

HOLSTON CONFERENCE

Insurance Coverage Guidelines

ARTICLE I: ELIGIBILITY & ENROLLMENT

The following persons are eligible to be covered in the Holston Conference ("Conference") insurance program:

1. All full-time employees of the Annual Conference, its local churches and its related agencies and institutions, more specifically defined as:
 - c. Members of the Annual Conference.
 - d. Pastors who are serving at least $\frac{3}{4}$ time.
 - e. Students under appointment as local pastors not covered by an insurance program of another annual conference.
 - f. Approved candidates for ministry who are students and are employed by local churches or other conference agencies and institutions.
 - e. Full-time lay employees of Conference agencies, institutions and local churches. (30 Hours or more a week constitutes a full-time employee)
2. Persons described in Section 1 above who are retired and who were covered by the Conference insurance program at the time of retirement.
3. Conference members on sabbatical leave.
4. Any person described in Section 1 above who becomes disabled.
5. Conference members taking honorable location or terminating their Conference relationship for any other reason shall not be eligible to continue in the Conference insurance program.

Active Participant Eligibility and Enrollment:

1. The date the person first enters an eligible category is considered to be his/her eligibility date.
2. The plan sponsor (Holston Conference) must notify an eligible person of his/her eligibility and give to him/her a BlueCross/BlueShield enrollment packet and form to complete and return to the plan sponsor. This notification must be done on a timely basis such that the person can complete and return the necessary forms to the plan sponsor for signature within 30 calendar days following his/her eligibility date. (The date is included in the 30-day count.) On the enrollment form, the participant indicates whether coverage is being accepted or declined on him/herself and/or other dependents. If coverage is being declined on an eligible person, the participant indicates whether that person has other group health coverage. "Other group health coverage" has the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Medicare does not qualify as "other group health coverage." The participant must complete and return the form to the plan sponsor such that the plan sponsor can audit and sign it within 30 calendar days following the participant's eligibility date.
3. The plan sponsor enters the enrollment information on the plan administrator database. The plan administrator maintains for administrative, communications and compliance purposes a record of all eligible participants

and their dependents, and their decisions about coverage. The plan administrator should receive the enrollment information as soon as possible since there are limitations on how far back in time coverage can be made effective.

4. If the 30-day plan sponsor signature requirement is not met, the plan administrator enrolls the participant in BlueCross/BlueShield and assigns an election of "No Coverage" under the medical, medical reimbursement account and dependent care account plans. In this case, the participant is unable to make an election of coverage until the next annual election period and coverage would not begin until the following plan year. The exception to this is if he/she subsequently experiences a special enrollment event as defined under HIPAA.
5. An eligible participant who declines coverage under BlueCross/BlueShield may apply for coverage under BlueCross/BlueShield in conjunction with any annual election period and coverage will begin with the following plan year. The eligible participant is encouraged to complete an enrollment/change form and indicate acceptance of coverage, and provide it to the plan sponsor by the September 1 prior to the annual election period. In this way the participant is assured of timely receipt of medical identification cards and other materials needed for accessing benefits. The latest an enrollment/change form will be accepted as part of annual election is November 30.
6. An eligible participant who declines coverage under BlueCross/BlueShield may also apply for coverage before annual election if he/she experiences a special enrollment event as defined under HIPAA.
7. If a participant who is in a retirement status resumes compensated employment within the connectional structure of the Church and is in an eligible category under the adoption agreement, he/she is treated as an active participant for BlueCross/BlueShield benefit purposes.

ARTICLE II: DEFINITIONS AND PROCEDURES ACTIVE/RETIREE/DEPENDENT ELIGIBILITY AND ENROLLMENT

The definition of an eligible dependent under the medical plan is provided below. To actually be covered under BlueCross/BlueShield, however, the eligible dependent spouse and/or child must be enrolled in the plan and the participant must indicate that coverage is desired on the eligible dependent. Even if the current coverage category of the participant allows for the inclusion of an additional person, any eligible dependent, including a newborn child, must be enrolled through the enrollment/change form process.

IT IS THE PARTICIPANT'S RESPONSIBILITY TO NOTIFY HIS/HER PLAN SPONSOR WHEN A NEW DEPENDENT IS ACQUIRED. A participant should notify his/her plan sponsor even if he/she declining coverage on the newly acquired dependent.

