Highlights of Your UCC Medical and Dental Benefits Plan

For individuals who are not eligible for Medicare

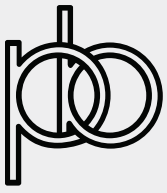
Health Coverage

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** *(for individuals who are not eligible for Medicare)*.

The Plan Year that begins on January 1, 2015 continues to reflect provisions mandated by The Patient Protection and Affordable Care Act, which was signed into law in March 2010. The UCC Medical Plan is considered a "grandfathered" plan under the law, which enables us to keep it functioning much as it has for a number of years, helping avoid many of the regulations imposed on other health plans and enabling us to keep costs low.

The UCC Plan continues to offer a schedule of comprehensive benefits to assist participants in maintaining healthy lifestyles, with an emphasis on preventive care, wellness, and chronic condition management.

Your UCC Medical and Dental Benefits Plan offers flexibility and choice, including:

- Three Health Plan options that offer various levels of deductibles and benefits
- 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
- Access to nationwide Preferred Provider Organizations *(PPOs)* for cost-effective medical, dental and vision care, as well as the flexibility to use In-Network and Out-of-Network providers

The Plan continues to benefit from the collective purchasing power made possible by our partnerships with other denominational health plans through the Church Benefits Association. Participants' use of in-network providers, generic medications and the free preventive care services offered by the Plan as a way to prevent more serious health conditions, have a significant financial impact on a Plan-wide basis.

We hope that you continue to be pleased with the benefits available to UCC Plan participants, and 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 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 are not eligible for Medicare and are:

- Serving in UCC-related employment as a minister or lay employee; or
- Attending a seminary or other institution of higher education pursuing a degree in theology or a related discipline; or
- A UCC minister who is pursuing an advanced degree; or
- A self-employed UCC minister who may be working for a non-UCC employer; or
- A UCC minister working for another denomination.

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 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

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

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
Access through ValueOptions, a nationwide network of mental health and substance abuse treatment providers managed by ValueOptions

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

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

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

CONTENTS

AVAILABLE PLANS

You are eligible to participate in one of the following UCC Health Plans if you meet the eligibility requirements listed on p. 7 and are not eligible for Medicare. Information contained in this booklet is also available on our website at **www.pbucc.org**.

HEALTH PLANS

- **Plan A:** A comprehensive health plan with the lowest out-of-pocket *(deductible and coinsurance)* cost.
- **Plan B:** A comprehensive health plan with mid-level out-of-pocket *(deductible and coinsurance)* cost.
- **Plan C:** A comprehensive health plan with the highest out-of-pocket *(deductible and coinsurance)* cost.
- **Plan M:** This plan is available to individuals whose eligibility will be determined by Wider Church Ministries.

Participation in any of the above health plans also includes mental health and substance abuse care through ValueOptions and prescription drug coverage through Express Scripts.

DENTAL PLANS

- **Dental 1800:** A comprehensive dental plan available to all eligible employees and their eligible dependents. The annual benefit maximum is $1,800 per person.
- **Dental 750:** A comprehensive dental plan available to eligible employees 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 employees and their eligible dependents to provide coverage for vision care services.

ELIGIBILITY FOR BENEFITS

You are eligible to participate in the UCC Health Plan if you are not eligible for Medicare*, and you are one of the following:

ELIGIBLE EMPLOYEE

- A full-time minister or lay employee who meets the eligibility requirements of a church or other UCC-related entity. *(If your employer does not state the eligibility requirements, you must be regularly employed for 20 or more hours per week.)*; or
- Attending a seminary or other institution of higher education pursuing a degree in theology or related discipline and working toward your first ministerial degree as a full-time student who is a Member in Discernment of a UCC Association, or a UCC minister with standing pursuing an advanced degree; or
- A self-employed UCC minister who may be working for a non-UCC employer; or
- A UCC minister working for another denomination.

