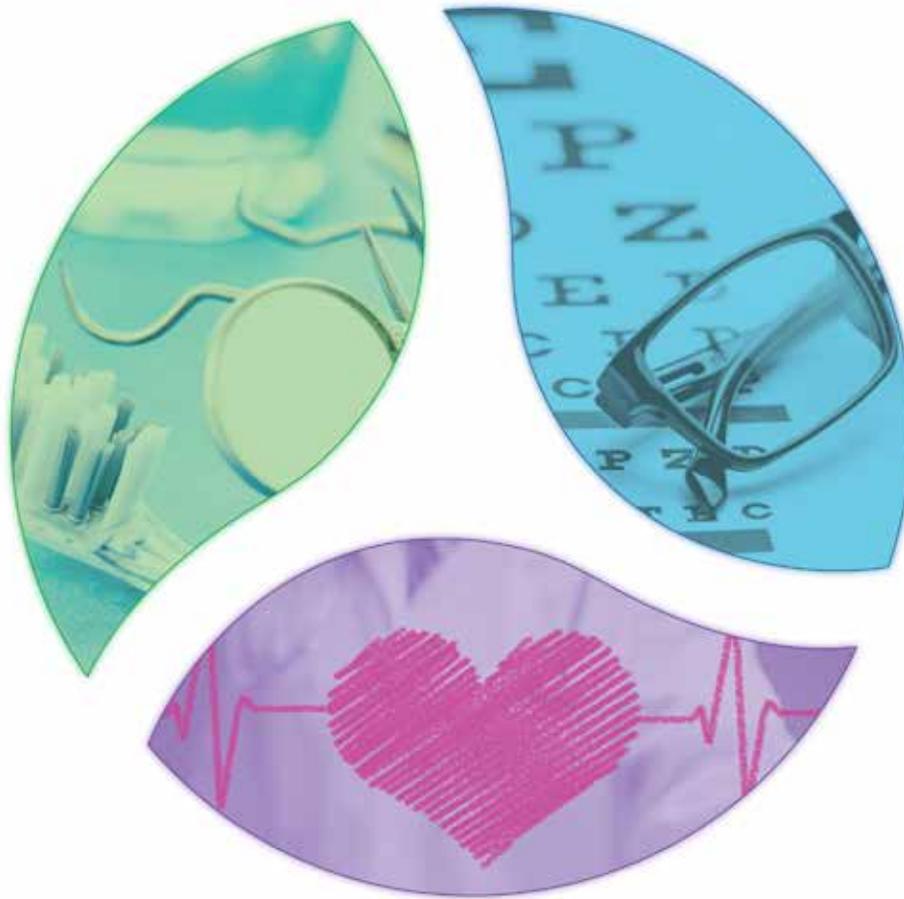




The Pension Boards
United Church of Christ, Inc.



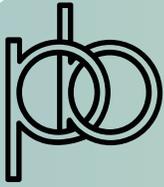
Highlights of Your UCC Medical and Dental Benefits Plan

*UCC Medicare Supplement Plan with Rx
For individuals who are enrolled in Medicare Parts A and B*

Health Coverage

Dental Coverage

Vision Coverage



The Pension Boards
United Church of Christ, Inc.

WHERE FAITH & FINANCE INTERSECT

Operating at the intersection of faith and finance, we are caring professionals partnering with those engaged in the life of the Church to provide valued services leading to greater financial security and wellness.

HEALTH PLAN MISSION

To provide the highest standard of service, access to care and options to active, inactive, and retired UCC clergy and lay employees.

January 2018

Dear UCC Colleague,

We are pleased to provide you with this copy of **Highlights of Your UCC Medical and Dental Benefits Plan: Medicare Supplement Plan with Rx** *(for individuals who are enrolled in Medicare Parts A and B)*.

The UCC Plans offer a schedule of comprehensive benefits to assist participants in maintaining healthy lifestyles with an emphasis on preventive care, including immunizations, wellness programs, and disease management.

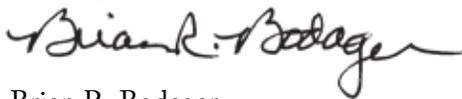
Your UCC Medicare Supplement Plan with Rx offers flexibility and choice, including:

- Annual physical and listing of preventive care schedule benefits covered at 100% with no additional cost;
- reimbursement of up to 80% of the amount not covered by Medicare for Medicare-eligible services;
- choice of two Medicare Part D pharmacy plans, Standard or Value, administered by Express Scripts, Inc.;
- two Dental Plan options, including a stand-alone entry-level Plan for those not previously enrolled in UCC dental coverage;
- an optional, stand-alone Vision Plan that does not require participation in the UCC Medical Plan; and
- access to nationwide Preferred Provider Organizations (PPOs) for cost-effective dental and vision care, as well as the flexibility to use In-Network and Out-of-Network providers.

We hope that you continue to be pleased with the benefits available to Plan participants, and we covenant to work with you to provide the best possible benefits at the most effective cost.

May you enjoy good health and abundant blessings.

Best regards,



Brian R. Bodager
President and Chief Executive Officer



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ABOUT THIS BOOKLET

The Pension Boards–United Church of Christ, Inc. is pleased to provide you and your family with a comprehensive health benefits program, offering flexibility and choice. This booklet contains information on the UCC Medical and Dental Benefits Plan (“the Plan”) and applies to you if you meet the eligibility requirements stated on p. 7.

In the event of any conflict between this booklet and the UCC Medical and Dental Benefits Plan Document, the UCC Medical and Dental Benefits Plan Document shall govern.

The UCC Medical and Dental Benefits Plan is designed to support employees of the UCC and UCC-affiliated entities in performing their ministries. The Plan is self-insured and administered by The Pension Boards–United Church of Christ, Inc. on behalf of all participants.

This Plan is intended to meet the requirements of a “church plan” within the meaning of Section 414(e) of the Internal Revenue Code of 1986 (the “Code”), as amended, and Section 3(33) of the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended. The Plan qualifies as a Section 125 Plan under the Code. The Plan is exempt from the requirements of Title I of ERISA.

The UCC Medical and Dental Benefits Plan is a “grandfathered health plan” under The Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan is not legally required to adopt certain consumer protections of the Affordable Care Act that apply to other plans; however, the Pension Boards has voluntarily adopted some, but not all, of these consumer protections. Grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act: for example, the elimination of lifetime limits on benefits.

PLAN ADMINISTRATION

The UCC Medical and Dental Benefits Plans are self-funded plans administered by The Pension Boards–United Church of Christ, Inc., an affiliated ministry of the United Church of Christ. The Pension Boards has engaged Highmark Blue Cross Blue Shield, Express Scripts, United Concordia Companies, Inc., and VSP to provide claims administration services. Claims administration services do not insure benefits under the Plan. Final interpretation of any and all Plan provisions is the responsibility of the Pension Boards. The Pension Boards is solely responsible for determination of, entitlements to, and payments of any amount due under this Plan. The Pension Boards retains the right to modify or terminate the Plan at any time.





**MEDICAL SERVICES
(INCLUDING MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES)**

Medical Services are provided by Medicare as a primary payer and Highmark Blue Cross Blue Shield as a Secondary Payer.

ACCESS TO HEALTH CARE SERVICES THROUGH PREFERRED PROVIDER ORGANIZATIONS



DENTAL SERVICES

Access through Advantage Plus 2.0, a nationwide network of dental providers managed by United Concordia Companies, Inc.



PHARMACY SERVICES

Access through Express Scripts, a nationwide network of retail pharmacies and Mail Order Pharmacy



VISION SERVICES

Access through VSP, a nationwide network of vision care providers managed by VSP



AVAILABLE PLANS

You are eligible to participate in the UCC Medicare Supplement Plan with Rx if you meet the eligibility requirements listed on p. 7. Information contained in this booklet is also available on our website at www.pbucc.org.

HEALTH PLANS

Medicare Supplement Plan with Rx: The UCC's comprehensive health plan for Medicare-eligible participants.

Participation in the health plan also includes prescription drug coverage through Express Scripts. You may not enroll in another Medicare Part D plan while enrolled in the UCC Medicare Supplement Plan with Rx.

DENTAL PLANS

Dental 1800: A comprehensive dental plan available to all eligible participants and their eligible dependents. The annual benefit maximum is \$1,800 per person.

Dental 750: A comprehensive dental plan available to eligible participants and their eligible dependents who were not covered by the UCC Dental Plan when first eligible to participate. Participants in the Dental 750 Plan will transition to the Dental 1800 Plan after one year. The annual benefit maximum is \$750 per person.

