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

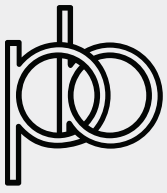
Health Coverage

Dental Coverage

Vision Coverage

Effective January 1, 2015

The Pension Boards
United Church of Christ, Inc.



The Pension Boards
United Church of Christ, Inc.

PARTNERS IN MINISTRY SINCE 1914

The Pension Boards administers comprehensive employee benefits programs for the United Church of Christ, providing the highest standards of service, access, and options to active and retired UCC clergy and lay employees.

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 2015

Grace to you, and peace!

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, wellness, and disease management.

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

- Reimbursement of up to 80% of the amount not covered by Medicare
- Two Dental Plan options, including a stand-alone entry-level Plan for those not previously enrolled in UCC dental coverage
- Three prescription drug benefit plans for working and retired/non-working UCC Medicare Supplement Plan participants
- An optional, stand-alone Vision Plan that does not require participation in the UCC Medical Plan
- 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
- Coverage for hearing aids, including exams, devices and fittings

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.

Faithfully,

Michael A. Downs
President/Chief Executive Officer
The Pension Boards–United Church of Christ, Inc.

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 Medicare Supplement Plan with Rx *("the Plan")* and applies to you if you are not enrolled in any other Medicare Part D plan and you are:

- Retired from UCC-related employment and enrolled in Medicare Parts A and B; or
- Age 65 or over and working for a UCC church or UCC-related entity with fewer than 20 employees.

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 Medicare Supplement Plan with Rx is designed to support retirees of UCC churches and UCC-related entities and active employees enrolled in Medicare Parts A and B. 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 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.

Access to Health Care Services through Preferred Provider Organizations

HIGHMARK. Blue Cross Blue Shield

Medical Services

Access through BlueCard, a nationwide network of physicians, hospitals and ancillary care providers managed by Highmark Blue Cross Blue Shield

EXPRESS SCRIPTS®

Pharmacy Services

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

UNITED CONCORDIA

Dental Services

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

vsp®

Vision Services

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

CONTENTS

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 PLAN

- **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 PLAN

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 live in the United States, are not enrolled in another Medicare Part D plan, and you are one of the following:

ELIGIBLE PARTICIPANT

- A retired minister or lay employee enrolled in Medicare Parts A and B who has participated in the UCC Medical Benefits Plan while a full-time 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 with UCC standing 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 DEPENDENT

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 *(if the partnership has existed six months or longer)*;
- Surviving spouse or surviving same-gender 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)*. You may request a copy of this booklet if it is not included in your enrollment materials by calling Member Services toll-free at **1.800.642.6543, Option 6**.

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 same-gender domestic partner, if applicable. Health coverage for your spouse or same-gender 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 same-gender domestic partner within 90 days of the six-month period following the commencement of your domestic partnership or your civil union/marriage.

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

PRE-EXISTING MEDICAL CONDITIONS

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

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 minister with UCC standing, 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;
- You are/were previously employed for 20 or more hours per week by a UCC church or other UCC-related religious or charitable organization, or self-employed in a field which, in the judgment of the Pension Boards, is related to the mission of the UCC and did not participate in the UCC Health Plan during that period of employment or self-employment;
- You were eligible for participation in the UCC Health Plan prior to becoming a minister and did not participate at that time.

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

WHEN COVERAGE STARTS

Participant

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.

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.

If your dependent is hospitalized when his/her coverage would normally begin, coverage will begin after he/she is discharged from the hospital or institution.