A dependent's eligibility date is the date he/she first meets the definition of an eligible dependent. This means, with respect to a new hire or newly eligible participant's dependent, an existing dependent's eligibility date is the same as the participant's. A newly acquired dependent's eligibility date is the date he/she first meets the dependent definitions stated below. For example, a newborn child's eligibility date is his/her birth date. The eligibility date of a dependent regaining eligibility (i.e., returning to school full-time) is the effective date of the event causing the dependent to regain eligibility (i.e., first day of the semester).

If the participant wishes to cover the newly acquired dependent, the participant must

notify the plan sponsor. The timing of this notification must be such that the plan sponsor can give (mail) the participant the enrollment/change form and other important information, and the participant can complete and return the necessary forms to the plan sponsor for signature within 30 calendar days following the newly acquired dependent's eligibility date. (The eligibility date is included in the 30 day count.)

The plan sponsor enters the enrollment/change form information on the plan administrator database. If the 30-day plan sponsor signature requirement is not met, the plan administrator enrolls the dependent in BlueCross/BlueShield and assigns to the dependent a status of "Not Covered" under the medical plan. The participant is unable to make an election of coverage for the dependent until the next annual election period and coverage will not begin until the following plan year. (The exception to this is if the participant or dependent experiences a special enrollment event as defined under HIPAA. A dependent is considered a late entrant for future enrollment purposes.

The plan definition of an "eligible spouse" is the husband or wife of an eligible participant, married in accordance with the law of the jurisdiction in which the eligible participant legally resides.

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

1. Any unmarried child of an eligible participant from birth through the last day of the month the child attains age 23.
2. Any unmarried child under age 25 of an eligible participant if the child is a registered student in regular full-time (as defined by the institution) attendance at an accredited college, university, or post-high school institution offering an associate degree, certification or accreditation. The child must be mainly dependent on the participant for care and support. Such child is considered an eligible child until:

The last day of the month following drop-out or withdrawal from the college, university or post-high school institution; The day the dependent child attains age 25, even if still in attendance at a school; or The last day of the third month after graduation from the college, university or post-high school institution (the month in which graduation occurs is considered the first of the three months).

Any unmarried child, without regard to the child's age, who is not self-supporting due to mental or physical impairment. The participant must give the plan administrator proof, when requested, that the child meets these conditions. 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 group health plan.

A "child" includes:

1. 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. (A child is considered legally adopted on the earlier of the date of placement or the date that the legal adoption proceedings have been started.)
2. Natural child, legally adopted child or child for whom the participant has obtained court ordered legal guardianship, under age 19, who is not living with the participant, and for whom the employee is responsible by legal decree for the majority of financial support of the child, or specifically for the medical health care expenses of the child.

To be eligible, dependents must reside in the United States.

The following is not considered an eligible dependent child: married child of any age.

1. Any grandchild or foster child who has not been legally adopted by the participant nor has court ordered legal custody.
2. Natural or legally adopted child, under age 19, who is living with a former spouse at another location, and for whom the participant is not responsible by legal decree for the majority of financial support of the child, or specifically for the medical healthcare expenses of the child.
3. Natural, legally adopted or step-child 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.
4. A newborn child is covered for 30 calendar days after the child's birth, even if the participant does not accept coverage on the child.

UMC Couples Eligibility

If both persons are eligible for BlueCross/BlueShield benefits because of their clergy, deacon or lay employee statuses, they are considered a UMC couple. If the member of the UMC couple who is listed as the "participant" loses eligibility, the covered dependent spouse will become the covered participant and maintain the existing coverage for any covered dependents.

Non-Salaried Active Participant Eligibility

The plan sponsor indicates which types of non-salaried statuses it considers to be eligible for BlueCross/BlueShield purposes and the length of time eligibility continues.