* Special Consideration for Medicare-Eligible Employees Who Are Actively Working

- If you continue UCC employment after age 65 and your employer has more than 20 employees, the Pension Boards recommends that you do not sign up for Medicare Part B at this time; however you must enroll in Medicare Part A. The UCC *(Non-Medicare)* Plan will remain the primary insurer until you retire, terminate employment with the UCC or terminate your medical benefit coverage through the UCC Health Plan.
- If you continue UCC employment after age 65 and your employer has fewer than 20 employees, you will be required to enroll in Medicare Parts A and B in order to maintain eligibility for benefits under the UCC Plan. Your coverage will be transferred to the UCC Medicare Supplement Plan with Rx. If you do not enroll for Medicare benefits, you will no longer be eligible for benefits through the UCC Plan. The booklet, **Highlights of Your UCC Medicare Supplement Plan**, is available online at **www.pbucc.org** or by calling the Pension Boards toll-free at **1.800.642.6543, Option 6.**

ELIGIBLE DEPENDENT

You may also enroll eligible dependents in the Plan. Eligible dependents include your:

- Spouse
- Same-gender domestic partner
- Children
  - Your natural child*(ren)* or stepchild*(ren)* under age 26;
  - Permanently disabled unmarried and unemancipated children age 26 and over if the disability began prior to their reaching age 26, and for whom you provide at least half their support;
  - Children under age 26 for whom you can provide documentation of adoption or guardianship *(including a child for whom legal adoption proceedings have been started)*;
  - Children for whom you are required to provide medical care through a Qualified Medical Child Support Order *(QMCSO)*.

APPLYING FOR COVERAGE

You may apply for coverage for yourself and your eligible dependent(s) by filing a Medical Benefits Enrollment Application with the Pension Boards within 90 days of your initial eligibility to participate in the UCC Medical and Dental Benefits Plan. You must apply for employee coverage in order to apply for 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 earlier of the following: the six-month anniversary of 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.

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 initial eligibility. Plan participation may be denied on health status after the first 90 days of eligibility.

WAIVING OR TERMINATING COVERAGE

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

PRE-EXISTING MEDICAL CONDITIONS

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

WHEN COVERAGE STARTS

UCC Health Plan coverage for you and your eligible dependent(s) begins on the first day of the month following receipt of your enrollment application if you apply for coverage within the 90-day eligibility period.

Newborn children are covered on the date of birth if you have properly notified the Pension Boards. You must notify the Pension Boards within 90 days following the birth; otherwise evidence of good health will be required in order to add your child to your coverage.

WHEN COVERAGE ENDS

Coverage for you and your dependent(s) will end when contributions are no longer paid, or on the last day of the month in which you or your dependent(s) are no longer eligible for coverage.

Coverage for your spouse or same-gender domestic partner will end when your coverage ends or when he/she no longer qualifies as your eligible dependent.

Your adult children cease to be eligible for coverage at the end of the month they turn 26.

SEMINARY STUDENTS

Plan participation for seminary students is permitted for up to four years while you are a full-time student pursuing your first ministerial degree or for up to three years as a full-time student seeking an advanced degree. At the end of the stated time limit, you may continue coverage under this Plan if you begin employment with a UCC church or UCC-related entity.

Once a year *(during the Fall semester)*, seminary students may enroll in the Plan without having to provide evidence of good health.

LIVING ABROAD

Your coverage may be continued for up to one year if you live outside the United States while on sabbatical, church business or business for a UCC entity. Dependents who normally live with you in the United States and move to another part of the world will be eligible for Plan coverage for up to one year. *This does not apply to participants in Plan M, whose eligibility will be determined by Wider Church Ministries.*

CONTINUATION OF COVERAGE

You may continue your health coverage for up to four years while you are a full-time student pursuing your first ministerial degree, or for up to three years as a full-time student seeking an advanced degree. At the end of the stated time limit, you may continue coverage under this Plan if you begin employment with a UCC church or UCC-related entity.

If your coverage ends because you are no longer employed, you may continue Plan coverage for up to 24 months by making contributions directly to the Plan. Should you gain employment of 20 or more hours per week prior to the 24-month limit, you may continue Plan coverage for up to 90 days after such employment begins. However, the 90 days may not extend beyond the 24-month overall limit.

If you retire while participating in the Plan, you may continue your coverage as long as you make contributions directly to the Plan.

In the event of your death, your spouse or same-gender domestic partner, and dependent child(ren), 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.

For all other events that cause a loss of coverage, dependent children *(under age 26)* will continue to be covered for up to 24 months.

