



CHHSM Health and CHHSM Rx FAQ's

CHHSM Health and CHHSM Rx are strategies that leverage the purchasing power of the church in the design, implementation and administration of cost-effective employee benefit plans. These plans may be medical, dental, vision or pharmacy coverage.

CHHSM members may:

- Design their own plan of benefits,
- Take advantage of successful purchasing coalitions for medical and pharmacy benefits through the Denominational Benefits Coalition*,
- Provide employees with coverage and access across all 50 states,
- Provide retail and mail-order pharmacy within the health plan or as a separate, stand alone benefit,
- Evaluate the alternate funding of fully insured or self-insured benefits,
- Assist employees in meeting health care costs through a Flexible Spending Account plan.

** The Denominational Benefits Coalition represents over 100,000 households for medical coverage and over 180,000 households for pharmacy coverage*

Who administers CHHSM Health/Rx?

The Pension Boards of the United Church of Christ (PBUCC) administers the plan.

What provider networks are involved?

Medical (physician, hospital, mental health/substance abuse, and pharmacy) services are provided through the Highmark Blue Cross/Blue Shield nation-wide BlueCard Preferred Provider Network (PPO). Medco Health Solutions is the Pharmacy Benefit Manager (PBM). Dental coverage is available through United Concordia. Vision Service Plan is the vision benefit provider.

How is coverage financed?

Coverage is financed in the manner that best fits the size, risk profile and finances of the CHHSM member. Funding of health and dental coverage can range from a fully insured plan to self-insurance at levels selected by the CHHSM member. The Pension Boards, upon receipt of required information will provide an actuarial projection of expected

claims expense for the CHHSM ministry and can assist with evaluation of the funding options and the acceptable level of risk. There is no risk pooling – the health experience for each CHHSM member will be separate and distinct from other CHHSM members and pricing is determined based upon the discreet experience of each entity. Insured plans may run on a year-to-year basis. However, to help assure a smoothing of financial results, self-insured programs require a commitment to remain with the plan for at least 3 years.

Is there a broker involved?

It is not necessary to pay the expense of a broker. The full services required for plan operations are available through PBUCC arrangements. Claims processing, member service support, and account administration may be accessed through the PBUCC's nation-wide network of vendors.

Are there commissions and administrative fees?

There are no commissions paid to PBUCC. The PBUCC and CHHSM do charge administrative fees that represent the extent of service and involvement with each individually designed set of benefit plans. In addition, there will be fees from provider networks for network access and from third-party administrators for claims processing. The good news is that these fees are at negotiated levels based on the full size of the coalitions, not on the size of the individual CHHSM member.

What level of benefits can be offered?

The larger CHHSM member (120 employees enrolled for health coverage) can design the benefit plan it wishes to offer, such as unique services, co-pays, and deductibles. The PBUCC will provide plan descriptions for employees that are customized to the CHHSM Ministry's specifications. The PBUCC is also able to serve CHHSM members with less than 120 enrolled employees. Contact the PBUCC to discuss the options for these special circumstances. The PBUCC can administer Flexible Spending Accounts and continuation coverage for terminated employees regardless of the number enrolled.

How are claims administered and paid?

Under the self-funded arrangement, deposits are made to a CHHSM member account with PBUCC. Medical claims (physician, hospital, mental health/substance abuse) are then adjudicated by Highmark; pharmacy claims are adjudicated by MEDCO and dental claims are adjudicated by United Concordia. The claims processing vendors submit

weekly claims expense totals to PBUCC. Arrangements are made with the CHHSM member for an electronic funds transfer for payments of claims expense. PBUCC distributes the various payments as needed from the CHHSM member's account.

How is the transition to CHHSM Health managed?

The transition process begins with the review of existing plans, billings, claims and employee information. Then design decisions are made by the CHHSM member. A 90-day period is required for successful implementation of the benefit plans and features selected by the CHHSM member. During this 90-day period an implementation team, comprised of representatives from the CHHSM member, PBUCC, and the applicable vendors will address the needs for enrollment, eligibility management, claims adjudication rules, payment, and reporting.

How do we get information specific to our ministry?

Collection of complete and accurate information is the basis for a sound business decision by each CHHSM member. The process begins with the completion of the attached CHHSM Health Survey. A sample letter is attached for your use in requesting this information from your current broker or provider. Next, send the most recent copies of plan booklets, descriptions and recent billings to the PBUCC. This survey and related information will allow CHHSM and PBUCC to determine the timeline to respond to your needs. As work for you proceeds, PBUCC may need additional information for preparation of the most complete proposal possible. The data analysis takes about four weeks from the date of receipt of the required information.

For more information contact Mike Readinger, CHHSM's Vice President for Business Services at 216-736-2258 or readingm@chhsm.org.