VISION PLANS

A stand-alone plan available to eligible participants and their eligible dependents to provide coverage for vision care services.



ELIGIBILITY FOR BENEFITS

You are eligible to participate in the UCC Medicare Supplement Plan with Rx if you are a citizen or reside in the United States, and you are one of the following:

ELIGIBLE EMPLOYEE

- A retired minister or lay employee enrolled in Medicare Parts A and B who has participated in the UCC Medical Benefits Plan while an employee of a UCC church or other UCC-related entity and elects coverage under the UCC Medicare Supplement Plan with Rx immediately upon retiring; or
- A retired minister enrolled in Medicare Parts A and B who did not previously participate in the UCC Medical Benefits Plan but provides satisfactory evidence of good health; or
- A minister or lay employee age 65 or over working for a UCC church or UCC-related entity with fewer than 20 employees.

ELIGIBLE DEPENDENTS*

Your Medicare-eligible dependent(s) may also participate in the Plan if they are enrolled in Medicare Parts A and B. They include your:

- Spouse;
- Same-gender domestic partner;
- Opposite-gender domestic partner;
- Surviving spouse or surviving domestic partner;
- Permanently disabled unmarried and unemancipated adult child(ren) if the disability began prior to their reaching age 26 and for whom you provide at least half their support.

*Health benefits for dependents who are not Medicare-eligible are described in the booklet *Highlights of Your UCC Medical and Dental Benefits Plan* (for individuals who are not eligible for Medicare).

APPLYING FOR COVERAGE

If you are covered under the UCC (Non-Medicare) Health Plan, you will receive information about the UCC Medicare Supplement Plan with Rx approximately three months before you turn age 65. If you wish to participate, you will be asked to submit proof of enrollment in Medicare Parts A and B for yourself and your spouse or domestic partner, if applicable. Health coverage for your spouse or domestic partner and other dependent(s) who are not eligible for Medicare will continue under the UCC (*Non-Medicare*) Health Plan if they are already enrolled for coverage. You must participate in the UCC Medicare Supplement Plan with Rx in order to continue dependent coverage.

If you do not have a dependent when you are first enrolled in the Plan, you must apply for dependent coverage within 90 days of the birth, adoption or placement of child in your care, or within 90 days of your marriage. You must apply for coverage for your domestic partner within 90 days of the six-month period following the commencement of your domestic partnership.

You may apply for such coverage at a later date, but satisfactory evidence of good health must be provided before coverage can begin.

WAIVING OR TERMINATING COVERAGE

If you choose to waive or terminate your coverage, you and your dependent(s) will not be eligible for future coverage under this Plan without first providing evidence of good health.

EVIDENCE OF GOOD HEALTH

Evidence of good health must be provided if you and/or your dependent(s) are not enrolled in the Plan within the first 90 days of eligibility. Plan participation may be denied on health status.



APPLYING FOR COVERAGE AFTER INITIAL ELIGIBILITY PERIOD*

If you are a UCC minister, you may apply for coverage under this Plan even if you have not previously participated in the UCC Health Plan, provided you satisfy evidence of good health and you are age 65 or over and enrolled in Medicare Parts A and B.

WHEN COVERAGE STARTS

PARTICIPANT RETIRED

UCC Medicare Supplement Plan with Rx coverage starts on the first day of the month following receipt of evidence of your enrollment in Medicare Parts A and B.

WORKING

The coverage start date for working participants begins the first of the month following receipt of the Medicare Coordination of Benefits approval.

When evidence of good health is required, coverage will begin on the first day of the month after you have been accepted as a Plan participant.

DEPENDENTS

Coverage starts on:

- The date you are covered if you also apply for dependent coverage at the time of your enrollment; or

- The first day of the month following receipt of application for dependent coverage if you apply for such coverage within the 90-day eligibility period; or
- The first day of the month after your dependent has been accepted by the Plan when evidence of good health is required.

WHEN COVERAGE ENDS

PARTICIPANT

Coverage for you will end:

- On the last day of the month in which contributions by you or on your behalf are no longer paid; or
- At the time of your death.

DEPENDENTS

Coverage for your dependent(s) will end:

- On the last day of the month in which contributions by you or on your behalf are no longer paid; or
- When your spouse or domestic partner or other dependent(s) no longer qualify as your eligible dependent(s).

* Retired lay employees are not eligible to enroll in the UCC Medical Plan after the expiration of their initial enrollment period.



CONTINUATION OF COVERAGE

In the event of your death, your spouse or domestic partner may continue Plan coverage by making contributions directly to the Plan.

If you divorce or dissolve your domestic partnership, your spouse or domestic partner may continue his/her coverage by making contributions directly to the Plan. The duration of this coverage is limited to 24 months or, if earlier, until 90 days after he/she becomes employed for 20 or more hours per week.

Coverage for dependent children (*under age 26*) will continue for up to a period of 24 months, or sooner if the child no longer qualifies as a dependent under the Plan.



HOW THE MEDICAL PLAN WORKS

To provide participants with quality, cost-effective health benefits, the Pension Boards has contracted for the following services:

MEDICAL CLAIMS PROCESSING

Highmark Blue Cross Blue Shield is the Plan’s benefit administrator/health claim processing service. Your medical card contains the information your provider or you will need to submit a claim to Highmark Blue Cross Blue Shield. If you find it necessary to submit medical claims, see the back of your medical ID card for information on claims not filed to the local plan.

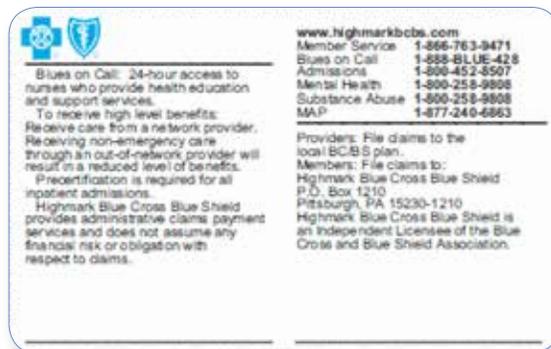
In order for the Medicare Supplement Plan with Rx to issue payment, Medicare approval is necessary. Contact Highmark at **1.866.763.9471** if you have questions regarding how a claim has been processed, or for additional benefits that may be available for services not approved by Medicare.

PAYMENT CROSSOVER OF PHYSICIAN AND HOSPITAL CLAIMS

To ensure proper claims processing, Plan participants should present both their Medicare and Highmark Blue Cross Blue Shield identification cards to medical providers when they seek medical services. Since Medicare is your primary insurance, please contact Medicare at **1.800.MEDICARE** or www.medicare.gov to obtain benefit information.

IDENTIFICATION CARDS

You will receive a medical identification card from Highmark Blue Cross Blue Shield for each member of your family who is enrolled in the UCC Medicare Supplement Plan with Rx. You may also access an electronic ID card for your smartphone by visiting www.highmarkbcbs.com. Login to your Highmark account for more information.



PRE-EXISTING MEDICAL CONDITIONS

There are no restrictions for pre-existing conditions for participants of the Plan.

An **Explanation of Benefits (EOB)** will be mailed to you when claims are processed. An EOB is a summary of the benefits paid by Highmark to your medical care provider. It lists the date of service, the service performed, the charges submitted and the total you may owe the provider according to the Medical Plan guidelines. You may also visit the Highmark Blue Cross Blue Shield website (www.highmarkbcbs.com) for more information about receiving electronic EOBs via e-mail.



 An Independent Licensee of the Blue Cross and Blue Shield Association 1800 CENTER STREET CAMP HILL PA 17089		Explanation of Benefits Need Help? Call 1-800-241-5704						
THIS IS NOT A BILL								
CONTRACT HOLDER NAME: JOHN DOE MEMBER ID: ABC123451284 GROUP NAME: XYZ COMPANY		EXPLANATION AT A GLANCE DATES OF SERVICE: 12/18/03–12/20/03 WE SENT CHECK TO: ABC HOSPITAL – A Network Facility CLAIM PAYMENT AMOUNT: \$567.79 PROVIDER MAY BILL YOU (IF NOT ALREADY PAID): \$221.94						
GROUP ID: 123456789 CLAIM ACTIVITY FOR: JANE DOE								
CLAIM NUMBER: 03363496597 CLAIM RECEIVED: 12/24/03								
Member Responsibility								
Provider Date of Service Type of Service Service Code (Number of Services)	Provider Charges	Our Allowance (Covered Charges)	Your Deductible	Amount Remaining	Health Plan Pays At	Health Plan Pays	Your Share of Amount Remaining	Amount You Owe Provider
ABC HOSPITAL 12/18/03–12/20/03 Inpatient Stay	789.73	789.73	80.00	709.73	80%	567.79	141.94	221.94
TOTALS	789.73	789.73	80.00	709.73		567.79	141.94	221.94

WELLNESS BENEFITS

Highmark has resources available to help you assess your health and lifestyle. Log in at www.highmarkbcbs.com and click **Member Discounts** to learn how to better care for yourself, have more energy, and maintain a healthy weight.