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

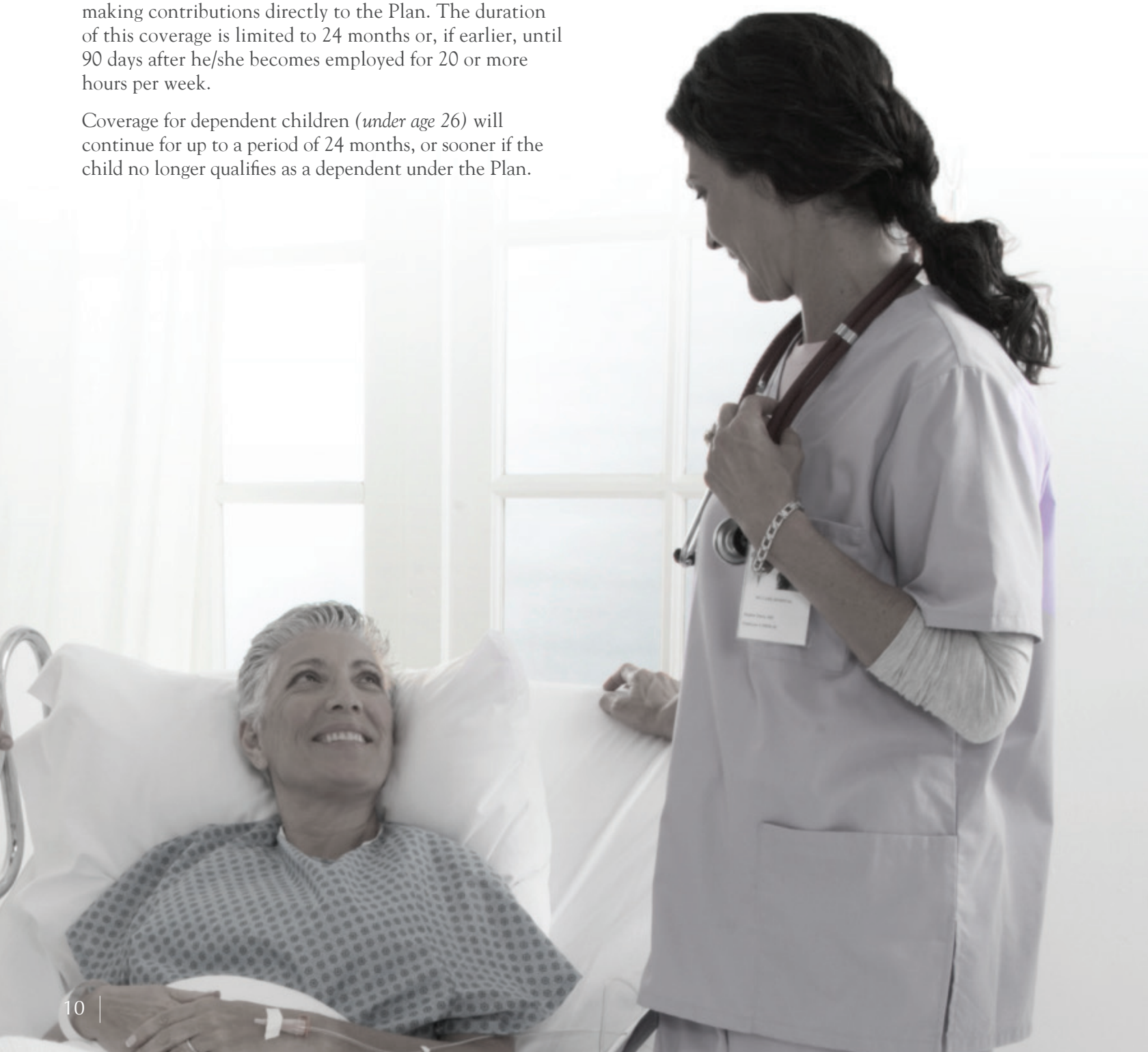
Coverage for your dependent(s) will end:

- 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 same-gender domestic partner or other dependent(s) no longer qualify as your eligible dependent(s).

CONTINUATION OF COVERAGE

In the event of your death, your spouse or same-gender domestic partner may continue Plan coverage by making contributions directly to the Plan. If you divorce or dissolve your domestic partnership, your spouse or same-gender 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.



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.

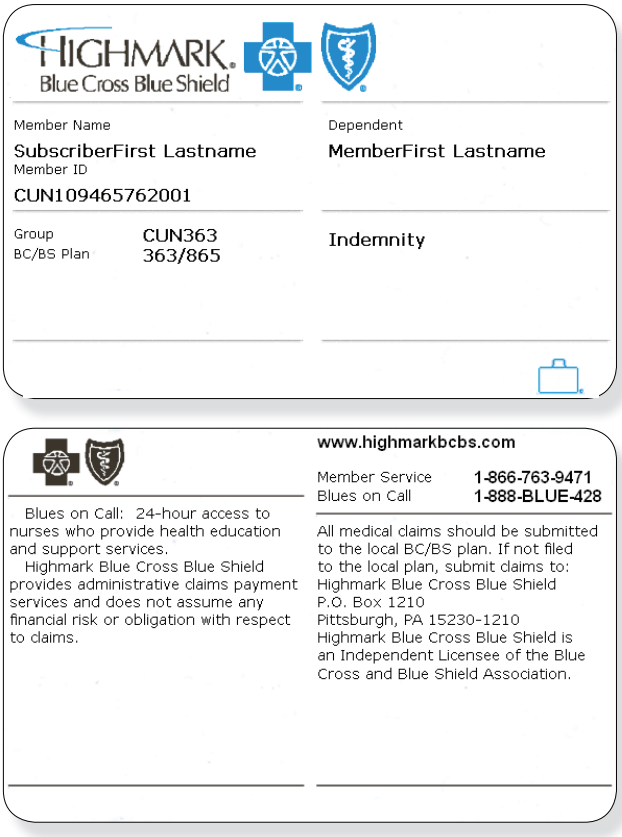
In order for the Medicare Supplement Plan with Rx to issue payment, Medicare approval is necessary, with the exception of a few select services. Contact Highmark at **1.866.763.9471** for additional benefits that may be available for services not approved by Medicare.

PAYMENT CROSSOVER OF PHYSICIAN AND HOSPITAL CLAIMS

Participants who provide the Plan administrator *(The Pension Boards–United Church of Christ, Inc.)* with a copy of their Medicare card can have their physician and hospital services billed electronically to Medicare. If you have not provided the Plan with a copy of your Medicare identification card *(and that of your Medicare-eligible dependent*(s), *if any)* and would like to take advantage of the crossover process, you may contact the Pension Boards at **1.800.642.6543, ext. 2870** and speak with a Health Plan Representative.

If the Plan does not have a copy of your Medicare identification card, you may need to submit your claims to Highmark on your own behalf.

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.



Foreign Medical Care

You will receive the lesser of 80% of the amount not paid by Medicare or the Plan allowance, for services for illness or injury received during foreign travel. Medical evacuation and repatriation of remains are not covered. Visit **www.highmarkbcbs.com.**

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.

