MSPSEE-eligible participant will not be modified until notice is provided by CMS that the MSPSEE has been approved. When an MSPSEE-eligible participant is no longer eligible for MSPSEE, Wespath will make the HealthFlex active plan the primary payer once confirmation of the change is received from CMS.

IMPORTANT INFORMATION

Participation by Plan Sponsors

As a multiple employer plan, HealthFlex allows Employers of Plan Sponsors who elect to allow the Small Employer Exception to elect treatment under the exception. Plan Sponsors are not required to participate in the Small Employer Exception. Instead, Plan Sponsor participation is voluntary. Participation in the Small Employer Exception is subject to, among others, the following rules:

- In order to participate in the Small Employer Exception, a Plan Sponsor must notify Wespath in writing of its intent to participate. A Plan Sponsor notifies Wespath by submitting a timely completed Exhibit B to its Adoption Agreement indicating such intent:
  - at least 5 months, or such other time period or date prescribed by Wespath, prior to the Plan Year for which the Plan Sponsor intends to participate; and
  - satisfying all administrative requirements associated with the Small Employer Exception.

- Unless terminated by Wespath, a Plan Sponsor's participation in the Small Employer Exception will remain in effect until the Plan Sponsor notifies Wespath of its intent to terminate participation for an upcoming Plan Year.

- In order for a Plan Sponsor to terminate participation in the Small Employer Exception, the Plan Sponsor must notify Wespath in writing of its intent to terminate participation. A Plan Sponsor notifies Wespath by submitting a timely completed Exhibit B to its Adoption Agreement indicating such intent at least five months, or such other time period or date prescribed by Wespath, prior to the Plan Year for which the Plan Sponsor wishes to end its participation in the Small Employer Exception. (Dis-enrollment process will be followed).

- If a Plan Sponsor does not provide Wespath with timely written notice of its intent to terminate participation in the Small Employer Exception, the Plan Sponsor's participation will remain in effect for an upcoming Plan Year, unless terminated by Wespath.

If a Plan Sponsor participates in the Small Employer Exception, HealthFlex will apply the Small Employer Exception to all Participants of Small Employers within the Plan Sponsor grouponce both the Participant and the Small Employer are approved by CMS.

Definitions
For purposes of the Administrative Guidelines described in this Appendix E, the terms below have the following meanings when capitalized and used in Appendix E:

- **Aged**—the period of time when an individual is considered to be "aged" begins on the first day of the month in which an individual attains age 65. An individual whose birthday falls on the first of the month will be considered "aged" on the first day of the month preceding his or her 65th birthday. For example, an individual whose 65th birthday falls on July 1, 2016 is deemed to be "aged" as of June 1, 2016.
- **Employee**—means an individual who: 1) is working for an Employer, or 2) is not working for an Employer but is receiving payments that are subject to FICA taxes (or would be subject to FICA taxes if the Employer were not exempt from such taxes). The term "Employee" generally does not include a Self-Employed Person or a volunteer who does not receive monetary or non-monetary remuneration for his or her services. For the purposes of the Small Employer Exception, though, self-employed clergypersons should be considered "Employees."
- **Employer**—means: 1) an individual or organization engaged in a trade or business, or 2) other entity exempt from income tax, such as a religious, charitable or educational institution. An Employer may include an individual, partnership or corporation.
- **Individual**—means an Employee or Self-Employed Person.
- **Self-Employed Person**—includes: 1) a consultant, 2) a director of a corporation (who is not a corporate officer), or 3) a self-employed member of the clergy or religious order who is paid for his or her services by a religious body or other entity.
- **Small Employer**—means an Employer that did not employ more than 19 Employees for each working day in each of 20 or more calendar weeks during the preceding or current calendar year. If an Employer employs more than 19 Employees for 20 or more weeks during the preceding or current year, it is not a Small Employer.
- **Spouse**—means a married, common-law, separated or divorced spouse.

How to Identify Individual Employers
For purposes of the Small Employer Exception, an annual conference or denomination, and each local church or other Salary-paying Unit within its conference, may be a separate Employer. An annual conference, local church or Salary-paying Unit will be considered to be a separate Employer, provided that the annual conference, local church or Salary-paying Unit: 1) is separately incorporated, or 2) has its own separate tax identification number for Federal tax purposes.