BLUES ON CALL

Blues on Call is a nurse helpline made available to all Plan participants to answer your medical care questions. You can reach them by calling **1.888.258.3428**.

HEARING AID COVERAGE

Plan participants are eligible for a \$3,000 allowance available every three years towards hearing aids.

PREVENTIVE SERVICES

The Plan provides coverage for healthy checkups (*annual physicals*) under physician outpatient services. This benefit encourages early detection and treatment of medical conditions and is not subject to the annual deductible. Contact a Pension Boards Health Services Representative if you need assistance with your annual physical claim.

See the Preventive Schedule on p. XX for more information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 mandates that all group health plans providing coverage for mastectomies also cover:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedema.

The Plan covers mastectomies and, therefore, covers the services in the paragraphs above as well. A consultation with your attending physician is necessary to determine the level of covered services.



SUMMARY OF BENEFITS: MEDICAL PLANS THROUGH HIGHMARK BLUE CROSS BLUE SHIELD

MEDICAL PLAN SCHEDULE OF BENEFITS

This is a summary of benefits of the UCC Medicare Supplement Plan with Rx. Additional information on covered services can be obtained by calling Highmark Member Service at 1.866.763.9471. Benefits provided may be reduced if you or your dependent(s) have other group health coverage. Your UCC Medicare Supplement Plan with Rx benefits are coordinated with your Medicare Parts A and B benefits and benefits are paid at the level(s) listed below, up to the Medicare Maximum Allowable Amount. Services listed below correspond to the Medicare Parts A and B benefits schedules. This schedule shows UCC Medicare Supplement Plan with Rx coverage only – benefits provided by Medicare are not listed.

Benefit	Medicare Supplement Plan with Rx
Deductible¹	\$300 per person <i>Includes deductibles paid for Medicare Parts A and B</i>
Out-of-Pocket Maximum <i>(inclusive of annual cash deductible)²</i>	\$2,000 per person <i>Includes deductibles paid for Medicare Parts A and B</i>
Annual Maximum	No Limit
Physician Office Visits/Services	80% after deductible
Preventive Care <i>Follows Enhanced Preventive Care Schedule</i>	See Preventive Care Schedule for additional benefits.
<ul style="list-style-type: none"> • Routine physical exams • Routine gynecological exams, including a Pap Test • Mammograms, as required 	100%—deductible does not apply 100%—deductible does not apply 100%—deductible does not apply
Emergency Room Services	80% after deductible
Ambulance	80% after deductible
Medical/Surgical Expenses and Supplies	80% after deductible
Gender Identity Services	80% after deductible
Spinal Manipulation/Chiropractic Services	80% after deductible <i>Limit: \$2,000 per person/year</i>
Diagnostic Services <i>(Lab, X-Ray and other tests)</i>	80% after deductible
Physical, Speech, Occupational Therapy	80% after deductible
Acupuncture	80% after deductible <i>Limit: \$2,000 per person/year</i>
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Hearing Aids	100% <i>Limit: \$3,000 per person/every 3 years</i>
Skilled Nursing Facility Care	
-Inpatient Stay 1-100 Days	80% after deductible
-Inpatient Stay beyond 100 Days ³	80% after deductible
Home Health Care/Visiting Nurse	80% after deductible
Private Duty Nursing	80% after deductible
Hospice⁴	80% after deductible



Benefit	Medicare Supplement Plan with Rx
Routine Eye Exams	Plan pays \$40 – one (1) exam/year, after deductible
Eyeglasses/Contacts <i>(Following cataract surgery only)</i>	80% after deductible
Hospital <ul style="list-style-type: none"> • Inpatient stay of 1-150 days/benefit period • Inpatient stay beyond 150 days/benefit period 	80% after deductible 80% after deductible ^{3, 5}
Rehabilitative Care <i>(Room, board, and services)</i> <ul style="list-style-type: none"> • Days 1-100/benefit period • Days beyond 100/benefit period 	80% after deductible 80% after deductible ^{3, 5}
Mental Health/Substance Abuse Care <ul style="list-style-type: none"> • Mental Health Inpatient Care • Mental Health Outpatient Care • Substance Abuse Inpatient Care – Detox • Substance Abuse Inpatient Care – Rehabilitation • Substance Abuse Outpatient Care 	80% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible

MEDICAL PLAN FOOTNOTES:

1. Excludes prescription drug copayments, difference paid for brand-name drugs in lieu of available generics, coinsurance for hospital stays beyond 150 days and your share of payments for rehabilitative care beyond 100 days per benefit period.
2. Precertification through Highmark will be required for stays beyond Medicare certified days.
3. Hospice services are covered only when under the supervision of a physician.
4. Your share of these expenses does not apply to the out-of-pocket maximum.



ADULT (AGE 19+) PREVENTIVE SCHEDULE

PLAN YOUR CARE: KNOW WHAT YOU NEED AND WHEN TO GET IT

Preventive or routine care helps us stay well or finds problems early, when they are easier to treat. The preventive guidelines on this schedule depend on your age, gender, health and family history. As a part of your health plan, you may be eligible to receive some of these preventive benefits with little to no cost sharing when using in-network providers. Make sure you know what is covered by your health plan and any requirements before you receive any of these services.

Some services and their frequency may depend on your doctor's advice. That's why it's important to talk with your doctor about the services that are right for you.

Adults: Ages 19+ Male Female

General Health Care	
 Routine Checkup* (This exam is not the work- or school-related physical)	<ul style="list-style-type: none"> • Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
 Pelvic, Breast Exam	Once a year
Screenings/Procedures	
 Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
 Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
 Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
 Cholesterol (Lipid) Screening	<ul style="list-style-type: none"> • Ages 20 and older: Once every 5 years • High-risk: More often
 Colon Cancer Screening (Including Colonoscopy)	<ul style="list-style-type: none"> • Ages 50 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
 Certain Colonoscopy Preps With Prescription	<ul style="list-style-type: none"> • Ages 50 and older: Once every 10 years • High-risk: Earlier or more frequently
 Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
 Hepatitis B Screening	High-risk
 Hepatitis C Screening	High-risk
 Latent Tuberculosis Screening	High-risk
 Lung Cancer Screening (Requires use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years
 Mammogram	Ages 40 and older: Once a year including 3-D
 Osteoporosis (Bone Mineral Density) Screening	Ages 60 and older: Once every 2 years
 Pap Test	<ul style="list-style-type: none"> • Ages 21 to 65: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
 Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)	Sexually active males and females

* Routine checkup could include health history; physical; height, weight and blood pressure measures; body mass index (BMI) assessment; counseling for obesity, fall prevention, skin cancer, and safety; depression screening; alcohol and drug abuse, and tobacco use assessment; and age-appropriate guidance.



Adults: Ages 19+



Immunizations	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
Diphtheria, Tetanus (Td/Tdap)	<ul style="list-style-type: none"> • One-time Tdap • Td booster every 10 years
Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
Hepatitis A	At-risk or per doctor's advice: One 2-dose series
Hepatitis B	At-risk or per doctor's advice: One 3-dose series
Human Papillomavirus (HPV)	To age 26: One 3-dose series
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
Shingles (Zoster)	Ages 60 and older: One dose
Preventive Drug Measures That Require a Doctor's Prescription	
Aspirin	<ul style="list-style-type: none"> • Ages 50 to 59 to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Raloxifene Tamoxifen	At-risk for breast cancer, without a cancer diagnosis, ages 35 and older
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
Vitamin D Supplements	Ages 65 and older who are at risk for falls
Low to Moderate Dose Select Generic Statin Drugs For Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater.
Preventive Care for Pregnant Women	
Screenings and Procedures	<ul style="list-style-type: none"> • Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening during pregnancy and postpartum • Rh typing at first visit • Rh antibody testing for Rh-negative women • Tdap with every pregnancy • Urine culture and sensitivity at first visit
Prevention of Obesity, Heart Disease and Diabetes	
Adults With BMI 25 to 29.9 (Overweight) and 30 to 39.9 (Obese) Are Eligible For:	<ul style="list-style-type: none"> • Additional annual preventive office visits specifically for obesity and blood pressure measurement • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: <ul style="list-style-type: none"> – ALT – AST – Hemoglobin A1c or fasting glucose – Cholesterol screening
Adult Diabetes Prevention Program (DPP)	
Applies to Adults	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.
Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and	
Overweight or obese (determined by BMI) and	
Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.	