If you, your spouse or same-gender domestic partner, or dependent child is or becomes totally disabled *(as defined by the Social Security Act)* at any time during the first 60 days of coverage, the continuation of coverage will be extended from 24 months to 29 months.

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

PREFERRED PROVIDER ORGANIZATION *(PPO)*–BLUECARD

A PPO is a network of physicians, hospitals, laboratories and other ancillary practitioners that have agreed to provide services at discounted rates. Use of in-network services is highly encouraged to receive the highest level of coverage. In-network providers are not permitted to bill Plan participants for charges in excess of network-allowable fees. PPO network access information can be found on your identification cards.

Health Care Services–BlueCard PPO Through Highmark Blue Cross Blue Shield

The Pension Boards–United Church of Christ, Inc. has partnered with Highmark Blue Cross Blue Shield to ensure that you get the medically necessary and appropriate care you need from the provider you select. When you or a covered family member needs medical care, you can choose between two levels of medical care services: in-network or out-of-network. In-network care is care you receive from providers in the PPO network. Out-of-network care is care you receive from providers who are not in the PPO network. When you receive services from an out-of-network provider, you may be responsible for paying the difference between the provider's actual charge and the Plan's allowable amount.

To find a **Highmark Blue Cross Blue Shield BlueCard PPO** network provider:

call **1.866.763.9471**
or
visit **www.highmarkbcbs.com**

When you use a BlueCard PPO provider, you are responsible only for your copayment at the time of your office visit. Your medical care provider will submit claims directly to their local Blue Cross Blue Shield plan, which will in turn submit them electronically to Highmark Blue Cross Blue Shield in Pittsburgh, Pennsylvania. Highmark will apply benefits and eligibility to the claims and finalize your benefit payments.

If your physician or other health care provider is not in the BlueCard network, they can contact the local Blue Cross Blue Shield plan serving their area to join.

PRECERTIFICATION

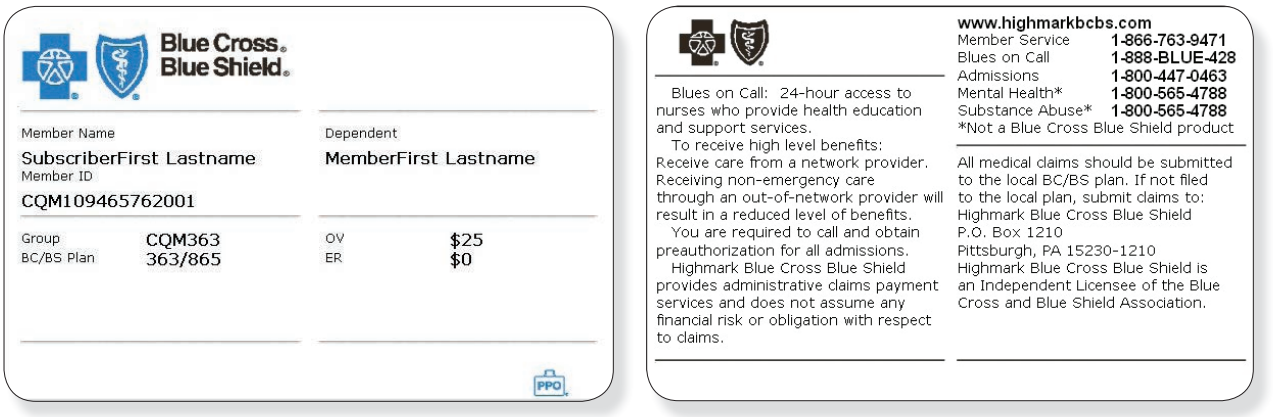
All inpatient hospital services must be precertified through Highmark Healthcare Management Services by calling **1.800.452.8507**. If precertification is not obtained as required, you will be subject to a $300 penalty that will not be applied toward your Plan Year out-of-pocket maximum.

Non-Emergency Admissions–you must notify Highmark Blue Cross Blue Shield at least 24 hours prior to a non-emergency hospital admission.

Emergency Hospital Admissions–you must notify Highmark Blue Cross Blue Shield within 48 hours of an emergency admission.

Mental Health/Substance Abuse Services–all mental health services must be precertified through ValueOptions. See p. 13 and 24 for additional information.

You will receive a medical identification card from Highmark Blue Cross Blue Shield for each member of your family who is enrolled in the Medical 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.