HIGHMARK. BLUE SHIELD
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
GROUP ID: 123456789
CLAIM ACTIVITY FOR: JANE DOE
CLAIM NUMBER: 03363496597
CLAIM RECEIVED: 12/24/03

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

	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

Remarks
We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

Wellness Resources

Highmark has resources available to help you assess your health and lifestyle. The website at **www.highmarkbcbs.com** can help you 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**.

WELLNESS BENEFITS

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. The Plan covers 100% of the cost, up to the Medicare Maximum Allowable Amount. The enrollee pays any charges in excess of the Medicare Maximum Allowable Amount.

See the Preventive Schedule on p. 16 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: MEDICARE SUPPLEMENT PLAN WITH RX 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 payments only – benefits provided by Medicare are not listed.

Benefit	Medicare Supplement Plan with Rx
Deductible [1]	$300 per person *Includes deductibles paid for Medicare Parts A and B*
Out-of-Pocket Maximum *(inclusive of annual cash deductible)* [1]	$2,000 per person *Includes deductibles paid for Medicare Parts A and B*
Annual Maximum	No Limit
Physician Office Visits/Services	80% after deductible
Preventive Care *Follows Enhanced Preventive Care Schedule* • Routine physical exams • Routine gynecological exams, including a Pap Test • Mammograms, as required	See Preventive Care Schedule for additional benefits. 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 *Limit: $25,000 per person/lifetime*
Spinal Manipulation/Chiropractic Services	80% after deductible *Limit: $2,000 per person/year*
Diagnostic Services *(Lab, X-Ray and other tests)*	80% after deductible
Physical, Speech, Occupational Therapy	80% after deductible *Combined Limit: $2,000 per person/year*
Acupuncture [2]	80% after deductible *Limit: $2,000 per person/year*
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Hearing Aids	100% *Limit: $2,500 per person/every 3 years*

Benefit	Medicare Supplement Plan with Rx
Skilled Nursing Facility Care [3]	80% after deductible
Home Health Care/Visiting Nurse	80% after deductible
Private Duty Nursing	80% after deductible
Hospice [4]	80% after deductible
Routine Eye Exams	Plan pays $40 – one (1) exam/year, after deductible
Eyeglasses/Contacts *(Following cataract surgery only)*	80% after deductible
Hospital • Inpatient stay of 1-150 days/benefit period • Inpatient stay beyond 150 days/benefit period	 80% after deductible 80% after deductible [5, 6]
Rehabilitative Care *(Room, board, and services)* • Days 1-100/benefit period • Days beyond 100/benefit period	 80% after deductible 80% after deductible [5, 6]
Mental Health/Substance Abuse Care	
• Mental Health Inpatient Care	80% after deductible
• Mental Health Outpatient Care	80% after deductible
• Substance Abuse Inpatient Care – Detox	80% after deductible
• Substance Abuse Inpatient Care – Rehabilitation	80% after deductible
• Substance Abuse Outpatient Care	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. *Acupuncture services are covered if medically necessary to treat a diagnosed medical condition and provided by a physician (MD, DO), or Doctor of Chiropractic, or a licensed acupuncturist. Acupuncture services will be limited to the treatment of the following conditions only: nausea associated with surgery, chemotherapy, and pregnancy; chronic low back pain; or chronic headache or migraine headache.*
3. *Precertification through Highmark will be required for stays beyond 100 days.*
4. *Hospice services are covered only when under the supervision of a physician.*
5. *Your share of these expenses does not apply to the out-of-pocket maximum.*
6. *Precertification is required once Highmark becomes primary.*

ADULT *(AGE 19+)* PREVENTIVE SCHEDULE

Save this Preventive Schedule and save your health!

This schedule is a reference tool for planning your family's preventive care, and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), 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 benefit coverage, please call the Member Service number on the back of your ID card.