* Meningococcal B vaccine per doctor's advice.



CHILDREN'S PREVENTIVE SCHEDULE

Preventive or routine care helps your child stay well or finds problems early, when they are easier to treat. Most of these services may not have cost sharing if you use the plan's in-network providers. Make sure you know what is covered by your health plan and any requirements before you schedule any services for your child.

It's important to talk with your child's doctor. The frequency of services, and schedule of screenings and immunizations depends on what the doctor thinks is right for your child.

Children: Birth to 30 Months¹

General Health Care	Birth	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Routine Checkup* (This exam is not the preschool- or day care-related physical.)	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●										
Screenings											
Autism Screening									●	●	
Critical Congenital Heart Disease (CCHD) Screening With Pulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Screening							●				
Lead Screening						●					
Newborn Blood Screening	●										
Immunizations											
Chicken Pox								Dose 1			
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)**						Ages 6 months to 30 months: 1 or 2 doses annually					
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1		Dose 2			Dose 3					
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years.

** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.




Children: 3 Years to 18 Years¹

General Health Care	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●				Once a year from ages 11 to 18
Ambulatory Blood Pressure Monitoring**												●
Depression Screening												Once a year from ages 11 to 18
Hearing Screening		●	●	●		●		●		●	●	
Visual Screening***	●	●	●	●		●		●		●	●	●
Screenings												
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Immunizations												
Chicken Pox		Dose 2										If not previously vaccinated: Dose 1 and 2 (4 weeks apart)
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5			1 dose of Tdap if 5 doses were not received previously							1 dose every 10 yrs.
Flu (Influenza)****	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)									Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses all other ages.			
Measles, Mumps, Rubella (MMR)		Dose 2 (at least 1 month apart from dose 1)										
Meningitis*****									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										
Care for Patients With Risk Factors												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening											High-risk	
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)									For all sexually active individuals			
Tuberculin Test	Per doctor's advice											

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. ** To confirm new diagnosis of high blood pressure before starting treatment. *** Covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4 and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit. **** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network. ***** Meningococcal B vaccine per doctor's advice



Children: 6 Months to 18 Years¹

Preventive Drug Measures That Require a Doctor's Prescription	
Oral Fluoride	For preschool children older than 6 months whose primary water source is deficient in fluoride
Prevention of Obesity and Heart Disease	
Children With a BMI in the 85th to 94th Percentile (Overweight) and the 95th to 98th Percentile (Obese) Are Eligible For:	<ul style="list-style-type: none"> • Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: <ul style="list-style-type: none"> – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
Adult Diabetes Prevention Program (DPP) Age 18	
 Applies to Adults <ul style="list-style-type: none"> • Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and • Overweight or obese (determined by BMI) and • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl. 	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

INFORMATION ABOUT THE AFFORDABLE CARE ACT (ACA)

This schedule is a reference tool for planning your family's preventive care, and lists items and services required under the Affordable Care Act (ACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, laws and regulations, and updates to clinical guidelines established by national medical organizations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at increased risk for a condition. Some services may require prior authorization. If you have questions about this schedule, prior authorizations or your benefit coverage, please call the Member Service number on the back of your member ID card.

¹INFORMATION ABOUT CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Because the Children's Health Insurance Program (CHIP) is a government-sponsored program and not subject to ACA, certain preventive benefits may not apply to CHIP members and/or may be subject to copayments.

The ACA authorizes coverage for certain additional preventive care services. These services do not apply to "grandfathered" plans. These plans were established before March 23, 2010, and have not changed their benefit structure. If your health coverage is a grandfathered plan, you would have received notice of this in your benefit materials.



WHAT THE MEDICAL PLAN DOES NOT COVER

Any claim submitted after one year (12 months) from the date of service will not be considered for payment. If you are unsure of any aspects of your medical coverage, contact Highmark at **1.866.763.9471** as this is not an exhaustive list of exclusions. The following services and/or supplies are not covered, unless otherwise specified:

1. Bereavement services not provided by hospice care.
2. Case management services for care, treatment, or services that have been disallowed under the provisions of the Plan's case management system.
3. Comfort/convenience items for personal hygiene and convenience items such as, but not limited to: air conditioners, humidifiers, or physical equipment, stair glides, elevators, lifts, or "barrier-free" home modifications, whether or not specifically recommended by a physician.
4. Confinement in a United States government or agency hospital, unless you would have to pay the expenses if you did not have coverage.
5. Corrective surgery for myopia, hyperopia or presbyopia, including radial keratotomy, LASIK, LASEK, and PRK.
6. Cosmetic surgery for cosmetic purposes done to improve the appearance of any portion of the body and from which no improvement in physiological function can be expected, except as otherwise provided herein. (Surgery to correct a condition resulting from an accident, a congenital birth defect, and/or a functional impairment that results from a covered disease or injury are covered under the Plan.)
7. Court-ordered services or services ordered by a tribunal as part of the participant's sentence.
8. Dental care, except for professional services and anesthesia for removal of bony impactions of third molar(s) when performed by a doctor of dental surgery.
9. Experimental/investigative services and clinical research programs. All charges relating to a diagnosis and treatment procedures that are, in the sole determination of the Pension Boards, deemed to be experimental, investigative, unproven, for purposes of research, not medically necessary, or not generally accepted by the United States medical profession or approved by the Food and Drug Administration. The Plan does not cover services that are considered experimental by the medical profession of the United States or any other country.
10. Eyeglasses or contact lenses, except for initial pair of glasses/contact lenses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury. Benefits are available under the stand-alone Vision Plan (see p. 31).
11. Fees for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form and the preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as premarital examinations.
12. Food including, but not limited to: enteral formulae, infant formulae, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.



13. Foot care, palliative or cosmetic, including flat-foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except capular or bone surgery), calluses, toenails (except surgery for ingrown nail), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
14. Genetic testing, unless medical documentation supports medical necessity.
15. Hospice services that are not provided under the supervision of a physician.
16. Inpatient admissions primarily for diagnostic studies and inpatient admissions primarily for physical therapy.
17. International medical services.
18. Light therapy products for treatment of medical and mental health disorders to include but not limited to a light box.
19. Medicare-covered services; however, this shall not apply when an employer is obligated by law to offer employees health benefits and the employee elects to enroll in the Plan as the primary payor.
20. Military service-related losses or expenses incurred while on active duty as a member of the armed forces of any nation or losses sustained or expenses incurred as a result of any war, whether or not declared.
21. Motor vehicle accident injuries—services for treatment for injuries resulting from the maintenance or use of a motor vehicle if the services/treatment have been paid or are payable under a plan/policy of motor vehicle insurance. This includes a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefit established by state law. Payment for such injuries may be coordinated with your other insurance after those benefits have first been exhausted. The Medical Plan will then pay on a secondary basis.
22. Nicotine cessation support programs and/or classes.
23. Nursing homes, assisted living facilities, a place for the aged, a place of rest, education, training, and bed and board while confined in an institution that is mainly a school or other institution for training. Custodial care, domiciliary care, or residential care, protective and supportive care including education services and convalescent care.
24. Physicals for school, camp, sports, travel, or any other administrative reason, which are not medically necessary and appropriate, except as provided herein or required by law.
25. Private duty nursing care, unless required by a physician.
26. Respite care.
27. Reversal of sterilization.
28. Services for which the Enrollee has no legal obligation to pay.
29. Services provided by an immediate family member.
30. Services provided by an individual residing in the patient's home.
31. Services that are not medically necessary and appropriate as determined by the Plan or have been disallowed under the provisions of the Plan's case management system.



32. Services provided prior to the Enrollee's effective date of coverage.
33. Services that are submitted by a certified registered nurse or another professional provider for the same services performed on the same date for the same Enrollee.
34. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
35. Treatment for injury or illness suffered while committing a felony.
36. Weight reduction programs, except for medical and surgical treatment of morbid obesity.
37. Workers' compensation-related illness or bodily injury, if benefits or compensation are available, in whole or in part, under the provisions of any federal, state or local government workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not the Enrollee files a claim for said benefits or compensation.