HIGHMARK. BLUE SHIELD
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.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Mental Health and Substance Abuse Services–ValueOptions PPO

When services are required, a ValueOptions case manager will provide referrals to network practitioners. **Precertification through ValueOptions is required for both inpatient and outpatient care.** For emergency admissions, notify ValueOptions as soon as possible. A delay beyond two business days will jeopardize benefit coverage. To find a provider in the ValueOptions network, or to request precertification, call **1.800.565.4788** or visit **www.achievesolutions.net/ucc**.

CENTERS OF EXCELLENCE

Centers of Excellence are part of an overall Blue Cross Blue Shield initiative called Blue Distinction. Blue Distinction includes centers for transplant, bariatric and cardiac care, and represents significant enhancements to quality critical care.

To obtain precertification for these services, contact Highmark Healthcare Management Services at **1.800.452.8507**. For more information about how to access the provider site or determine eligibility, contact the Highmark Blue Cross Blue Shield Customer Service Center at **1.866.763.9471**.

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**.

MEDICAL REFERRALS

No physician referrals are required except in limited instances. If you are unsure whether your procedure will require a referral, call Highmark Blue Cross Blue Shield at **1.866.763.9471**.

FOREIGN MEDICAL CARE

The BlueCard Worldwide program enables you to receive inpatient and outpatient hospital care and physician services while outside the United States. It includes medical assistance services and an expanded network of health care providers throughout the world.

If you need assistance finding a foreign provider, call **1.800.810.2583**. If you are unable to use the toll-free number, you can call BlueCard collect at **1.804.673.1177**.

A medical coordinator will arrange hospitalization if necessary, or make an appointment with a physician. In an emergency, you should go directly to the nearest hospital.

These services are available 24 hours a day, 365 days a year, anywhere in the world. There is no charge for any referral or coordination help you need, and any medical services you receive will be covered in accordance with the Plan limits. See the **Summary of Benefits** *(p. 16)* for additional information regarding covered medical services.

CASE MANAGEMENT SERVICES

The Plan includes case management services provided by Blues on Call (BOC). These services provide assistance with chronic or complex medical care services.

Case managers, physicians, and institutional providers collaborate to assess your needs and to plan and coordinate appropriate care options and services. For those with chronic conditions, Health Coaches offer customized interventions and support, help you understand your condition and treatment plan and address adherence issues and barriers to care. For those with complex needs related to major and/or multiple medical issues, Highmark Blue Cross Blue Shield offers case management services to ensure the most appropriate care is received in the most appropriate setting. You may contact Blues on Call (BOC) at **1.888.258.3428**. Choose option 1 if you know the 10-digit phone number of your Health Coach, otherwise choose option 2 to speak to a Health Coach for the first time.

MATERNITY EDUCATION AND SUPPORT

Participants who become pregnant can take advantage of programs available through Highmark Blue Cross Blue Shield. To enroll in the programs, call **1.866.918.5267** toll-free. Under the Baby BluePrints Maternity Education and Support Program, participants have access to:

- a welcome package containing a comprehensive Maternity Guide;
- discounts on important classes and services;
- support/assistance from a Health Coach;
- free online classes and educational information; and
- free gifts throughout the pregnancy, including a pregnancy book of your choice, baby photo album, baby dish and cup set, and a book on child emergency first aid care.

MOTHERS' AND NEWBORNS' PROTECTION RIGHTS ACT

In accordance with federal law, the Plan will cover at least 48 hours of hospitalization for a vaginal delivery, and at least 96 hours of hospitalization for a Caesarean section, for both the mother and child. In consultation with her physician, the mother may decide to be discharged earlier. The mother may also decide, after conferring with the baby's physician, to have the baby discharged earlier.

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.

WELLNESS BENEFITS

Healthy Stewards

Healthy Stewards is the UCC Medical Plan's well-being philosophy, rooted in the biblical understanding that we are called to be stewards of all our resources, including our health.

The Plan offers a well-being improvement program through Highmark Blue Cross Blue Shield that provides participants with free information and tools needed to make positive lifestyle choices.