Adult *(age 19+)* Preventive Schedule

General Health Care	
Physical Exams/Health Guidance[1]	Every 1-2 years for adults 19-49 years of age. Every year for adults 50 years of age and older.
Pelvic / Breast Exam by Practitioner	Annually.
Screening / Procedures	
Abdominal Aortic Aneurysm Screening	One-time screening by ultrasonography for men between age 65 and 75 who previously smoked.
Annual Routine EKG	Annually.
Annual Routine Urinalysis	Annually.
Annual Routine CBC	Annually.
BRCA Mutation Screening	One-time genetic assessment for breast and ovarian cancer susceptibility as recommended by your doctor. Annual preventative breast MRI if BRCA positive or immediate family of BRCA carrier but untested. (If you have/have had cancer, or your mammogram is positive, annual MRI's are diagnostic and will follow your diagnostic benefits.)
Bone Mineral Density Screening	Once every 2 years: All women 65 years and older or men 70 years and older. Or, younger post-menopausal women who have had a fracture or have one or more risk factors for osteoporosis.
Chlamydia, Gonorrhea, HIV and Syphilis Screenings	All sexually active males and females, as recommended by your doctor.
Colorectal Cancer Screening (and certain colonoscopy preps with prescription)	All: beginning at age 50 annual screening with fecal occult blood test (FOBT), or screening with flexible sigmoidoscopy every 5 years with or without annual FOBT, or double contrast barium enema every 5 years or colonoscopy every 10 years. High-risk: Earlier or more frequently as recommended by your doctor.
Fasting Blood Glucose	For high-risk patients screenings should start at age 45 at three-year intervals. Earlier screening may be indicated based on individual risk factors.
Hepatitis B Screening	For high-risk patients as recommended by your doctor.
Hepatitis C Screening	For high-risk patients: As recommended by your doctor.
Cholesterol Screening[2]	Routine screening every 5 years beginning at age 20. More frequent testing of those at risk for cardiovascular disease.
Lung Cancer Screening	Annually for adults age 55-80 years with 30 pack/year smoking history and currently smokes or quit within the past 15 years.
Mammogram	Starting at age 40, performed annually if recommended by your doctor.
Pap Test	Ages 21-65: Every 3 years, or annually as recommended by your doctor. From ages 30-65: can be performed every 5 years if combined Pap and HPV are negative. Over age 65: As recommended by your doctor.
Immunizations	
Chicken Pox (Varicella)	One series of two doses at least one month apart for adults with no history of chicken pox.
Diphtheria, Tetanus *(Td / Tdap)*	One-time Tdap. Td booster every 10 years for all adults.
Hepatitis A	Based on individual risk or physician recommendation: One two-dose series.
Hepatitis B	Based on individual risk or physician recommendation: One three-dose series.
H. Influenzae B (HIB)[3]	Based on individual risk by physician recommendation.
Human Papillomavirus *(HPV)*	For individuals age 9 to 26, one three-dose series. Dose 2 at 2 months from Dose 1. Dose 3 at 6 months from Dose 1.
Influenza	Annually.
Measles, Mumps, Rubella *(MMR)*	One to two doses as recommended by your doctor.
Meningococcal	Based on individual risk or physician recommendation: One or two doses per lifetime.
Pneumococcal	High-risk or at age 65: One to two doses as recommended by your doctor.
Shingles *(Zoster)*	One dose at 60 years of age and older.

1. Includes discussion of alcohol use, blood pressure screening, depression, intimate partner and domestic violence, sexually transmitted diseases, aspirin therapy and tobacco use.

2. In the previous Preventive Schedule, Cholesterol Screening was labeled Lipid Screening. The benefit remains the same.

3. Hib (Haemophilus influenza type b) is recommended for adults with certain specified 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 influenza vaccine.

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Prevention of Obesity

Benefits for Children	Benefits for Adults

Children with a body mass index (BMI) in the 85th to 94th percentile (overweight) and the 95th to 98th percentile (obese) are eligible for:
• Additional annual preventive office visits specifically for obesity
• Additional nutritional counseling visits specifically for obesity
• Recommended laboratory studies:
  • Alanine Aminotransferase (ALT)
  • Aspartate Aminotransferase (AST)
  • Hemoglobin A1c or Fasting Glucose (FBS)
  • Cholesterol Screening
	Adults with a BMI over 30 are eligible for:
	• Additional annual preventive office visits specifically for obesity and blood pressure measurement
	• Additional nutritional counseling visits specifically for obesity
	• Recommended laboratory studies:
	  • ALT
	  • AST
	  • Hemoglobin A1c or Fasting Glucose (FBS)
	  • Cholesterol Screening

CHILDREN'S PREVENTIVE SCHEDULE

As a parent, you want to keep your child healthy and happy. That's why we put together this preventive health schedule for children. This schedule was developed based on recommendations from the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians and the Centers for Disease Control and Prevention, and is designed to help you and your child's doctor develop a plan for preventive health care for your child. If you have questions, talk to your child's doctor. For questions regarding benefits, contact Member Service at the number on

	BIRTH	1 MONTH	2 MONTHS	4 MONTHS	6 MONTHS	9 MONTHS	12 MONTHS	15 MONTHS	18 MONTHS	24 MONTHS	30 MONTHS
Hearing Screening[1]	✓										
Visual Screening[1,2]											
Wellness Exam[3]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SCREENINGS											
Autism Screening[9]									✓	✓	
Critical Congenital Heart Disease (CCHD) Screening with Pulse Oximetry	✓										
Developmental Screening[9]						✓			✓		✓
Lead Screening						✓					
Hematocrit or Hemoglobin							✓				
Newborn Blood Screening[10]	✓										
IMMUNIZATIONS[4]											
Chicken Pox[5]							Dose 1				
Diphtheria/ Tetanus/ Pertussis (DTaP)[6,7]			Dose 1	Dose 2	Dose 3			Dose 4 (15 to 18 months)			
Hepatitis A[5]							Dose 1		Dose 2		
Hepatitis B[5]	Dose 1		Dose 2		Dose 3 (6 to 18 months)						
H. Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3[6]		Dose 4 (12 to 15 months)				
Influenza[5]					One or two doses annually for all children 6 months to 18 years of age						
Measles/Mumps/ Rubella (MMR)[5]							Dose 1 (12 to 15 months)				
Meningococcal[6]											
Pneumococcal Conjugate (PCV)[6,8]			Dose 1	Dose 2	Dose 3		Dose 4 (12 to 15 months)				
Polio (IPV)[6]			Dose 1	Dose 2	Dose 3 (6 to 18 months)						
Rotavirus			Dose 1	Dose 2	Dose 3						

1. As shown and when conditions indicate. If patient is uncooperative, rescreen within six months.
2. Vision screening is a covered benefit. It is performed in the physician's office, by having the child read letters of various sizes on a Snellen chart. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit.
3. This includes, at appropriate ages, height, weight and Body Mass Index (BMI) measurement, developmental assessment.
4. Additional immunizations and expanded age ranges may be eligible based on state mandates for childhood immunizations.
5. Children can get this vaccine at any age if not previously vaccinated.
6. Or other series/schedule as recommended by the doctor.
7. DTaP is given to children under age 7, in order to develop immunity to diphtheria, tetanus and whooping cough. Tdap provides continued protection in older children and adults.
8. Previously unvaccinated older infants and children who are beyond the age of the routine infant schedule should follow the dosing guidelines recommended by their doctor.
9. In the previous Preventive Schedule the Autism/Developmental Screening benefit information was located in a footnote for the Wellness Exam. The benefit remains the same.
10. In the previous Preventive Schedule, Newborn Blood Screening was labeled Hereditary/Medical Screening. The benefit remains the same.