HOW THE PRESCRIPTION DRUG PLAN WORKS

To provide participants with quality, cost-effective health benefits, the Pension Boards has contracted for the following services:

PRESCRIPTION DRUG BENEFITS–EXPRESS SCRIPTS

Prescription drugs can be purchased at discounted prices with copayments through the Express Scripts nationwide Retail Pharmacy Drug Program and the Mail Order Pharmacy, eliminating the need for claims submission. If the price of a prescription is less than the applicable copayment, you will pay the lesser of the two costs. If you purchase a brand-name drug when a generic substitute is available, you will be required to pay the copayment, plus the price difference. Prescription drug copayments are not included in the annual deductible or the annual out-of-pocket maximum.

RETIREE DRUG PLAN- FOR RETIRED/NON-WORKING PARTICIPANTS OF THE UCC MEDICARE SUPPLEMENT PLAN WITH RX

RETAIL PRESCRIPTION DRUG PURCHASES

You may purchase up to a 90-day supply of prescription drugs with a copayment at participating Express Scripts network retail pharmacies.

MAINTENANCE (LONG-TERM) PRESCRIPTION DRUG REFILLS

Your pharmacy coverage includes access to a 90-day supply of medication via Express Scripts Mail Order Pharmacy. While it is not required that you utilize mail order for your maintenance medications, you will have a lower co-pay with the Mail Order Pharmacy than when utilizing a retail pharmacy.

WORKING PARTICIPANTS OF THE UCC MEDICARE SUPPLEMENT PLAN WITH RX

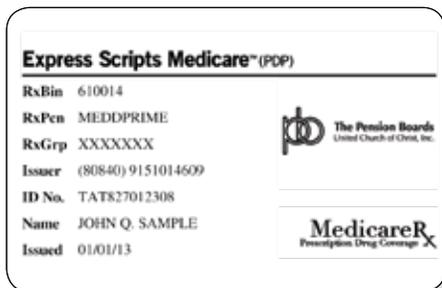
RETAIL PRESCRIPTION DRUG PURCHASES

You may purchase up to a 30-day supply of prescription drugs with a copayment at participating Express Scripts network pharmacies.

MAINTENANCE (LONG-TERM) PRESCRIPTION DRUG REFILLS

Your pharmacy coverage includes a refill limit for maintenance (long-term) prescription drugs purchased at participating retail pharmacies. Up to two refills plus the original prescription may be purchased at the retail drug copayment; after that, you will pay the entire cost of the maintenance drug unless you purchase future refills through the Mail Order Pharmacy.

If you need to start a maintenance drug immediately, ask your physician to write two prescriptions – one for a 14-day supply to be filled at a local network pharmacy, and another for a 90 –day supply with refills to be obtained through the Mail Order Pharmacy. Mail Order is the choice for maintenance drugs.



<p>Members</p> <ul style="list-style-type: none"> This card must be presented at a participating retail pharmacy when ordering prescription drugs. To locate a participating retail pharmacy, obtain a claim form, or find out more about your prescription drug benefit, please call Customer Service at 1-866-544-6963 (TTY users: 1-800-716-3231), or visit our website: www.Express-Scripts.com. If you are required to submit a claim for reimbursement, please use a claim form for proper processing of your claim. <p>Submit claim forms to: Express Scripts P.O. Box 14718, Lexington, KY 40512</p>	<p>Pharmacists</p> <p>Submit claims via the <i>Tri-PALP</i> System only for the person for whom the prescription was written. Dispense preferred brand-name and generic drug products where applicable in accordance with prevailing pharmacy laws and regulations. For more information, contact the Pharmacy Services Help Desk at 1-800-922-1557 or visit the Pharmacist Resource Center at www.medco.com/rph.</p>
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Patient Customer Service:	800.939.3781
TDD:	800.759.1089
Accredo Specialty:	800.939.3781
Pharmacist Use Only:	800.922.1557
Express-Scripts.com	Accredo.com



PHARMACY BENEFIT MANAGEMENT

Your pharmacy benefit includes the following programs to provide patient safety:

RATIONALMED

Pharmacists review participant drug profiles and alert prescribing physicians of potential drug interactions.

PRIOR AUTHORIZATION

Just as some healthcare plans approve some medical procedures before they're done to ensure those procedures are needed, some drugs need a "prior authorization" to make sure they are right for you and your condition and are covered by your pharmacy benefit.

Prior authorization is a program that lets you get the effective medicine that you and your family need and helps your plan sponsor maintain affordable prescription-drug coverage for everyone your plan covers. When your pharmacist tells you that your prescription needs a prior authorization, Express Scripts needs more information to know if your plan covers the drug. Only your own physician can provide this information and request a prior authorization.

SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS THROUGH EXPRESS SCRIPTS

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a pharmacy that is in the network, you'll receive the higher level of benefits.

If you receive services from a pharmacy that is not in the network, you'll receive the lower level of benefits. In either case, you coordinate your own care. Below are specific benefit levels.

Benefit Schedule for working participants of the UCC Medicare Supplement Plan	
Benefit: Prescription Drugs ¹	UCC Medicare Supplement Plan with Rx
When purchased at an Express Scripts network retail pharmacy <i>Up to a 30-day supply</i>	\$17 for a generic drug \$30 for a brand-name drug on the formulary \$45 for a brand-name drug not listed on the formulary
When purchased through the Mail Order Pharmacy <i>Up to a 90-day supply</i>	\$34 for a generic drug \$75 for a brand-name drug on the formulary \$115 for a brand-name drug not listed on the formulary

PRESCRIPTION DRUG FOOTNOTES:

1. Coinsurance for prescription drugs is not included in the annual medical deductible or annual medical out-of-pocket maximum.



THE UCC MEDICARE SUPPLEMENT PLAN WITH RX FOR RETIRED/NON-WORKING PARTICIPANTS NOW OFFERS TWO PHARMACY PLAN OPTIONS: STANDARD AND VALUE.

The Standard Plan offers a more robust benefit structure with lower copays and no “donut hole.” This is the default plan option for participants of the UCC Medicare Supplement Plan with Rx.

The Value Plan offers a lower premium; however, participants will have higher out-of-pocket costs for a deductible and copays, as well as a “donut hole.” The Value Plan is available for retired participants of the UCC Medicare Supplement Plan with Rx after their first year of enrollment in the Standard Plan.

Standard Benefit Schedule for <i>retired/non-working</i> participants of the UCC Medicare Supplement Plan			
Additional benefit information will be provided to you with your Express Scripts Medicare Welcome Kit.			
Drug Class	Retail: One-Month (31-day) Supply	Retail: Three-Month (90-day) Supply	Mail Order: Three-Month (90-day) Supply
Generic Drugs	\$17 copayment	\$55 copayment	\$34 copayment
Preferred Brand Drugs	\$35 copayment	\$105 copayment	\$90 copayment
Non-Preferred Brand Drugs	\$50 copayment	\$150 copayment	\$125 copayment

After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$5,000, you will pay the greater of 5% coinsurance or:

- a \$3.35 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage Stage.
- an \$8.35 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage Stage.



Value Benefit Schedule for *retired/non-working* participants of the UCC Medicare Supplement Plan

Additional benefit information will be provided to you with your Express Scripts Medicare Welcome Kit.
(The Value Plan is available for retired participants after they've completed their first year in the Standard Benefit Plan)

Drug Class/Coverage Stage	Retail: One-Month (31-day) Supply	Retail: Three-Month (90-day) Supply	Mail Order: Three-Month (90-day) Supply
Deductible: Retail and Mail Order deductible cross-accumulates	\$100		
Initial Coverage Stage			
Generic	20% Minimum: \$17 Maximum: \$34	20% Minimum: \$55 Maximum: \$110	20% Minimum: \$34 Maximum: \$68
Preferred Brand Drugs	20% Minimum: \$35 Maximum: \$70	20% Minimum: \$105 Maximum: \$210	20% Minimum: \$90 Maximum: \$180
Non-Preferred Brand Drugs	35% Minimum: \$50 Maximum: \$100	35% Minimum: \$150 Maximum: \$300	35% Minimum: \$125 Maximum: \$250
Coverage Gap ("Donut Hole")			
<i>When pharmacy expenses total \$3,750, the Plan will cover generic medications only at the same level as the Initial Coverage Stage. Plan payments for brand medications will be reduced to 15% (after applicable manufacturer discount of 50%). Once pharmacy expenses exceed \$5,000, you will move into the Catastrophic Coverage Phase.</i>	<p>Brand Drugs: Member pays 35% coinsurance, plus a portion of the dispensing fee</p> <p>Generic Drugs: Member pays the same as the Initial Coverage Stage (see above)</p>	<p>Brand Drugs: Member pays 35% coinsurance, plus a portion of the dispensing fee</p> <p>Generic Drugs: Member pays the same as the Initial Coverage Stage (see above)</p>	<p>Brand Drugs: Member pays 35% coinsurance, plus a portion of the dispensing fee</p> <p>Generic Drugs: Member pays the same as the Initial Coverage Stage (see above)</p>
Catastrophic Stage			
When pharmacy expenses total \$5,000.01	<p>Brand & Generics: the greater of 5% coinsurance or:</p> <ul style="list-style-type: none"> -a \$3.35 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage Stage -an \$8.35 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage Stage. 	<p>Brand & Generics: the greater of 5% coinsurance or:</p> <ul style="list-style-type: none"> -a \$3.35 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage Stage -an \$8.35 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage Stage. 	<p>Brand & Generics: the greater of 5% coinsurance or:</p> <ul style="list-style-type: none"> -a \$3.35 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage Stage -an \$8.35 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage Stage.