Some local churches may provide services to the public and their congregation, such as day care services. Local churches may view such services as being performed by a separate entity and individuals who are not Employees of the local church. In some instances, this may be correct. However, in many instances, the services are actually performed as an integrated component of the local church and through Employees of the local church. Due to differing facts and circumstances, this issue must be addressed on a case-by-case basis. If questions related to this issue arise and assistance is needed, the Plan Sponsor should contact the Wespath Client Relationship Manager or Client Service Manager.

How to Define Employees
An Employee is an individual working for an Employer or not working but receiving payments that are subject to FICA taxes (or would be subject to FICA taxes if the Employer were not exempt from such

taxes). Employees generally include individuals for whom an IRS *W-2* form is filed under an Employer's Federal tax identification number. Even though an Employer does not file an *IRS W-2* form, an individual may still be an Employee of the Employer. To determine whether an individual is an Employee, the relationship between the individual and the Employer must be examined. It is important to note that self-employed clergy, who are Self-Employed Persons, should be considered Employees in counting how many Employees work for a particular Employer, for the purposes of the Small Employer Exception.

How to Measure Employer Size
In order to administer the Small Employer Exception, a Plan Sponsor must determine whether each Employer, offering coverage through HealthFlex, is a Small Employer. Consider the following:

Small Employers

A Small Employer is an Employer that did not employ more than 19 Employees for each working day in each of 20 or more calendar weeks during the preceding or current calendar year. An Employee is employed each working day of a particular week if the Employee was on the Employer's employment rolls each working day of that week. For purposes of determining an Employer's size, the following rules apply:

- The "20 or more calendar weeks" do not have to be consecutive weeks.
- *All Employees* should be counted, regardless of whether they:
  - are full-time, part-time, temporary or seasonal Employees,
  - actually work on a particular day,
  - are expected to report for work on a particular day, or
  - are eligible or actually enrolled for coverage through HealthFlex.

Small Employer Test

The following test should be used to determine whether an Employer is a Small Employer.
See "Examples," which illustrates how the Small Employer Test may be applied.

Question #1: Did the employer employ more than 19 Employees for each working day in each of 20 or more calendar weeks during the preceding calendar year?

If ***yes***, the Employer is not a Small Employer for the preceding or current calendar year (even if the Employee count is or falls below 20 during the current calendar year).

If ***no***, go to Question #2.

Question #2: To date, did the Employer employ more than 19 Employees for each working day in each of 20 or more calendar weeks during the current calendar year?

If ***yes***, the Employer is not a Small Employer for the current or following calendar year (even if the Employee count falls below 20 during such calendar years).

If ***no***, the Employer is a Small Employer. However, if the Employer subsequently employs more than 19 Employees, for each working day in each of 20 or more calendar weeks during the current calendar year, the Employer will not be a Small Employer for the current or following calendar year.

Examples

The following examples illustrate how the Small Employer Test may apply:

Example #1

Throughout the previous calendar year, Employer X had no more than 16 lay employees and two self-employed clergy working for Employer X. As of May 31, Employer X had, for each working day in each of 20 or more calendar weeks during the current calendar year, no more than 17 lay employees and two self-employed clergy working for Employer X.

Question: As of June 1, is Employer X a Small Employer?

Yes. Employer X did not employ more than 19 Employees for each working day in each of 20 or more weeks during the previous or current calendar year. For purposes of determining whether an Employer is a Small Employer, all Employees (including self-employed clergy) are counted. If Employer X subsequently has more than 19 lay employees, for each working day in each of 20 or more calendar weeks during the current calendar year, Employer X will no longer be a Small Employer for the current or subsequent calendar year.

Example #2

During the previous calendar year, Employer Y had, for each working day in each of 20 or more calendar weeks, 20 lay employees and two self-employed clergy working for Employer Y. As of May 31, Employer Y had, for each working day in each of 20 or more calendar weeks during the current calendar year, no more than 18 lay employees and two self-employed clergy working for Employer Y.

Question: As of June 1, is Employer Y a Small Employer?

No. Employer Y employed more than 19 Employees for each working day in each of 20 or more calendar weeks during the previous calendar year. Therefore, Employer Y is not a Small Employer for the previous or current calendar year. Further, Employer Y will not be a Small Employer for the current calendar year (even if the Employee count remains below 20 throughout the current calendar year).

