



*Benefits with a Choice*

## Covenant Employee Benefits

As a Covenant pastor or ministry staff person, you have the opportunity to select from three health insurance plan options for your 2023 benefits. Complete and return the enclosed form to your employer, who will enter your information on a secure online portal and keep the form in their personnel records. **For more information and to ask questions, register for our 60-minute webinar on Tuesday, October 4 at noon CST.**

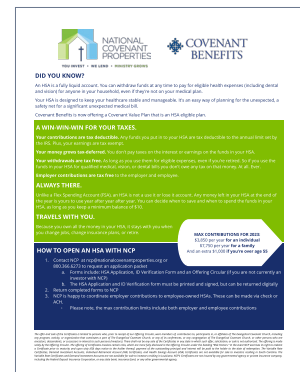
### What's the same?

#### All plans have:

- Broad, nationwide Blue Cross Blue Shield PPO network
- Preventive services and drugs covered 100%
- Concierge service
- Wellness rewards: earn cash for completing simple tasks to learn about your health and stay on track with preventive care
- Medical policy: the same services are covered by all plans and the total cost is the same, but you will pay different amounts based on the plan you choose
- Prescription formulary: the same prescriptions are covered by all plans and the total cost is the same, but you will pay different amounts based on the plan you choose
- Teladoc: access to primary care physicians, dermatologists, and mental health providers via telephone and video

### What's different?

- The amount covered by insurance and paid by the employee
- The premium cost charged to the employer (and most likely a payroll deduction for the higher plan(s) and/or a Health Savings Account contribution for the Value Plan, depending on your employer's policies)
- The availability of **Health Savings Account contributions** if you meet IRS requirements (only available in conjunction with the Covenant Value Plan): you can make your own contributions to your Health Savings Account to add tax-advantaged savings to your pocket for future use on medical expenses.



***Covenant Benefits is now offering a Covenant Value Plan that is an HSA eligible plan.***

(SEE ENCLOSED HSA FLYER FROM NATIONAL COVENANT PROPERTIES)



## Medical and Prescription

Choose from three health insurance options tailored to meet a variety of preferences and needs.

	Covenant Plus Plan	Covenant Standard Plan	Covenant Value Plan (HSA eligible)
MEDAL LEVEL	PLATINUM	GOLD	SILVER
<b>Out-of-Pocket costs*</b>			
Deductible	\$400	\$2,000	\$6,250
Family Deductible	\$800	\$4,000	\$12,500
Coverage percentage after deductible	80%	80%	100%
Maximum Out-of-Pocket	\$2,700	\$5,500	\$6,250
Family Maximum Out-of-Pocket	\$5,400	\$11,000	\$12,500
Primary Care Physician	\$20	\$35	deductible
Specialist Physician	\$20	\$45	deductible
<b>Prescription costs**</b>			
Generic 30-day/90-day	\$8/\$16	\$8/\$16	deductible
Preferred brand 30-day/90-day	\$40/\$85	\$40/\$85	deductible
Non-preferred brand 30-day/90-day	\$65/\$140	\$75/\$160	deductible
Specialty 30-day/90-day	\$100/\$225	\$125/\$280	deductible

\*Maximum out-of-pocket includes all in-network applicable deductible, copay and coinsurance amounts.

\*\*90-day prescription fills available through Express Scripts mail order and Walgreens pharmacies.

**The plan you choose is determined by your needs and preferences.** The Value Plan, when partnered with a Health Savings Account, can offer an income tax savings and the potential to grow savings for future years, especially if your employer adds a contribution to your HSA on your behalf. If you prefer to pay copays for your prescriptions instead of accumulating toward your deductible at the beginning of the year, the Plus or Standard Plan may be for you.

**You can research what your prescription drugs and upcoming medical procedures may cost by logging onto [express-scripts.com](https://express-scripts.com) and [highmarkbcbs.com](https://highmarkbcbs.com).** This will help you determine your estimated out-of-pocket costs for the year. When you take your estimated costs and your contribution to the premium cost into account, you can make an educated decision on which plan is right for you.



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# Covenant Benefits Open Enrollment Form

## ALSO AVAILABLE ONLINE

This form should be completed by every benefits-eligible employee and used by the employer to update benefits information in the online enrollment portal. This form should be retained in the employer's records for at least seven years.

### 1. YOUR INFORMATION

Name: \_\_\_\_\_ ☐ Male ☐ Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code : \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

### 2. TYPE OF COVERAGE

Select the coverage that best fits your needs.

#### Medical/Prescription family tier level (choose one)

- ☐ None (only available if health coverage is provided by another employer or subsidized government plan; proof of coverage may be requested)
- ☐ Single
- ☐ Employee plus child(ren)
- ☐ Employee plus spouse
- ☐ Full family (child(ren) and spouse)

#### Dental/Vision family tier level (choose one)

- ☐ None
- ☐ Single
- ☐ Employee plus child(ren)
- ☐ Employee plus spouse
- ☐ Full family (child(ren) and spouse)

#### Medical/Prescription plan (choose one)

- ☐ Covenant Plus Plan
- ☐ Covenant Standard Plan
- ☐ Covenant Value Plan



### 3. DEPENDENT INFORMATION

Include family members' information. Children under age 26 are eligible. Verification of marriage, birth, or adoption may be requested.

**Name of Spouse:** \_\_\_\_\_ ☐ Male ☐ Female

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of Child:** \_\_\_\_\_ ☐ Male ☐ Female

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of Child:** \_\_\_\_\_ ☐ Male ☐ Female

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of Child** \_\_\_\_\_ ☐ Male ☐ Female

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of Child:** \_\_\_\_\_ ☐ Male ☐ Female

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 4. LIFE INSURANCE BENEFICIARIES

(full-time employees only; if newly enrolling or not already on file)

#### Primary Beneficiary

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

#### Contingent Beneficiary

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_