HIGHMARK Blue Cross Blue Shield

the back of your ID card. Services performed at the time of the preventive care office visit that are not listed here will be processed at the normal Plan benefit levels. Plan deductible and coinsurance will apply to those additional services.

	3 YEARS	4 YEARS	5 YEARS	6 YEARS	7 YEARS	8 YEARS	9 YEARS	10 YEARS	11 YEARS	12 YEARS	15 YEARS	18 YEARS
Blood Pressure	✓	✓	✓	✓	✓	✓	✓	✓	Every year from age 11 through 18			
Depression Screening									Every year beginning age 11			
Hearing Screening[1]		✓	✓	✓		✓		✓		✓	✓	
Visual Screening[1,2]	✓	✓	✓	✓		✓		✓		✓	✓	✓
Wellness Exam[3]	✓	✓	✓	✓	✓	✓	✓	✓	Every year from age 11 through 18			
SCREENINGS												
Lead Screening	When indicated. (Please also refer to your state specific recommendations.)											
Hematocrit or Hemoglobin			Annually for females during adolescence and when indicated.									
IMMUNIZATIONS[4]												
Chicken Pox[5]		Dose 2			Children not receiving the vaccine prior to 18 months can receive the vaccine at any time. Children 13 years or older who haven't been vaccinated and haven't had chicken pox should receive two doses of the vaccine at least 4 weeks apart. Second dose, catch-up is recommended for those who previously received only 1 dose.							
Diphtheria/ Tetanus/ Pertussis (DTaP)[6,7]		Dose 5 (4 to 6 years)			One dose of Tdap if five doses were not received previously							Td every 10 years
Hepatitis A[5]												
Hepatitis B[5]												
Human Papillomavirus (HPV)							One three dose series for individuals between 9 and 26 years old. Dose 2 at two months from Dose 1. Dose 3 at six months from Dose 1.					
Influenza[5]	One or two doses annually for all children 6 months to 18 years of age											
Measles/Mumps/ Rubella (MMR)[5]		The second dose of MMR is routinely recommended at 4 to 6 years, but may be administered during any visit, provided at least one month has elapsed since receipt of the first dose and that both doses are administered at or after age 12 months.										
Meningococcal[6]									Dose 1		One time booster at 16	
Pneumococcal Conjugate (PCV)[6,8]												
Polio (IPV)[6]		Dose 4 (4 to 6 years)										
CARE FOR PATIENTS WITH RISK FACTORS (Including discussion of alcohol use, sexual activity and tobacco use.)												
BRCA Mutation Screening					As recommended by doctor							
Cholesterol Screening	Screening will be done at the doctor's discretion, based on the child's family history and risk factors											
Fluoride Varnish	Service provided by the primary care doctor or their staff in the doctor's office only. As recommended by your doctor for ages 5 years and younger. Benefit does not apply to services provided by a dentist.											
Hepatitis B Screening									When indicated for high-risk			
Hepatitis C Screening												When indicated for high-risk
Chlamydia, Gonorrhea, HIV and Syphilis Screening[9]	As recommended by doctor for all sexually active males and females and other high-risk individuals.											
Tuberculin Test	Testing should be done upon recognition of high-risk factors. Frequency should be determined by community and personal risk factors.											

1. As shown and when conditions indicate. If patient is uncooperative, rescreen within six months.
2. Vision screening is a covered benefit. It is performed in the physician's office, by having the child read letters of various sizes on a Snellen chart. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit.
3. This includes, at appropriate ages, height, weight and Body Mass Index (BMI) measurement, developmental and behavioral assessment, including autism screening, education and brief counseling to prevent the initiation of tobacco use, and other care as determined by the doctor. Coverage is based on a calendar year.
4. Additional immunizations and expanded age ranges may be eligible based on state mandates for childhood immunizations.
5. Children can get this vaccine at any age if not previously vaccinated.
6. Or other series/schedule as recommended by the doctor.
7. DTaP is given to children under age 7, in order to develop immunity to diphtheria, tetanus and whooping cough. Tdap provides continued protection in older children and adults.
8. Previously unvaccinated older infants and children who are beyond the age of the routine infant schedule should follow the dosing guidelines recommended by their doctor.
9. Routine screening for all sexually active females and males.

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**. The UCC Medical Plan does not cover the following services and/or supplies, 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. Custodial care, domiciliary care, or residential care, protective and supportive care including education services and convalescent care.

9. 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.

10. Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home.

11. 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.

12. 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. 32)*

13. 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.

WHAT THE MEDICAL PLAN DOES NOT COVER *(cont'd.)*

14. 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.

15. 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.