Example #3

Throughout the previous calendar year, Employer Z had no more than 18 lay employees and two self-employed clergy working for Employer Z. As of May 31, Employer Z had, for each working day in each of 20 or more calendar weeks during the current calendar year, 20 lay employees and two self-employed clergy working for Employer Z.

Question: As of June 1, is Employer Z a Small Employer?

No. Employer Z employed more than 19 Employees for each working day in each of 20 or more calendar weeks during the current calendar year. Therefore, Employer Z is not a Small Employer for the current or subsequent calendar years (even if the Employee count subsequently falls below 20 during the current or subsequent calendar years).

Individuals Subject to the Exception

The exemption provided by the Small Employer Exception is limited. The Small Employer Exception only exempts the following individuals from the Working Aged Rules:

- Aged Individuals who have coverage by virtue of current employment status with a Small Employer; and
- Aged Spouses of Individuals (of any age) who have coverage by virtue of current employment status with a Small Employer.

Under Medicare's secondary payer rules, "coverage by virtue of current employment status" exists when coverage is based on employment and an individual has "current employment status." Although there are a number of ways for an individual to have current employment status, Medicare's secondary payer rules indicate that current employment status exists if, among other things, an individual is working for an Employer as an Employee. Further, Medicare's secondary payer rules contain a special rule for clergy. The special rule indicates that a clergyperson has current employment status with a church or religious organization if he or she receives cash remuneration from the church or religious organization for services rendered. Therefore, clergy who receive cash remuneration from a local church for their services are considered to have current employment status with that local church.

It is important to note that appointment and employment changes could cause individuals (and/or their Spouses) to become: 1) exempt from the Working Aged Rules, 2) no longer exempt from the Working Aged Rules.

Limitations of the Exception

As indicated above, the exemption provided by the Small Employer Exception is limited. The Small Employer Exception does not exempt the following individuals from the Working Aged Rules:

- individuals who have coverage by virtue of current employment status with an Employer that is not a Small Employer;
- individuals entitled to Medicare based on disability;
- individuals eligible for, or entitled to, Medicare based on end-stage renal disease (ESRD); or
- individuals entitled to Medicare based on dual entitlement (i.e., age and ESRD).

As indicated above, the Small Employer Exception does not exempt individuals who have coverage by virtue of current employment status with an Employer that is not a Small Employer. Therefore, if an Aged clergyperson (active or retired) receives remuneration from an Employer (that is not a Small Employer) for services rendered, the clergyperson will not be exempt from the Working Aged Rules. Similarly, an Aged Spouse of an active or retired clergyperson (of any age) who receives remuneration from an Employer (that is not a Small Employer) for services rendered will not be exempt from the Working Aged Rules.

NEED FOR MEDICARE PART B

If an Aged Individual or Aged Spouse is exempted from the Working Aged Rules due to the Small Employer Exception, he or she will need to enroll for Medicare Part B to avoid a gap in coverage. If a working Aged Individual does not enroll in Part B, the Plan will assume payment by Medicare Part B before benefit determination is made. This would result in higher out-of-pocket costs for the Aged Individual. If supplemental coverage is offered through Via Benefits, enrollment in Medicare Part B is required. A Plan Sponsor should ensure that Aged Individuals and Aged Spouses investigate any such need and enroll for Medicare Part B (if needed). Plan Sponsors should contact the Wespath Client Relationship Manager or Client Service Manager for more details.

IMPORTANT FORMS RELATED TO THE SMALL EMPLOYER EXCEPTION

Employer Certification Form

What is this form used for?

Employers complete this form and submit it to Wespath to seek approval for the Medicare Secondary Payer Small Employer Exception for the first time or if they already have the exception approved, but have not submitted a certification within the last year. Wespath forwards the form to CMS for approval and communicates with the Employee and Plan Sponsor once approval is received.

Instructions for Plan Sponsors

- Complete the form below with the requested information regarding the Employer. (Note that the “current employee count” should be a count of all Employees (including part-time Employees) at the Employer, **not** just those Employees in the Plan or qualifying for the Small Employer Exception).
- An authorized representative of the Employer must sign the letter.
- Send the completed letter and list to:

  Wespath Benefits and Investments
  Attn: *Health Team—MSP*
  1901 Chestnut Ave.
  Glenview, IL 60025

The Health Team will submit this request directly to CMS for consideration, along with information regarding the individual Participants seeking approval. Once CMS approves the request, Wespath will inform the Participant(s) and Plan Sponsor directly that Medicare is now the primary payer. If CMS inadvertently responds to the Employer or Plan Sponsor directly, rather than Wespath, please be certain to send a copy of the CMS response to the Health Team as soon as possible.