Retiree Benefit Eligibility and Enrollment

1. In order to be eligible for retiree benefits under BlueCross/BlueShield as a retiree or a retiree dependent, both plan sponsor eligibility requirements and BlueCross/BlueShield eligibility requirements must be met. Participants need to obtain information on plan sponsor-specific eligibility requirements from their plan sponsor (Holston Conference).
2. Under BlueCross/BlueShield eligibility requirements, an active participant is eligible for retiree medical coverage if he/she completes ten consecutive years of coverage upon retirement under a group health plan maintained by a participating BlueCross/BlueShield plan sponsor and retires from active salaried or non-salaried service with a participating BlueCross/BlueShield plan sponsor.
3. Under BlueCross/BlueShield eligibility requirements, a dependent spouse or child is eligible for retiree coverage if the retiring participant has satisfied BlueCross/BlueShield retiree eligibility requirements.
4. Any eligible participant who is retiring must be notified by the plan sponsor of his/her eligibility for BlueCross/BlueShield retiree benefits and be given a BlueCross/BlueShield retiree enrollment packet and forms to complete and return to the plan sponsor. The recommended time for this material to be given to the retiring participant is three months prior to his/her retirement date.
5. On the enrollment form, the participant indicates whether coverage is being accepted or declined on him/herself and/or other dependents. If coverage is being declined, the participant indicates whether that person has other group health coverage. Upon reaching the retirement date the participant and spouse

will have individual policies except in the case of a dependent child who is under age 23. The participant also indicates the legal residence he/she will have as of the retirement date.

6. It is recommended that the retiring participant complete the enrollment/change form and pension withholding form and return them to the plan sponsor no later than two months prior to his/her retirement date.
7. The plan sponsor enters the enrollment/change form information on the plan administrator database. It is recommended that this be done no later than two months prior to the participant's retirement date. Because there are limitations on how far back in time coverage and election changes can be made, it is important for the plan administrator to receive the forms as soon as possible.
8. If an eligible retiree or retiree dependent declines BlueCross/BlueShield retiree coverage when first eligible for such coverage without having other group health coverage, all future coverage rights are lost with respect to that person.
9. If a covered retiree or retiree dependent subsequently declines retiree coverage, all future coverage rights are lost with respect to that person and, in the case of the retiree's declination, all dependents.

A NEW SPOUSE OR DEPENDENT ACQUIRED BY A RETIREE AFTER RETIREMENT IS NOT AN ELIGIBLE DEPENDENT UNDER BLUECROSS/BLUESHIELD. The exception to this is a retiree gaining a new dependent child through court ordered legal guardianship, in which case the child is considered eligible.

Medical premium contributions of retirees are after-tax. The General Board of Pension and Health Benefits may deduct premiums from pension benefits payable under benefits administered. Certain plan sponsors require this on a mandatory basis. In other cases, the plan sponsor bills and collects these premiums from the retiree.

Surviving Dependent Eligibility and Enrollment

1. Survivors of active participants: The covered dependent of a deceased active covered participant is eligible for medical coverage as a "surviving dependent." This means that both the deceased participant and survivor dependent must be covered at the time of death in order for survivor benefits to be available under BlueCross/BlueShield.
2. The plan sponsor must notify all eligible covered surviving dependents of their eligibility for BlueCross/BlueShield survivor benefits and give them important information about BlueCross/BlueShield survivor benefits. This notification of survivors must be done on a timely basis.
3. If a survivor wishes to decline survivor benefits, the plan sponsor includes in the information packet an enrollment/change form for the survivor to complete and indicate declination of coverage. The plan sponsor signs and dates the form within 60 days following the participant's death and faxes (mails) the form to the plan administrator. (The date of death is included in the 60-day count.) If a surviving dependent declines BlueCross/BlueShield survivor coverage when first eligible for such coverage, all future rights to BlueCross/BlueShield coverage are lost with respect to that dependent.
4. A covered surviving dependent spouse may continue under the active medical until age 65 and then until death under the retiree medical.