WHAT THE PRESCRIPTION PLAN DOES NOT COVER

Any claim submitted after one year (12 months) from the date of service will not be considered for payment. If you are unsure of any aspects of your pharmacy coverage, contact Express Scripts at **1.800.939.3781**. The UCC Prescription Plan does not cover the following services and/or supplies, unless otherwise specified:

1. Allergy sera.
2. Anti-obesity medications.
3. Charges for the administration or injection of any drug.
4. Contraceptive jellies, creams, foams, non-clinical devices or over-the-counter contraceptives.
5. Drugs for which there are over-the-counter equivalents and for which the Plan has discontinued coverage.
6. Drugs used to treat impotency, unless approved following prostate surgery.
7. Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
8. Drugs labeled “Caution—limited by federal law to investigational use,” or experimental drugs, even though a charge is made to the participant.
9. Durable medical equipment (see Medical Summary of Benefits, p. 14).
10. Glucowatch/blood glucose sensors.
11. International pharmacy claims.
12. Lost, stolen, or damaged drugs.
13. Medication for which the cost is recoverable under any workers’ compensation or occupational disease law or any state or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the participant.
14. Non-federal legend drugs, which are not approved by the Food and Drug Administration (FDA).
15. Non-sedating antihistamines.
16. Nutritional/dietary supplements or supplies.
17. Ostomy supplies.
18. Prescription drugs for which there are over-the-counter equivalents and for which the Plan has discontinued coverage.
19. Smoking deterrents, unless those prescribed by your physician.
20. Therapeutic devices or appliances.



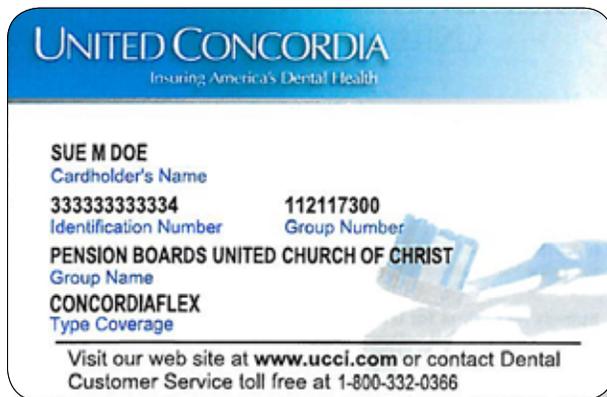
HOW THE DENTAL PLAN WORKS

The UCC Dental Plan is a stand-alone plan that provides preventive, therapeutic, restorative, and prosthetic services, as well as orthodontic services for you and your covered dependent(s). The Dental Plan is administered by United Concordia Companies, Inc. (UCCI). You will receive an ID card from United Concordia for each member of your family who is enrolled in the Dental Plan. You may also access an electronic ID card for your smartphone by visiting www.ucci.com. Log in to your United Concordia account for more information.

PREFERRED PROVIDER ORGANIZATION (PPO)–ADVANTAGE PLUS 2.0

Advantage Plus 2.0 network dentists provide services at discounted rates and submit claims directly to United Concordia Companies, Inc., our dental claims processor. You are later billed for your share of dental services in accordance with the Plan's provisions. You are not required to submit payment at the time you receive services, although the provider may request that you pay your deductible. Network providers may not bill you for charges in excess of network allowable fees.

This Plan provides open access, allowing you to see any dentist you choose. However, use of Advantage Plus 2.0 PPO network providers is highly encouraged in order to maximize your dental benefits. You will not receive a discount if you obtain services from providers who do not participate in the Advantage Plus 2.0 PPO network, and you are likely to be required to file a claim for services. If you wish to encourage your dentist to become an Advantage Plus 2.0 PPO network provider, you can ask them to contact Highmark Blue Cross Blue Shield to join.



To find an
Advantage Plus 2.0 PPO
network provider:
call 1.866.851.7576 or
visit www.ucci.com

Submit dental claims to:
United Concordia Companies, Inc.
Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421



The following is a sample copy of an **Explanation of Benefits (EOB)** from United Concordia Companies, Inc. (UCCI). You will receive an EOB from UCCI each time you or a covered family member receives dental treatment.

UNITED CONCORDIA		DENTAL EXPLANATION OF BENEFITS			DENTAL CUSTOMER SERVICE P.O. BOX 69420 HARRISBURG, PA 17106-9420		
KEEP FOR YOUR TAX RECORDS							
Subscriber: John Doe		ID Number: 999 99 9999		Page: 1 of 2			
Patient: John Doe		Claim Number: 01260354768		Date: 09/27/01			
Provider: PACO FRALICK DDS INC (000848516)							
PROCEDURE DESCRIPTION PROCEDURE CODE (NUMBER OF SERVICES)	SERVICE DATE(S)	PROVIDER'S CHARGE	ALLOWANCE	AMOUNT PAID	AMOUNT NOT PAID	REMARKS	
PERIODIC EVALUATION D0120	(001) 09/10/01	25.00	23.00	23.00	2.00	Q1030	
PROPHYLAXIS ADULT D110	(001) 09/10/01	51.00	47.00	47.00	4.00	Q1030	
BITEWINGS FOUR FILMS D0274	(001) 09/10/01	34.00	30.00	30.00	4.00	Q1030	
TOTALS		110.00	100.00	100.00	10.00		
Q1030 These services were performed by a Participating Provider. This Provider has agreed not to bill you for the difference between the PROVIDER'S CHARGE and the ALLOWANCE for this service.							
The Provider has been paid the amount shown in the AMOUNT PAID column.							
UNITED CONCORDIA America's Premier Dental Insurer							
HAVE A QUESTION? PLEASE CALL 1-800-299-1910 Business Hours: 8am-8pm E.T. Service for the Deaf via TDD Equipment is available at 1-800-345-3837							
THIS IS NOT A BILL							



SUMMARY OF BENEFITS: DENTAL BENEFITS THROUGH UNITED CONCORDIA COMPANIES, INC.

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a dentist who is in the PPO network, you'll receive the higher level of benefits. If you receive services from a dentist who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. Below are specific benefit levels.

Benefit		
Dental Services	Dental 1800	Dental 750 ¹
Annual Deductible	\$100/person or \$200/family	\$100/person or \$200/family
Annual Benefit Maximum/per person	\$1,800	\$750
Type of Service	In-Network ²	Out-of-Network ³
<i>Applies to both Dental 1800 and Dental 750 Plans</i>		
Preventive Services and Supplies: <ul style="list-style-type: none"> Cleaning and oral examination—two times per calendar year Fluoride application to child's teeth, age 16 and under—two times per calendar year Dental sealants, age 16 and under Space maintainers, age 16 and under 	100%	Plan pays 100% up to R&C limits
Diagnostic and Therapeutic Services and Supplies: <ul style="list-style-type: none"> Periodontal cleanings—two times per calendar year Full mouth X-rays—once in a three-year period Bite-wing X-rays—two times in a calendar year Oral examination—two times in a calendar year Emergency care⁴ Extractions Treatment of gums Root canals General anesthetics for oral surgery Injectable antibiotics 	80%	Plan pays 80% up to R&C limits
Restorative Services and Supplies: <ul style="list-style-type: none"> Fillings⁵ Crowns⁵ 	80% 50%	Plan pays 80% up to R&C limits Plan pays 50% up to R&C limits
Prosthetic Services and Supplies: <ul style="list-style-type: none"> Full or partial dentures or fixed bridges Repair or rebasing of dentures or bridges 	50%	Plan pays 50% up to R&C limits
Orthodontics for dependent children age 16 and under, up to a \$1,500 lifetime maximum	50% after separate deductible per child	50% up to R&C limits after separate deductible per child

DENTAL PLAN FOOTNOTES:

- Participants in the Dental 750 Plan will transition into the Dental 1800 Plan after one (1) year.
- Advantage Plus 2.0 PPO network provides access to dental care at a lower cost than out-of-network providers.
- Benefit payments are based on Reasonable and Customary (R&C) limits.
- Treatment received for the unexpected onset of severe pain or other symptoms, which, if not treated immediately, could reasonably be expected to result in serious health threat or impair the health of the individual.
- Fillings and crowns will only be covered on the same tooth once every five (5) years unless the need for replacement is due to poor quality of the existing restoration.