The program consists of three components:

- an online Wellness Profile
- setting a health goal with a Health and Wellness Coach or online via WebMD My Health Assistant; and
- a Blood Screening Test via a home test kit, a LabCorp voucher, or a Physicians Results Form

After completing the online Wellness Profile and Blood Screening via the fingerstick home test kit, participants will receive a personal score and health report. All information is kept confidential.

Preventive Services

The Plan provides coverage according to the schedule recommended by the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, and the American College of Obstetricians and Gynecologists. The Plan covers 100% of the cost when in-network providers are used. When out-of-network providers are used, the Plan will pay 100% of the Reasonable and Customary (R&C) limit. The participant pays any charges in excess of the R&C limit. See the **Preventive Schedule** *(p. 19-23)* for more information.

Condition/Disease Management

The Plan provides chronic condition management services at no cost to participants through Highmark Blue Cross Blue Shield. The program:

- assists participants in the management of their total health;
- offers educational resources and materials on a wide range of diseases or chronic conditions, along with access to a personal health coach; and
- identifies individuals for participation based on medical and pharmacy claims received from their providers.

CLAIMS PROCESSING SERVICES

If you receive services from an out-of-network provider, you may be required to submit your claim to Highmark. Contact Highmark at **1.866.763.9471** to request a claim form. Complete the form and mail it *(along with your receipt)* to the address on the form.

Summary of Benefits: Medical Plans Through Highmark Blue Cross Blue Shield

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.

Benefit	Plan A		Plan B
	In-Network	Out-of-Network [2]	In-Network
Deductible [1] Individual Family	$300 $600	$600 $1,200	$500 $1,500
Payment Level/Coinsurance [3]	80% after deductible until out-of-pocket maximum is met; then 100%	60% after deductible until out-of-pocket maximum is met; then 100%	80% after deductible until out-of-pocket maximum is met; then 100%
Out-of-Pocket Maximums	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$5,000 Individual $15,000 Family
Annual Maximum [4]	No Limit	No Limit	No Limit
Physician Office Visits	100% after $25 copayment [5]	60% after deductible	80% after deductible
Preventive Care *Follows Preventive Care Schedule* *Adult* Routine physical exams	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
Eye exam	$40 after deductible	$40 after deductible	$40 after deductible
Routine gynecological exams, including a Pap Test	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
Mammograms, as required	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
Child Routine physical exams	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
Pediatric immunizations	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
Emergency Room Services	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible
Ambulance	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible
Hospital Expenses Inpatient [6]	80% after deductible	60% after deductible	80% after deductible
Outpatient	80% after deductible	60% after deductible	80% after deductible
Maternity Office Visits	100% - copay and deductible do not apply	60% after deductible	100% - copay and deductible do not apply
Outpatient (Labs, diagnostic services, etc.)	100% after deductible	60% after deductible	100% after deductible
Inpatient (Labor and delivery room, etc.)	100% after deductible	60% after deductible	100% after deductible
Infertility Counseling, Testing and Treatment [7]	80% after deductible	60% after deductible	80% after deductible
Autism Spectrum Disorder [13]	Limit: $2,500 per person/year	Limit: $2,500 per person/year	Limit: $2,500 per person/year
Medical/Surgical Expenses (Except Office Visits)	80% after deductible	60% after deductible	80% after deductible
Gender Identity Services Inpatient	Combined Inpatient/Outpatient Limit: $25,000 per person/lifetime 80% after deductible	Combined Inpatient/Outpatient Limit: $25,000 per person/lifetime 60% after deductible	Combined Inpatient/Outpatient Limit: $25,000 per person/lifetime 80% after deductible
Outpatient	100% after $25 copayment [5]	60% after deductible	80% after deductible
Spinal Manipulation/Chiropractic Services	80% after deductible Limit: $2,000 per person/year	60% after deductible Limit: $2,000 per person/year	80% after deductible Limit: $2,000 per person/year
Diagnostic Services (Lab, X-Ray and other tests)	80% after deductible	60% after deductible	80% after deductible
Physical, Speech, Occupational Therapy	80% after deductible Combined Limit: $2,000 per person/year	60% after deductible Combined Limit: $2,000 per person/year	80% after deductible Combined Limit: $2,000 per person/year
Acupuncture [8]	80% after deductible Limit: $2,000 per person/year	60% after deductible Limit: $2,000 per person/year	80% after deductible Limit: $2,000 per person/year
Allergy Testing	80% after deductible Limit: 60 tests per person/year	60% after deductible Limit: 60 tests per person/year	80% after deductible Limit: 60 tests per person/year
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible	80% after deductible
Hearing Aids	100% Limit: $2,500 per person/every 3 years	100% Limit: $2,500 per person/every 3 years	100% Limit: $2,500 per person/every 3 years
Skilled Nursing Facility Care	80% after deductible	60% after deductible	80% after deductible
Home Health Care	80% after deductible	60% after deductible	80% after deductible
Private Duty Nursing	80% after deductible	60% after deductible	80% after deductible
Hospice [9]	80% after deductible	60% after deductible	80% after deductible
Precertification Requirements [10]	Performed by Participant	Performed by Participant	Performed by Participant