Sample Employer Certification Form

1901 Chestnut Avenue
Glenview, Illinois 60025-1604
1-800-851-2201
wespath.org

Employer Certification – Medicare Secondary Payer Rules

Part 1 – General Information

Medicare Secondary Payer (MSP) rules determine how Medicare and HealthFlex pay medical benefits for the following two groups:

1. participants age 65 or older who are currently employed by the employer completing this form; and/or
2. covered spouses age 65 or older of participants who are currently employed by the employer completing this form.

MSP rules state that, for the two groups named above, HealthFlex medical plans will be the "primary" payer of medical claims for employers that had 20 or more employees on the payroll for 20 or more calendar weeks in the current or preceding calendar year. The condition is met as long as the total number of individuals on the employer's payroll for the week adds up to at least 20 regardless of the number of employees who actually work or who are expected to report for work on a particular day. If an employer does not meet this condition, Medicare will be the "primary" payer of medical claims, and the cost of medical coverage may be lower for the two groups named above.

An "employee" is anyone who has been carried on the payroll, whether currently working or not, including all full-time and part-time employees, any employees receiving disability benefits from which FICA taxes are withheld and any clergy.

To determine if your organization is subject to MSP rules: List the number of employees on the payroll during each week in the current calendar year and previous calendar year. Count the number of weeks in each year in which your organization had 20 or more employees on the payroll on any given day. If, in the preceding year or in the current year (viewed independently), your organization had 20 or more weeks with 20 or more employees on the payroll, your organization is not exempt from MSP rules.

- Wespath Benefits and Investments (Wespath) must receive this signed form no later than 30 days prior to an employee's Medicare enrollment date.
- In order to update a participant to the Medicare-eligible plan, Wespath must receive a completed form indicating the employer's MSP exemption and must receive approval from the Centers for Medicare & Medicaid Services.

Employer name ____________ Phone # ____________

Address ____________ UMCID ____________

____________ Employer Tax I.D. # (EIN) ____________

Part 2 – Signature

☐ I certify that the above-named employer has had 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding year. This means the employer is subject to the MSP rules and HealthFlex will remain the primary payer of claims for individuals meeting the guidelines above.

☐ I certify that the above-named employer has not had more than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding year. This means the employer is exempt from the MSP rules and Medicare will become the primary payer of claims for individuals meeting the guidelines above.

(over)

Please indicate the current employee count for your organization:

☐ 1-19 employees ☐ 20-99 employees ☐ More than 100 employees

Wespath must be notified immediately if an increase or decrease in the number of employees changes the employer's MSP exemption status. Providing incorrect information on this form may result in retroactive charges for HealthFlex medical coverage or charges for reimbursement by the participant for claim overpayment.

Employer's authorized representative (please print) ______________________

Title ______________________ Phone # ______________

Signature ______________________ Date ______________

Wespath Use Only:

UMCID ______________ Date ______________

Representative ______________________

Please complete this form and send it by:

- E-mail (scanned copy) to **healthteam@wespath.org** or
- Fax to **1-847-866-2724** or
- Mail to Wespath Benefits and Investments
  Health Team
  1901 Chestnut Ave.
  Glenview, IL 60025-1604

Be sure to keep a copy for your records.