16. Genetic testing, unless medical documentation supports medical necessity.

17. Hospice services that are not provided under the supervision of a physician.

18. Inpatient admissions primarily for diagnostic studies and inpatient admissions primarily for physical therapy.

19. Light therapy products for treatment of medical and mental health disorders to include but not limited to a light box.

20. 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.

21. Mental health services for treatment of mental illness, except for the treatment of serious mental illness, except as provided in the schedule of benefits. Services for any care that extends beyond traditional medical management related to conditions such as Autism Spectrum Disorders *(ASD)*, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, and includes the following: (a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom type setting; (b) neuropsychological testing, educational testing *(such as I.Q., mental ability, achievement, or aptitude testing)*, except for specific evaluation purposes directly related to medical treatment; (c) services provided for purposes of behavior modification and/or training; (d) services related to learning disorders; (e) services provided primarily for social or environmental change unrelated to medical treatment; (f) development or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills that the Enrollee has not yet attained; and (g) services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period of time.

22. 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.

23. 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.

24. Nicotine cessation support programs and/or classes.

25. 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.

26. Prescription drugs for which there are over-the-counter equivalents and for which the Plan has discontinued coverage.

27. Private duty nursing care, unless required by a physician.

28. Respite care.

29. Reversal of sterilization.

30. Services for which the Enrollee has no legal obligation to pay.

31. Services provided by an immediate family member.

32. Services provided by an individual residing in the patient's home.

33. 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.

34. Services provided prior to the Enrollee's effective date of coverage.

35. 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.

36. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.

37. Services provided by a social worker, including a psychological or psychiatric social worker, except for the services included under mental health and substance abuse treatment or hospice services.

38. Services provided by a licensed pastoral counselor, unless performed under mental health and substance abuse treatment.

39. Treatment for injury or illness suffered while committing a felony.

40. Weight reduction programs, except for medical and surgical treatment of morbid obesity when determined by the Pension Boards, or its medical advisors, to be medically necessary.

41. 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 BENEFIT – 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.

Retail Pharmacy Prescription Drug Purchases

You may purchase up to a 30-day supply of prescription drugs with a copayment at participating Express Scripts network pharmacies. If you must obtain prescription drugs at a retail pharmacy that does not participate in the Express Scripts network, you will need to submit a claim to Express Scripts for reimbursement of expenses. Claim forms are available from Express Scripts or on the Pension Boards' website at **www.pbucc.org**.

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 treatment 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.

More information on the Express Scripts Retail and Mail Order Pharmacy programs is available by contacting Express Scripts. For general information and to find a participating Express Scripts network pharmacy, call **1.800.939.3781** or visit **www.express-scripts.com**.

Submit claims for non-participating retail pharmacy drug purchases to:

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

Mail Order Pharmacy Orders should be sent to:

Express Scripts
Mail Order Pharmacy
P.O. Box 182050
Columbus, OH 43218-2050

PHARMACY BENEFIT MANAGEMENT

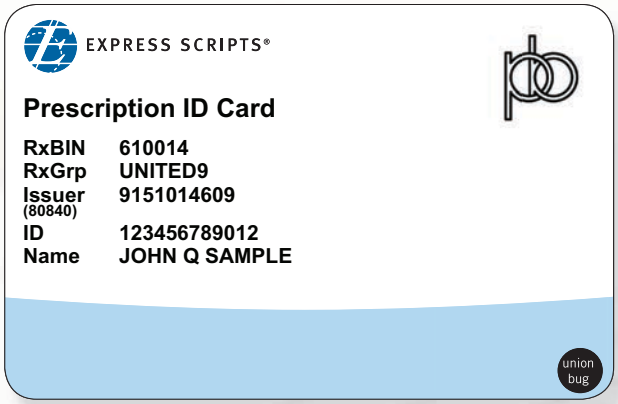
Your pharmacy benefit includes the following programs to provide patient safety:

RationalMed

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

Prior Authorization

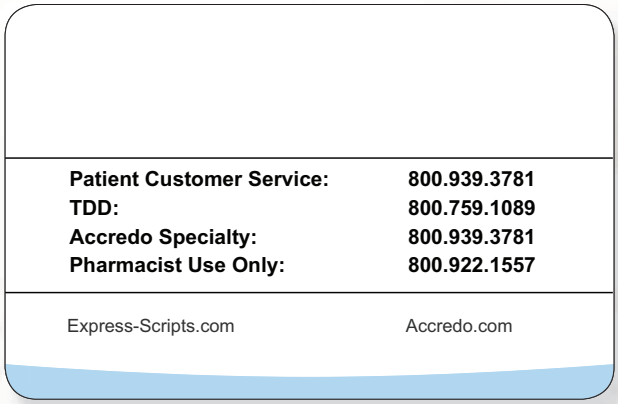
Pre-approval of prescriptions for specified drugs is required if the prescribed dosage exceeds the maximum daily allowance recommended by the Food and Drug Administration *(FDA)*.