5. A covered surviving dependent child may continue under the active non-salaried medical until
6. he/she no longer meets the plan definition of an eligible child.
7. If a covered surviving dependent subsequently declines BlueCross/BlueShield coverage, all future coverage rights are lost.
8. A legally separated or divorced spouse of a deceased participant is not eligible for survivor benefits.
9. Premiums for survivor coverage are billed and collected by the plan sponsor.
10. Survivors of retirees: The above also applies to the survivor of an eligible retiree. However, if the surviving dependent of an eligible retiree is not a covered dependent under BlueCross/BlueShield but has other group health coverage, he/she may decline survivor coverage at the time of the retiree's death and retain future coverage rights.
11. Those rights can be exercised in conjunction with any annual election for coverage commencing at the beginning of the next BlueCross/BlueShield plan year, so long as she/he maintains the other employer sponsored group health coverage through the last day of the BlueCross/BlueShield plan year preceding the commencement of BlueCross/BlueShield coverage.
12. If prior to the end of the BlueCross/BlueShield plan year the surviving dependent loses other group health coverage and he/she wishes to exercise his/her coverage rights, it is the survivor's responsibility to notify the plan sponsor. The survivor should notify the plan sponsor on a timely basis such that the plan sponsor can give (mail) the survivor the enrollment/change form and other important information, and the survivor can complete and return the necessary forms to the plan sponsor for processing within 30 calendar days following the loss of that other group health coverage. (The first day of being without coverage is counted as the first of the 30 days.) If this 30-day requirement is not met, all future surviving dependent coverage rights are lost.
13. If a non-covered surviving dependent of a retiree declines BlueCross/BlueShield survivor coverage when first eligible for such coverage without having other group health coverage, all future coverage rights are lost with respect to that dependent.

Divorced Spouse Eligibility and Enrollment

1. Divorced spouse of an active participant: The medical plan also considers as eligible the covered legally separated or divorced spouse of a covered participant, provided the participant is responsible by legal decree for:
 - a. the majority of financial support of the former spouse, or specifically for the medical, or other health care expenses, of the spouse.
2. The participant must notify the plan sponsor when there is an eligible "divorced spouse" who meets the conditions above and for whom the participant wishes to obtain BlueCross/BlueShield coverage. This notification must be done on a timely basis such that the plan sponsor can give (mail) the "divorced spouse" an enrollment/change form and the "divorced spouse" can complete and return it to the plan sponsor within 30 days of the date of the legal decree. If this 30-day requirement is not met, all future divorced spouse rights under BlueCross/BlueShield are lost.

3. On the enrollment/change form, the “divorced spouse” indicates whether coverage is being accepted or declined on him/herself. The divorced spouse also indicates his/her legal residence. The only coverage category available to a “divorced spouse” is “participant only.” If coverage is declined, the “divorced spouse” loses all future rights for coverage under BlueCross/BlueShield.
4. A covered “divorced spouse” may continue under the active medical until age 65 and then until death under the retiree medical option. In no event, however, will BlueCross/BlueShield eligibility extend beyond the period specified in the legal decree, the date of the participant’s death or the period for which premiums are paid.
5. If a “divorced spouse” remarries, he/she remains eligible for BlueCross/BlueShield benefits, unless otherwise provided for in the legal decree. BlueCross/BlueShield will consider as ineligible any newly acquired dependent of a “divorced spouse.”
6. A “divorced spouse” of a deceased participant is not eligible for survivor benefits unless legal decree requires it.
7. If a covered “divorced spouse” subsequently declines coverage, all future coverage rights are lost.
8. Premiums for “divorced spouse” coverage are billed and collected by the plan sponsor. Any contribution paid by the participant must be paid on an after-tax basis.
9. Divorced spouse of a retiree participant: The above also applies to a legally separated or divorced spouse of an eligible retiree. However, if the “divorced spouse” is not a covered dependent under BlueCross/BlueShield but has other group health coverage, he/she may decline “divorced spouse” coverage at the time of the legal separation or divorce and retain future coverage rights. Those rights can be exercised in conjunction with any annual election for coverage commencing at the beginning of the next BlueCross/BlueShield plan year, so long as she/he maintains the other group health coverage through the last day of the BlueCross/BlueShield plan year preceding the commencement of BlueCross/BlueShield coverage.
10. If prior to the end of the BlueCross/BlueShield plan year the “divorced spouse” loses other group health coverage and he/she wishes to exercise his/her coverage rights, it is the “divorced spouse’s” responsibility to notify the plan sponsor. The “divorced spouse” should notify the plan sponsor on a timely basis such that the plan sponsor can give (mail) the “divorced spouse” the enrollment/change form and other important information, and the “divorced spouse” can complete and return the necessary forms to the plan sponsor for processing within the 30 calendar days following the loss of the other group health coverage. (The first day of being without coverage is considered the first of the 30 days.) If this 30-day requirement is not met, all future “divorced spouse” coverage rights are lost.
11. If a “divorced spouse” declines BlueCross/BlueShield coverage, all future coverage rights are lost.
12. If a covered “divorced spouse” of a retiree subsequently declines coverage, all future coverage rights are lost.