In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician *(PCP)* to coordinate your care. Below are specific benefit levels. Footnote explanations are located on **p. 18**.

	Plan C		Plan M [11]
Out-of-Network	**In-Network**	**Out-of-Network**	**Comprehensive Coverage [12]**
$1,500 $4,500	$1,000 $3,000	$3,000 $9,000	$200 $400
60% after deductible until out-of-pocket maximum is met; then 100%	70% after deductible until out-of-pocket maximum is met; then 100%	50% after deductible until out-of-pocket maximum is met; then 100%	85% after deductible until out-of-pocket maximum is met; then 100%
$15,000 Individual $45,000 Family	$6,000 Individual $18,000 Family	$18,000 Individual $54,000 Family	$2,000 Individual $4,000 Family
No Limit	No Limit	No Limit	No Limit
60% after deductible	70% after deductible	50% after deductible	100% after $25 copayment
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
$40 after deductible	$40 after deductible	$40 after deductible	$40 after deductible
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
80% after in-network deductible	70% after in-network deductible	70% after in-network deductible	85% after deductible
80% after in-network deductible	70% after in-network deductible	70% after in-network deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible	100% - copay and deductible do not apply	50% after deductible	100% - after copayment
60% after deductible	100% after deductible	50% after deductible	85% after deductible
60% after deductible	100% after deductible	50% after deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
Limit: $2,500 per person/year	Limit: $2,500 per person/year	Limit: $2,500 per person/year	Limit: $2,500 per person/year
60% after deductible	70% after deductible	50% after deductible	85% after deductible
Combined Inpatient/Outpatient Limit: $25,000 per person/lifetime 60% after deductible	Combined Inpatient/Outpatient Limit: $25,000 per person/lifetime 70% after deductible	Combined Inpatient/Outpatient Limit: $25,000 per person/lifetime 50% after deductible	Combined Inpatient/Outpatient Limit: $25,000 per person/lifetime 85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible Limit: $2,000 per person/year	70% after deductible Limit: $2,000 per person/year	50% after deductible Limit: $2,000 per person/year	85% after deductible Limit: $2,000 per person/year
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible Combined Limit: $2,000 per person/year	70% after deductible Combined Limit: $2,000 per person/year	50% after deductible Combined Limit: $2,000 per person/year	85% after deductible Combined Limit: $2,000 per person/year
60% after deductible Limit: $2,000 per person/year	70% after deductible Limit: $2,000 per person/year	50% after deductible Limit: $2,000 per person/year	85% after deductible Limit: $2,000 per person/year
60% after deductible Limit: 60 tests per person/year	70% after deductible Limit: 60 tests per person/year	50% after deductible Limit: 60 tests per person/year	85% after deductible Limit: 60 tests per person/year
60% after deductible	70% after deductible	50% after deductible	85% after deductible
100% Limit: $2,500 per person/every 3 years	100% Limit: $2,500 per person/every 3 years	100% Limit: $2,500 per person/every 3 years	100% Limit: $2,500 per person/every 3 years
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
Performed by Participant	Performed by Participant	Performed by Participant	Performed by Participant

Medical Plan Footnotes:

1. *In-network and out-of-network deductibles cross-accumulate. Excludes prescription drug copayments, physician office visit copayments, difference paid for brand-name drugs in lieu of available generics, penalty for failure to precertify hospital admissions and payments over Reasonable and Customary (R&C) limits.*