EXPRESS SCRIPTS®

Prescription ID Card

RxBIN 610014
RxGrp UNITED9
Issuer (80840) 9151014609
ID 123456789012
Name JOHN Q SAMPLE

union bug


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


RxBin 610014
RxGrp
Issuer MEDCO
ID No.
Name

www.medco.com
Prescription Benefit Card

medco®

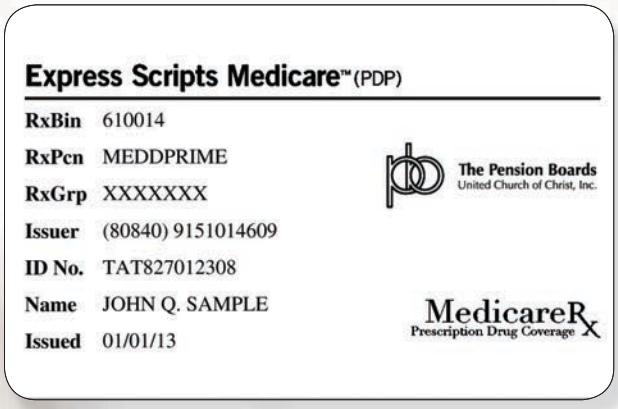

Members:
- This card must be presented at a participating pharmacy when purchasing prescription drugs.
- **To locate a participating pharmacy, obtain a claim form, or find out more about your prescription benefit, please visit our website or call Member Services.**
- If you are required to submit a claim for reimbursement please use a claim form for proper processing of your claim.

Pharmacists: Submit claims via the *TelePAID*® 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 Service Help Desk at 1 800 922-1557** or visit the **Pharmacist Resource Center at www.medco.com/rph**.

Submit claim forms to:
Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

To obtain claim forms:
Member Services: **1 800 939-3781**
Visit our website at: **www.medco.com**

You will receive prescription ID cards for you and your covered dependent(s) from Express Scripts upon enrollment in the Medical Plan. For **working** participants of the UCC Medicare Supplement Plan: Express Scripts and Medco have recently completed their merger. You will not be issued new ID cards at this time. Please continue to use your current Medco ID cards.


Express Scripts Medicare™ (PDP)

RxBin 610014
RxPcn MEDDPRIME
RxGrp XXXXXXX
Issuer (80840) 9151014609
ID No. TAT827012308
Name JOHN Q. SAMPLE
Issued 01/01/13

The Pension Boards
United Church of Christ, Inc.

MedicareRx
Prescription Drug Coverage


Members
- 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.

Submit claim forms to: Express Scripts
P.O. Box 14718, Lexington, KY 40512

Pharmacists
Submit claims via the *TelePAID*® 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**

For **retired/non-working** participants of the UCC Medicare Supplement Plan: You will receive new ID cards with the Express Scripts logo inside your Express Scripts Medicare Part D Welcome Kit.

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 *Up to a 30-day supply*	$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 *Up to a 90-day supply*	$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 *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.**			
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 (excluding payments made by the Plan) reach $4,700, you will pay the lesser of 5% of the total drug cost or the copay listed above for the appropriate drug class.

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")			
When pharmacy expenses total $2,960, 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 5% (after applicable manufacturer discount of 50%)****. Once pharmacy expenses total $4,700, you will pay 5% of the total drug cost.*	Brand Drugs: Member pays 45% coinsurance **Generic Drugs:** Member pays the same as the Initial Coverage Stage (see above)	**Brand Drugs:** Member pays 45% coinsurance **Generic Drugs:** Member pays the same as the Initial Coverage Stage (see above)	**Brand Drugs:** Member pays 45% coinsurance **Generic Drugs:** Member pays the same as the Initial Coverage Stage (see above)
Catastrophic Stage			
When pharmacy expenses total $4,700.01+	Brand & Generics: 5% coinsurance	Brand & Generics: 5% coinsurance	Brand & Generics: 5% coinsurance

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, devices or over-the-counter contraceptives.

5. Drugs used to treat impotency, unless approved following prostate surgery.

6. Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.

7. Drugs labeled "Caution–limited by federal law to investigational use," or experimental drugs, even though a charge is made to the participant.

8. Durable medical equipment ***(see Medical Summary of Benefits,*** *p. 14)*.

9. Glucowatch/blood glucose sensors.

10. Immunization agents and vaccines. *(see* ***Adult Preventive Care Schedule,*** *p. 16 and* ***Children's Preventive Care Schedule,*** *p. 18-19). Certain vaccines require the participant to purchase them at a local retail pharmacy. These services will be reimbursed to the participant by Highmark BCBS. Visit our website at* ***www.pbucc.org*** *for a* ***Highmark Member Submitted Health Insurance Claim Form***.

11. Lost, stolen, or damaged drugs.

12. 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.