Continuants – Active Participants and Their Dependents, Surviving Dependents, “Divorced Spouses”, Retiree Dependents:

1. When a covered participant and/or dependent loses eligibility under the medical plan, coverage is lost the first of the month coincident with or next following the month in which the event that causes the loss of eligibility occurs. This is the same date on which any change in billing is effective.
2. It is the responsibility of the participant to notify the plan sponsor when dependent eligibility is lost. It is the responsibility of the plan sponsor to notify the participant of his/her loss of eligibility.
3. Once the plan sponsor is aware of the loss of eligibility, the plan sponsor must give the participant or dependent an enrollment form for continuation purposes. This must be done within 60 calendar days following the date the person loses coverage. (The first day of being without coverage is the first of the 60 days.) It is important for the person to accept continuation coverage and return the form to the plan sponsor within those same 60 days. The plan sponsor signs and dates the form, authorizing the continuation of coverage. This must be done within the same 60-day period. The plan sponsor processes the enrollment and enters the information on the plan administrator's database.
4. If the participant or dependent does not elect continuation coverage or if the plan sponsor does not audit and sign the enrollment/change form within the 60-day period, all continuation rights with respect to that person or persons are lost.
5. BlueCross/BlueShield considers as ineligible any newly acquired dependent of a continuant.
6. Premiums for continuation coverage are billed and collected by the plan sponsor. Contributions are paid on an after-tax basis.

When a Participant's Membership Conference Changes

1. In the event participant's employment, membership or appointment changes from one BlueCross/BlueShield plan sponsor to another, the participant is treated as a new hire for eligibility, enrollment and election purposes. For retiree eligibility and determination of continuous coverage purposes, however, the prior period of continuous coverage will carry over to the new plan sponsor.
2. In the event a participant's membership results in him/her joining a non-BlueCross/BlueShield plan sponsor, the participant is considered to have lost eligibility under BlueCross/BlueShield. Continuous coverage for retiree eligibility purposes is lost. The exception to this is in the case of a ¶337.1 appointment. If the participant returns to a BlueCross/BlueShield plan sponsor and he/she has maintained continuous medical coverage while on the ¶337.1 appointment, he/she will be considered to have continuous coverage under BlueCross/BlueShield.

EFFECTIVE DATES OF COVERAGE AND BILLING

At the Time of Hire or on Becoming a Newly Eligible Participant

1. Within a week to ten calendar days of the plan administrator receiving the participant's enrollment/change form, the participant receives a health administration system-generated election worksheet listing the alternative options available to him/her. The participant has 30 calendar days from the date the worksheet is generated to make his/her elections using the BlueCross/BlueShield election line, which includes accepting the plan sponsor's base options. Once elections are made no changes are permitted until the next annual election period, or unless a family status change or special enrollment event occurs.

2. A participant and his/her dependents must be covered under the same options, even if they live in different geographic areas. The exception to this is a retiree where the covered person who is age 65 or over may be covered under an option that is different from that of the covered person who is under age 65.

On Becoming an Active Non-salaried Participant

1. If a participant goes on a disability leave of any type, leave of absence, a family medical leave or a maternity/paternity leave as defined in The Book of Discipline and determined by the plan sponsor, the following occurs:
2. The participant maintains his/her medical, as if he/she were an active salaried participant, for three calendar months from the end of the month in which that particular leave status began. In the case of a participant receiving disability benefit payments under a plan administered by the General Board of Pensions and Health Benefits, the participant may request for his/her premium amounts to be paid out of his/her disability benefit (certain plan sponsors may require this on a mandatory basis).

Disability and Medicare

1. If an active participant becomes entitled to Medicare due to a disability, the medical options available to the participant are the same as those offered retirees age 65 and over. Dependents of the participant remain in their current options.
2. If a covered dependent of an active participant becomes entitled to Medicare due to a disability, the medical options available with respect to the dependent are the same as for the active participant.
3. If a covered retiree dependent under age 65 becomes entitled to Medicare due to a disability, the medical coverage available to him/her is the same as for Medicare eligible retirees. If the retiree also happens to be eligible for Medicare, the dependent goes into the coverage as the retiree. If the retiree is not eligible for Medicare, the dependent will be covered under the active coverage.