WHAT THE DENTAL PLAN DOES NOT COVER

Any claim submitted after one year (12 months) from the date of service will not be considered for payment. If you are unsure of any aspects of your dental coverage, contact United Concordia at 1.866.851.7576. The UCC Dental Plan does not cover the following services and/or supplies, unless otherwise specified:

1. Charges for reline/rebase of dentures or bridges are not covered more than once every 36 months. Repair of dentures is not covered more than once per arch per 36-month period.
2. Facings on pontics or crowns posterior to the second bicuspid.
3. Implants, except in limited circumstances. Please contact United Concordia Dental for review.
4. Motor vehicle accident injuries—services for treatment for injuries resulting from the maintenance or use of a motor vehicle if the services/treatment have been paid or are payable under a plan/policy of motor vehicle insurance. This includes a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefit established by state law. Payment for such injuries may be coordinated with your other insurance after those benefits have first been exhausted. The Dental Plan will then pay on a secondary basis.
5. Oral surgery for bony impactions of third molars (wisdom teeth). Contact Highmark BCBS for benefits that might be available under the Medical Plan.
6. Orthodontic services that occurred before enrollment in this Plan or after enrollment is terminated.
7. Procedures, restorations and appliances to increase vertical dimension or to restore occlusion.
8. Replacement of an existing crown or gold filling will not be covered unless for tooth decay.
9. Services and supplies furnished in a U.S. governmental hospital for which you would not be required to pay if there were no coverage.
10. Services and supplies in connection with illness and injury caused by war whether declared or not, or by international armed conflict.
11. Services and supplies partially or wholly cosmetic in nature.
12. Training in or supplies used for dietary counseling, oral hygiene, or plaque control.
13. Treatment by someone other than a dentist or physician, except where performed by a duly qualified technician under the direction of a dentist or physician.
14. Workers' compensation-related illness or bodily injury, if benefits or compensation are available, in whole or in part, under the provisions of any federal, state or local government workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not the enrollee files a claim for said benefits or compensation.



HOW THE VISION PLAN WORKS

This is a summary of the Vision Plan that is administered by VSP. The Vision Plan is a stand-alone benefit with a separate application and premium, and a Plan Year that runs from April 1 through March 31. You will not receive identification cards from VSP; your vision care provider will verify your eligibility and benefits when you schedule your appointment. If you have questions regarding your vision benefits or to locate a provider, contact VSP at **1.800.877.7195**.

PREFERRED PROVIDER ORGANIZATION (PPO)–VSP

VSP's network consists of over 30,000 providers to provide professional vision care for persons covered under this Plan. When you want to obtain services, call a VSP provider to make an appointment. While you may obtain services from any eye care provider of your choice, you will receive your maximum eye care benefits from a VSP provider.

Vision services are covered on a "Service Year" basis. This means you will be eligible for your next covered benefit 12/24 months from the date of your last service: 12 months for exams, 24 months for frames. For example: If you had an eye exam on May 1, 2017, you will not be eligible for another eye exam until May 1, 2018. If you received eyeglass frames on July 1, 2016, you will not be eligible for new frames until July 1, 2018.

Your in-network provider will submit your claim directly to VSP.

If you obtain services from a non-VSP provider, contact VSP Customer Service at **1.800.877.7195** for an Out-of-Network Claim Form.

VSP will not provide ID cards at the time of enrollment. A confirmation letter from PBUCC will be sent to the participant once their initial application has been processed.

Participants interested in printing an ID card for their VSP Plan may do so by creating a personal account at www.vsp.com. ID cards are not required to obtain services.

Vision plan enrollment is intended to be continuous in order to provide low out-of-pocket costs to the participant. Should a participant have a break in coverage, a one-year lapsed premium will be due at the time of re-enrollment.



SUMMARY OF BENEFITS: VISION BENEFITS THROUGH VSP

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the higher level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. Below are specific benefit levels.

VSP Doctor Network: VSP Signature

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Doctor			
WellVision Exam	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$10 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	<ul style="list-style-type: none"> \$130 allowance for a wide selection of frames 20% off amount over your allowance 	Combined with exam	Every 24 months
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children 	Combined with exam	Every 12 months
Lens Options	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average 35-40% off other lens options 	\$50 \$80 - \$90 \$120 - \$160	Every 12 months
Contacts (instead of glasses)	<ul style="list-style-type: none"> \$130 allowance for contacts and contact lens exam (fitting and evaluation) 15% off contact lens exam (fitting and evaluation) 	\$0	Every 12 months
Diabetic Eyecare Program	<ul style="list-style-type: none"> Services related to type 1 diabetes; ask your VSP doctor for details 	\$20	As needed
Extra Savings and Discounts	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam. <p>Retinal Screening</p> <ul style="list-style-type: none"> Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam. <p>Laser Vision Correction</p> <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor 		
Your Coverage with Other Providers			
Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.			
Exam.....	up to \$50	Single Vision Lenses.....	up to \$50
Frame.....	up to \$70	Lined Bifocal Lenses.....	up to \$75
		Lined Trifocal Lenses.....	up to \$100
		Progressive Lenses.....	up to \$75
		Contacts.....	up to \$105
VSP guarantees coverage from VSP doctors only.			



COORDINATION OF BENEFITS

MEDICARE

UCC Medicare Supplement Plan with Rx benefits are coordinated with your Medicare Part A and Part B benefits.

SUBROGATION

If a covered participant or dependent is injured or becomes ill through the act of a third party, the Plan shall provide for the care of the injury or illness. Acceptance of such services and benefits will constitute consent to assist the Plan with recovery of injury-or illness-related Plan expenses. If the participant receives or is entitled to receive payment from a third-party suit or settlement, or otherwise, of an amount up to and including the value of any such health services or supplies covered by the Plan, the participant is obligated to reimburse the Plan for the value of such benefits paid by the Plan.

PARTICIPANT'S COOPERATION

In some circumstances, the participant's help will be requested to assist with the administration of the Plan. Enrollment in the Plan constitutes an agreement by the participant and by his or her covered dependents to cooperate with the Plan's administration requirements and efforts to enforce the Plan's rights to subrogation and reimbursement.

PLAN ADMINISTRATION

The UCC Medical and Dental Benefits Plans are self-funded plans administered by The Pension Boards—United Church of Christ, Inc., an affiliated ministry of the United Church of Christ. The Pension Boards has engaged Highmark Blue Cross Blue Shield, Express Scripts, United Concordia Companies, Inc., and VSP to provide claims administration services. Claims administration services do not insure benefits under the Plan. Final interpretation of any and all Plan provisions is the responsibility of the Pension Boards. The Pension Boards is solely responsible for determination of, entitlements to, and payments of any amount due under this Plan. The Pension Boards retains the right to modify or terminate the Plan at any time.



YOUR RIGHTS TO APPEAL

If you have additional information for the reconsideration of a claim, please send it with your request. You are entitled to obtain copies of documents related to the claim. In some cases, approval may be needed to release confidential information such as medical records. A decision will be made within 30 days after receipt of a written request for a review, or the date all information required from you is received. You will receive the decision in writing. Appeals must be initiated within 12 months of the date of service in question.

FIRST LEVEL:

Medical Claim

If you wish to appeal the denial of a medical claim by Highmark Blue Cross Blue Shield, you should submit a written request for a review to: Highmark Blue Cross Blue Shield, Member Grievance and Appeals, Attention: Review Committee, P.O. Box 535095, Pittsburgh, PA 15253-5095. Medicare denials must be addressed by contacting Medicare.