Wespath
BENEFITS | INVESTMENTS

Caring For Those Who Serve

1901 Chestnut Ave.
Glenview, IL 60025-1604
1-800-851-2201
wespath.org

Version Control

Date of Issue	Description
10/9/2018	2019 Updates: • Updated the IRS defined deductible for 2019; • Added footnote to the Change of Status Event for legal separation to state a Participant must provide documentation proving legal separation; • Clarified the HRA table within the HRA Plan section to clarify that if a participant goes from full time to part time, the HRA remains intact through retirement until it is exhausted or participant dies. If participant terminates employment from the UMC, the HRA is available for 90 days following this termination or until it is exhausted—whichever is earlier; • Clarified the Retiree policy to capture the scenario where a Participant had coverage under his spouse's plan and therefore was never in HealthFlex, then he retired and was moving to the conference's retiree plan (not Via Benefits) and his dependents were going to be enrolled in HealthFlex coverage; • Clarified the Termination of Non-Payment policy to state that if the FSA is terminated for non-payment, the Participant will have 30 days from date of termination to submit claims for expenses incurred prior to the date the FSA was terminated; • Added statement to MSPSEE section that participant must be enrolled in active HealthFlex coverage immediately prior to moving to MSPSEE; • Added new sub-section in the Change of Status policy for UMC Couples who experience a change of status event impacting eligibility; • Added a new sub-section in the HRA Plan section for UMC Couples to address HRAs when the UMC Couple change who is the primary participant and who is the dependent; • Updated Newborn change of status event to permit 60 days to enroll newborn (change from 31 days). • Appeals section and Appendix C removed, following Appendices renamed. Appeals are covered in the Benefit Booklet and Summary Plan Description.

11/14/2019	• Clarified that participants who retire as Ministers of Other Denominations are not treated as retired for HRA purposes. They are treated as terminated participants. • Added section regarding funding file cut-off date (i.e., December 4th). • Updated 2020 limits (i.e., HSA limits, FSA limits). • Clarified in the *Flexible Spending Account* section that healthcare FSA amounts can be carried over by one year. If this amount is not claimed in that year, the amount is not carried over to a subsequent year. • Removed Dental PPO 1000 and added Dental HMO reference. • Updated the *When a Participant's Conference Changes* section to clarify rules for HRA/HSA funding and transfer of deductible and OOP limits. • Added information regarding Medicare and continuation coverage in the Continuation *Coverage—Active Participants and their Dependents, Surviving Dependents, Divorced Spouses and Dependents of Retired Participants* section.
9/22/2020	• Updated 2021 limits (i.e., HSA limits, FSA limits). • Updated Continuation Coverage to 18 months for all Plan Sponsors • Updated Special Enrollment/Change of Status Events to align with stand-alone notice and also updated for IRS extended timeframes for change of status events (i.e., 60 days after COVID-19 Emergency ends) • Updated Termination of Participation of a Plan Sponsor section with new HealthFlex Premium Collection Policy. • Removed prescription requirement for over-the-counter medications to be reimbursed under FSA (CARES Act). • Updated requirements for participant and dependents to be covered under medical/dental/vision. • Updated requirements for participant to receive premium credit. Participant must be covered under medical in order to receive premium credit.
11/30/2021	• Removed the rule that Individuals covered under Continuation Coverage are not required to take Health Check to avoid a higher plan deductible. • Updated the Risk Pool section language to reflect a single Risk Pool. • Updated "Termination of HRA participation" section with: 'No Record of Appointment', 'Special Appointment outside US' and 'Lay employee goes from full-time to part-time and loses HF eligibility' statuses. • Clarified 'Disability' section. • Updated section on Medical Benefit Options for Medicare-Eligible Participants and added Flow Chart "Coordination of Benefits with Medicare"

11/21/2022	• Clarified that if the Medicare-Eligible participant and/or spouse waives HealthFlex coverage to be on Medicare, the waiver applies to all: medical, dental and vision coverage. • Updated policy that Department of Health and Human Services extended the COVID-19 public health emergency period until at least January 11, 2023. • Clarified that Treasury Regulations define Medicare or Medicaid Entitlement as Enrollment in Medicare or Medicaid, as applicable (i.e., when participant becomes enrolled). • Updated IRS limits for HSA/FSA. • Clarified health care FSA carry over rule.
2/9/2023	• Clarified policy for domestic partners considerations. • Updated policy that COVID-19 public health emergency period ends May 11, 2023. • Updated HRA chart for participants of another denominations.
10/23/2023	• Added information about “mini-COBRA” laws and 2% surcharge on the continuation premium. • Removed references to United Health Care and Out-Of-Area and clarified Claims Administrator duties between Quantum Health and BCBSIL. • Updated Plan Sponsor definition. • Clarified that continuation coverage is not available if coverage is ending due to failure to pay required contributions by the plan sponsor or participant. • Updated IRS limits for HSA for 2024. • Removed references to temporary rules related to the COVID-19 public health emergency.