Upon Regaining Eligibility in the Same Plan Year

1. When a person regains eligibility during the same plan year in which he/she lost eligibility, there are certain rules that apply to the benefits available to him/her. This situation occurs when a person is rehired in the same plan year as his/her previous employment terminated with the same plan sponsor or when a person loses BlueCross/BlueShield 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 goes into an ineligible leave status and returns to active service in the same plan year.
2. When the person returns, he/she indicates on the enrollment/change form whether he/she accepts or declines coverage. The process and 30-day plan sponsor signature requirement apply as for a newly eligible participant.

ARTICLE III: ACTIVE CLERGY, SPOUSES AND DEPENDENTS

1. Insurance shall be provided, at current premium rates, for enrolled clergy who are under Episcopal appointment (and for the spouses and dependents of those clergy), and who are:
2. Full-time clergy of local churches, or
3. Full-time clergy whose salaries are paid by the Conference

ARTICLE IV: DISABLED CLERGY, SPOUSES AND DEPENDENTS

1. Insurance shall be continued, at current premium rates, on Conference members and full-time local pastors who become disabled according to the standards of the Comprehensive Protection Plan, the Social Security Administration or other comparable standards, who were covered by the Conference insurance program at the time of their becoming disabled. an uncured
2. For a Conference member or a full-time local pastor who becomes disabled according to the above standards, insurance shall be continued, at current premium rates, on the spouse and dependents of such disabled clergy, provided such spouse and dependents were covered by the Conference insurance program at the time the clergy became disabled and provided.
3. Coverage shall terminate on the spouse of a disabled clergy when such spouse accepts employment where medical coverage is offered at no expense to such spouse.

ARTICLE V: SURVIVING SPOUSES AND OTHER DEPENDENTS

1. Insurance shall be continued, at current premium rates, on spouses and dependents of deceased Conference members and deceased full-time local pastors provided such spouses and dependents were covered by the Conference insurance program at the time of the death of the member or pastor.
2. Conference funding shall terminate for a surviving spouse upon remarriage prior to age sixty or through acceptance of employment where medical coverage is offered at no expense to such spouse.
3. Surviving spouses and dependents of other deceased persons covered by the Conference insurance program may continue in the program provided they were insured under the Conference program at the time of such person's death and their premium is timely and regularly paid to the Conference in accordance with guidelines from time to time established by the Conference.

ARTICLE VI: RETIRED CLERGY, THEIR SPOUSES AND DEPENDENTS

1. Subject to the limitations of Article VIII below, medical insurance shall be continued, at Conference expense, on retired clergy, their spouses and dependents, where such clergy were, at the time of their retirement:
2. Conference members who had served at least ten (10) years in the Conference, were 65 years of age or older, were covered by the Conference insurance program at the time of retirement
3. Conference members who had served at least ten (10) years in the Conference, were under 65 years of age, were eligible to retire under the "40 years of service" rule, were covered by the Conference insurance program at the time of retirement.
4. Local pastors who had served full-time for at least ten (10) years in the Conference, were 65 years of age or older, were covered by the Conference insurance program at the time of retirement.

Conference members and local pastors who retire after the year 2004 shall receive the supplement benefit according to the following schedule of service years with the Holston

Conference:

25 or more service years	100% of the conference contribution
20-24 service years	80% of the conference contribution
15-19 service years	60% of the conference contribution
10-14 service years	40% of the conference contribution
0-9 service years	0% of the conference contribution

Years of service shall be as determined by General Board of Pensions' records and standards.

ARTICLE VII: EARLY RETIREMENT

Subject to the limitations of Article VIII below, a clergy entitled to early retirement pursuant to ¶

359.2b of the 2004 DISCIPLINE shall be entitled to continue medical coverage under Conference Insurance program as follows:

1. The early retirement must have been approved by the Conference in accordance with its guidelines.
2. The retiring clergy shall pay for covering such clergy and the spouse and dependents of such clergy (where such additional persons are to be covered) under the program from the effective date of retirement until the earlier of the clergy attaining age 65.
3. The monthly amount to be paid by the retired clergy's family unit for coverage shall continue until the earlier of (a) the death of the clergy, or (b) the month in which the clergy attains 65 years of age.
4. The amounts to be paid for such early retirement coverage shall be paid to the Conference in accordance with such procedures and guidelines as are established from time to time by the Conference.