Pharmacy Claim

If you wish to appeal the denial of a pharmacy claim by Express Scripts, you should submit a written request for a review to: Express Scripts, 8111 Royal Ridge Parkway, Irving, TX 75063.

Dental Claim

If you wish to appeal the denial of a dental claim by United Concordia Companies, Inc., you should submit a written request for a review to: Claim Appeal Department, United Concordia Companies, Inc., P.O. Box 69421, Harrisburg, PA 17106-9421.

Vision Claim

If you wish to appeal the denial of a vision claim by VSP, you should submit a written request to: VSP, P.O. Box 997105, Sacramento, CA 95899-7105.

SECOND LEVEL:

If you wish to appeal the decision related to the request for a review, you should submit a written request for the appeal within 180 days following the date of the denial of a medical claim by Highmark, pharmacy claim by Express Scripts, dental claim by United Concordia, or vision claim by VSP to: Director of Health Plan Operations, Pension Boards–UCC, 700 Prospect Ave, 5th Floor, Cleveland, OH 44115. Your request should include all information pertinent to your appeal.



DEFINITIONS AND RELATED INFORMATION

Annual: For the purposes of the Plan, the period of time from January 1 through December 31 of each Plan Year.

Benefit Administrator: A third-party administrator that performs claims processing services.

Brand-Name Drug: A proprietary drug approved by the federal Food and Drug Administration (FDA) and protected by trademark registration.

Coinsurance: An insurance policy provision under which the insurer and the insured share costs incurred after the deductible is met, according to a specific formula.

Continuation of Coverage: Covered participants and their covered dependents may retain Plan coverage under certain circumstances. See p. 9 for more information.

Coordination of Benefits: When coverage exists under two health plans, benefits may be paid under both plans. Certain restrictions and guidelines apply with regard to reimbursement amount, which plan is primary, etc. See p. 36 for additional information.

Copay: The amount an insured person is expected to pay for a medical expense at the time of the visit.

Custodial Care: Any type of care that does not require a trained medical professional and is for the primary purpose of attending to a person's daily living activities. These services are not covered under the Plan.

Deductible: An out-of-pocket expense that must be satisfied per Plan Year for each individual or family, before benefits are paid for covered medical or dental expenses. There is no Plan Year deductible for preventive care services.

Dependent: An eligible spouse, domestic partner, or child(ren). See p. 7 for additional information.

Domestic Partner: A person who meets the financial, cohabitation and other requirements

established by the Pension Boards. To apply for benefits, you must submit a Statement of Domestic Partnership after you have been in the domestic partnership for at least six months.

Enrollee: Any participant or dependent for whom contribution rates have been paid and who is listed on the UCC Health Plan Enrollment Application submitted by the participant.

Essential Health Benefits: The essential health benefits under Section 1302(b) of the Affordable Care Act and the regulations issued thereunder.

Formulary: A list of preferred, commonly prescribed drugs that includes both brand-name and generic drugs.

Generic Drug: A drug containing the same active ingredients found in a brand-name drug. A generic drug is known only by its formula name and is available to any pharmaceutical company. Generic drugs are rated by the FDA to be as safe and effective as brand-name drugs and typically cost less.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) – and the regulations promulgated thereunder, as each may be amended from time to time – that establishes health portability, non-discrimination, privacy, and security rights for individuals. The Plan is subject to certain HIPAA requirements, but is exempt from others. The privacy notice required by HIPAA is available online at www.pbucc.org.

Medically Necessary: Services or supplies that are appropriate and consistent with a diagnosis in accordance with accepted medical standards as described in the Plan **Summary of Benefits** (see p. 16-17). Medical necessity, when used in relation to services, shall have the same meaning as medically necessary services. All services are subject to the medical necessity requirement and to the exclusions and limitations described in this Plan.



Non-Formulary: A list of non-preferred prescription drugs that are not commonly prescribed and are subject to higher copayment.

Non-PPO Provider: A hospital, physician, or other health care practitioner that has not contracted with the Plan's preferred provider organizations (PPOs) to provide services at discounted prices.

Out-of-Pocket Maximum: The maximum out-of-pocket cost a participant will have to pay per Plan Year for expenses covered under this Plan. The maximum is the sum of all applicable deductibles and coinsurance payments. Amounts paid above Reasonable and Customary (R&C) charges, office visit copayments and prescription copayments are excluded from the out-of-pocket maximum calculation.

Participant: A person who meets eligibility requirements and is covered by the Plan.

Plan: The UCC Medical and Dental Benefits Plan.

Plan Year Benefit Maximum: The maximum amount the Dental Plan will pay in a Plan Year per covered individual. The amounts can be found on the Dental **Summary of Benefits** (see p. 31).

PPO Provider: A hospital, physician, or other health care practitioner that has voluntarily contracted with a preferred provider organization (PPO) to provide services at discounted prices.

QMCSO: Qualified Medical Child Support Order. A court order that requires health coverage for an participant's child(ren).

Reasonable and Customary (R&C): Fees for medical services are considered Reasonable and Customary when they are in line with average fees for said services in the same geographic area. Charges in excess of R&C are not covered under the Plan and are the responsibility of the Plan participant.

Service Year: For purposes of the Vision Benefit, the Service Year is considered 12 months from the date of your last service. Vision services are payable either 12 months or 24 months apart (12 months for an exam, 24 months for frames).

Spouse: A person to whom a participant is legally married. To apply for benefits, you must submit a copy of your legal marriage certificate.



CONTACTS

MEDICAL SERVICES



1.866.763.9471
www.highmarkbcbs.com

Blues on Call
1.888.258.3428

Precertification for Inpatient Services
Highmark Healthcare Management
1.800.452.8507

CLAIMS PROCESSING

Medical Claims
Highmark Benefit Administrator
Highmark Blue Cross Blue Shield
1.866.763.9471
Your BlueCard PPO provider will submit your in-network claims through the local Blue Cross Blue Shield Plan

Participant-Submitted Claims
If the provider does not submit your claim to their local Blue Cross Blue Shield plan, send your claim to:

Highmark Blue Cross Blue Shield
P.O. Box 1210
Pittsburgh, PA 15230-1210

PRESCRIPTIONS



Express Scripts Retail Pharmacy
1.800.939.3781

Mail Order Pharmacy
1.800.633.2662
www.express-scripts.com

CLAIMS PROCESSING

Prescription Claims Mail Order Pharmacy
P.O. Box 182050
Columbus, OH 43218-2050

* Preferred Provider Organizations

For direct pharmacy claims (retail drug purchases made outside of the Express Scripts network):

Express Scripts
P.O. Box 2187
Lee's Summit, MO 64063-2187

DENTAL SERVICES



United Concordia Companies, Inc.
1.866.851.7576
www.ucci.com

CLAIMS PROCESSING

Dental Claims
United Concordia Companies, Inc.
P.O. Box 69421
Harrisburg, PA 17106-9421

VISION SERVICES



1.800.877.7195
www.vsp.com

CLAIMS PROCESSING

Vision Claims
VSP providers will submit your claim to VSP. If you obtain services from an out-of-network provider, contact VSP at 1.800.877.7195 for a claim form:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

GENERAL ADMINISTRATION

The Pension Boards–United Church of Christ, Inc.
475 Riverside Drive
Room 1020
New York, NY 10115
1.800.642.6543
www.pbucc.org



PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information. The Pension Boards–United Church of Christ, Inc. is the plan sponsor of the UCC Medical and Dental Benefits Plan and is committed to maintaining the privacy of your personal health information under the Plan in accordance with HIPAA privacy standards, which became effective April 14, 2003. The Plan and those administering it will use and disclose health information only as allowed by Federal law. The Plan has provided you with a **Notice of Privacy Practices**, describing how health information about you may be used or disclosed by the Plan.

PROTECTED HEALTH INFORMATION (PHI)

Protected health information (*PHI*) is the identifiable health information about you that is created, received, or maintained by the Plan. The privacy of your health information that is used or disclosed by the Plan is protected by HIPAA.

The Plan is required by law to:

- Maintain the privacy of your PHI
- Provide you with a notice of the Plan's legal duties and privacy practices with respect to your PHI

The Plan may use, share, or disclose protected health information to pay your health care benefits, operate the Plan or for treatment by a health care practitioner. In addition, the Plan may use or disclose your information in other special circumstances described in the privacy notice. For any other purpose, the Plan will require your written authorization for the use or disclosure of your protected health information. An authorization form is available online at www.pbucc.org or by calling Member Services at 1.800.642.6543.