13. Non-federal legend drugs, which are not approved by the Food and Drug Administration *(FDA)*.

14. Non-sedating antihistamines.

15. Nutritional/dietary supplements or supplies.

16. Ostomy supplies.

17. Smoking deterrents.

18. Therapeutic devices or appliances.

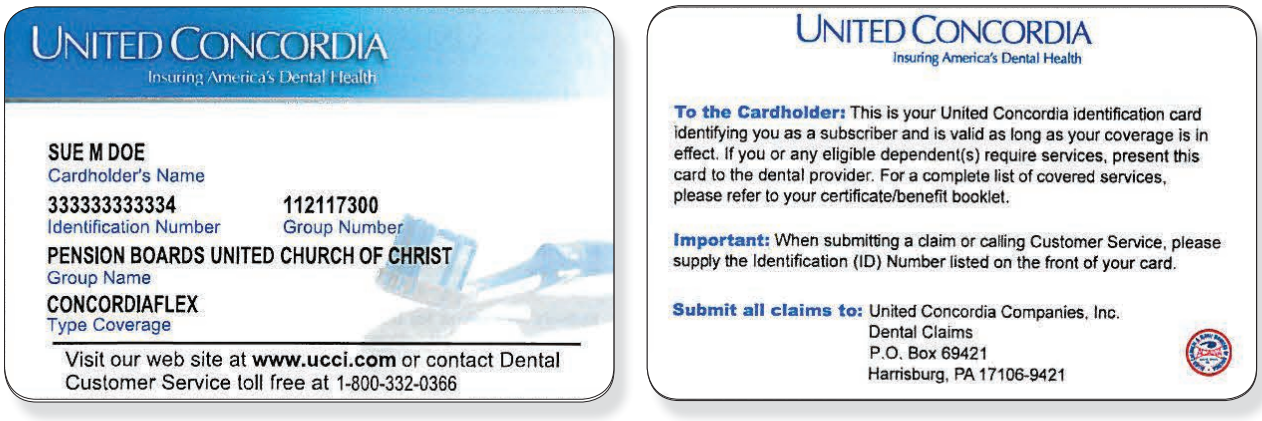
HOW THE DENTAL PLAN WORKS

The UCC Dental Plan 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.

PREFERRED PROVIDER ORGANIZATION *(PPO)* – ALLIANCE

Alliance 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 Alliance 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 Alliance 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 Alliance PPO network provider, you can ask them to contact Highmark Blue Cross Blue Shield to join.



To find an **Alliance 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 17106-9431

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 dependent receives dental treatment.

UNITED CONCORDIA

DENTAL
EXPLANATION OF BENEFITS
KEEP FOR YOUR TAX RECORDS

DENTAL CUSTOMER SERVICE
P.O. BOX 69420
HARRISBURG, PA 17106-9420

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 D1110	(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 Annual Benefit Maximum/per person	$100/person or $200/family $1,800	$100/person or $200/family $750
Type of Service *Applies to both Dental 1800 and Dental 750 Plans*	**In-Network** [2]	**Out-of-Network** [3]
Preventive Services and Supplies: • Cleaning and examination–two times per calendar year • Fluoride application to child's teeth, age 16 and under–two times per calendar year • Space maintainers, age 16 and under	100%	Plan pays 100% up to R&C limits
Diagnostic and Therapeutic Services and Supplies: • 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 care [4] • 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: • Fillings [5] • Crowns [5]	80% 50%	Plan pays 80% up to R&C limits Plan pays 50% up to R&C limits
Prosthetic Services and Supplies: • 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:

1. *Participants of the Dental 750 Plan will transition into the Dental 1800 Plan after one (1) year.*
2. *Alliance PPO network provides access to dental care at a lower cost than out-of-network providers.*
3. *Benefit payments are based on Reasonable and Customary (R&C) limits.*
4. *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.*
5. *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 repair/rebasing of dentures or bridges you receive while covered under this Plan.

2. Facings on pontics or crowns posterior to the second bicuspid.

3. 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.

4. Oral surgery for bony impactions of third molars (wisdom teeth). Contact Highmark BCBS for benefits that might be available under the Medical Plan.

5. Orthodontic services that occurred before enrollment in this Plan or after enrollment is terminated.

6. Procedures, restorations and appliances to increase vertical dimension or to restore occlusion.

7. Replacement of an existing crown or gold filling will not be covered unless for tooth decay.

8. Sealants.

9. Services and supplies furnished in a U.S. government 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, 2014, you will not be eligible for another eye exam until May 1, 2015. If you received eyeglass frames on July 1, 2014, you will not be eligible for new frames until July 1, 2016.

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.

To find a VSP provider:

call **1.800.877.7195**
or
visit **www.vsp.com**

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	• Focuses on your eyes and overall wellness	$10 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $140 allowance for a wide selection of frames • 20% off amount over your allowance	Combined with exam	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Options	• 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)	• $140 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	• Services related to type 1 diabetes; ask your VSP doctor for details	$20	As needed
Extra Savings and Discounts	**Glasses and Sunglasses** • 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. **Retinal Screening** • Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam. **Laser Vision Correction** • 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 Out-of-Network 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	Lined Trifocal Lenses....up to $100	Contacts.....up to $105
Frame.....up to $70	Lined Bifocal Lenses.....up to $75	Progressive Lenses.....up to $75	

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.

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.

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 contact VSP at **1.800.877.7195** or 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, 475 Riverside Drive, Room 1020, New York, NY 10115. 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.

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. 34 for additional information.

Continuation of Coverage: Covered participants and their covered dependents may retain Plan coverage under certain circumstances. See p. 10 for more information.

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, same-gender 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 same-gender 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.

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. 14-15)*. 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.

Medicare Part D: A federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 *(MMA)* and went into effect on January 1, 2006.

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 Medicare Supplement Plan with Rx.

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. 30)*.

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.

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.

MEDICAL SERVICES

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1.866.763.9471
www.highmarkbcbs.com

Blues on Call
1.888.258.3428

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

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

* **Preferred Provider Organizations**

CONTACTS *(cont'd.)*

DENTAL SERVICES

UNITED CONCORDIA*

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

VSP*

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

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, Option 6**.

NOTES

The Pension Boards
United Church of Christ, Inc.
475 Riverside Drive
Room 1020
New York, NY 10115

11/2014