As soon as the clergy who retires early reaches the of age 65. thereafter be provided in accordance with Article VI above.

If the clergy dies while covered under this Article VII and before coverage would have started

under Article VI above, coverage for the spouse and dependents of the clergy will be according to Article V above.

ARTICLE VIII

After July 1, 2004, Conference members will not be entitled to coverage under the Conference insurance program with Conference premium participation under Articles VI or VII above unless such member has been covered by the Conference insurance program for ten (10) years immediately preceding retirement or has been continuously covered by the Conference insurance program or the member is otherwise entitled to coverage under Articles VI and VII.

Conference members not entitled to coverage with Conference premium participation under Articles VI and VII because of the limitations contained in paragraph 1 of this Article VIII who would otherwise be entitled to such coverage, may apply for coverage

under the Conference insurance program, subject to such restrictions and limitations as are from time to time established by the insurance carrier, and, if such members are accepted for coverage by the insurance carrier, pay the full cost of providing the coverage to the Conference in accordance with guidelines and procedures which are established by the Conference from time to time.

Lay employees of the Holston Conference, local church, district, conference board or agency with 10 years of continuous insurance coverage with any United Methodist Conference are eligible to keep the conference insurance with full payment of current premium rates.

ARTICLE IX: CONTINUATION COVERAGE (COBRA)

1. If you are no longer an employee of the Holston Conference you will need to apply for continuation coverage (COBRA) adopted by the Conference if you wish to keep insurance coverage.
2. 36 months where the member is a surviving spouse or child of a deceased Subscriber, a separated or divorced spouse of the Subscriber or a Dependent who no longer meets the definition of eligible Dependent under the contract.
3. 18 months where the loss of coverage would be due to a reduction in hours or termination of employment (unless due to gross misconduct)
4. 29 months where the loss of coverage would be due to a reduction in hours of work or termination of employment and the Member is considered disabled under Title II or Title XVI of the Social Security Act.

Application forms for the continuation coverage (COBRA) are available from the plan sponsor and must be filled out and returned to the plan sponsor within 30 days. Failure to return this form will result in cancellation of coverage

Subscriber will be responsible for the full premium amount due a month in advance. Failure to make the required payments will result in cancellation of coverage. Note: COBRA rules are subject to change and the Holston Conference will automatically adopt these changes.

ARTICLE X: NON PAYMENT OF HEALTH INSURANCE PREMIUMS

After 30 days a letter will be sent to the Pastor/employee with a copy to the District Superintendent. After 60 days there will be NO coverage without total payment of premiums. After 60 days, coverage may be re-instated by paying full premiums due and proof of insurability.

ARTICLE XI: LOCAL CHURCH. RELATED AGENCY AND INSTITUTIONS PARTICIPATION GUIDELINES

All local churches, related agencies and institutions of the Annual Conference will be considered sub-groups of Holston Conference for insurance purposes. The following requirements will apply:

They must follow the current guidelines for participation.

1. Must have 75% of their eligible employees enrolled in the Holston Conference

Health Insurance. If they fall below 75% there will be a grace period of one year for churches to find other insurance coverage or reach the 75% enrollment.

2. Employees covered under group insurance plan will be considered part of the 75% enrollment.
3. No new churches, related agencies and institutions will be enrolled in the Holston Conference Health Insurance after 7/1/2004 unless the 75% enrollment guideline is followed.
4. Present churches, related agencies and institutions will be allowed to stay on the Holston Conference Health Insurance but no new employees will be enrolled unless the 75% enrollment guideline is followed.
5. New enrollments, terminations and changes in coverage must be sent to the Holston Conference in a timely manner for processing. If premiums are incurred because terminations or changes were not sent within 30 days of the effective date the church, related agency or institution will be responsible for those premium amounts.
6. Churches, related agencies or institutions are responsible for offering COBRA coverage to any employees leaving employment with them. A form must be signed by the employee and sent to Holston Conference for processing.
7. Churches, related agencies or institutions will be required to sign a sub group contract form with Holston Conference.
8. An employee must work 30 hours or more per week to be a full-time employee.

ARTICLE XI: AMENDMENTS

These guidelines may be amended from time to time by the Conference in its discretion