2. *Benefit payments are based on Reasonable and Customary (R&C) limits.*

3. *In-network and out-of-network out-of-pocket maximums cross-accumulate. Excludes prescription drug copayments, physician office visit copayments, difference paid for brand-name drugs in lieu of available generics, penalty for failure to precertify hospital admissions and payments over Reasonable and Customary (R&C) limits.*

4. *The annual maximum is the total paid in "essential health benefits" from January through December of each Plan Year.*

5. *Not subject to deductible.*

6. *Room and board charges for a semi-private or private room when medically necessary.*

7. *Treatment includes coverage for the correction of a physical or medical problem associated with infertility.*

8. *Acupuncture services are covered if medically necessary to treat a diagnosed medical condition and are 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.*

9. *Hospice services are covered only when under the supervision of a physician.*

10. *Participant is required to contact Highmark Healthcare Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered, plus an additional $300 penalty.*

11. *Eligibility for Plan M will be determined by Wider Church Ministries.*

12. *Under the comprehensive benefits program, health care benefits are provided as one integrated program. These benefits include coverage for hospital services, physician services, and many other covered services. Most benefits are subject to deductible and coinsurance provisions, which require you to share a portion of the medical costs.*

13. *Autism Spectrum Disorder (ASD) services are administered by ValueOptions. See page 24 for inpatient and outpatient benefit information. Precertification through ValueOptions is required (***1.800.565.4788***) for both inpatient and outpatient care. Benefit is limited to $2,500 per person/year. Benefits for physical therapy, speech therapy, and/or occupational therapy for ASD treatment is covered by the Plan's current combined therapy limit of $2,000 per person/year and will not reduce the Plan's annual limit for ASD services.*

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, the laws and regulations of the Commonwealth of Pennsylvania, 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 or prior authorizations, please call the Member Service number on 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.

Adult *(age 19+)* Preventive Schedule

General Health Care	
Pelvic / Breast Exam by Practitioner	Annually.
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.
Screening / Procedures	
Abdominal Aortic Aneurysm Screening	One-time screening by ultrasonography for men between age 65 and 75 who previously smoked.
Annual Routine CBC	Annually.
Annual Routine EKG	Annually.
Annual Routine Urinalysis	Annually.
Bone Mineral Density Screening	Once every 2 years: All women 65 years and older or men 70 years and older. Or, younger postmenopausal women who have had a fracture or have one or more risk factors for osteoporosis.
BRCA Mutation Screening	One-time genetic assessment for breast and ovarian cancer susceptibility as recommended by your doctor. Annual 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 MRIs are diagnostic and will follow your diagnostic benefits.)
Chlamydia, Gonorrhea, HIV and Syphilis Screenings	All sexually active males and females, 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.
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.
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 60 years of age and older.

1. *Includes discussion of alcohol use, blood pressure screening, depression, interpersonal 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.*

WOMEN'S SERVICES SCHEDULE

Services	
Contraception and Counseling	All women with reproductive capacity: patient education, counseling and Food and Drug Administration (FDA)-approved contraceptive methods, including sterilization and procedures as prescribed.
Well-Woman Visits	Up to 4 visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and the first visit to determine pregnancy.
Screenings/Procedures	
Gestational Diabetes Screening	All women: between 24 and 28 weeks of gestation. High-risk: at the first prenatal visit.
Human Immunodeficiency Virus (HIV) Counseling and Screening	Annually for all sexually active women.
Human Papillomavirus (HPV) Screening Testing	Screening every 3 years beginning at age 30.
Interpersonal and Domestic Violence Screening and Counseling	Annually.
Lactation (Breastfeeding) Counseling, Support and Supplies	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
Sexually Transmitted Infections Counseling	Annually for all sexually active women.

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

HAVE A GREATER HAND IN YOUR HEALTH

Maternity

The following services are considered preventive care for pregnant women.

You should expect to receive the following screenings and procedures.

- Gestational Diabetes Screening
- Hematocrit and/or Hemoglobin (Anemia)
- Hepatitis B screening and immunization, if needed
- HIV screening
- Rh typing during your first visit
- Rh antibody testing for Rh-negative women
- Tdap with every pregnancy
- Urine Culture and Sensitivity (C&S)

In addition, your doctor may discuss breastfeeding during weeks 28 through 36 and/or post-delivery, tobacco use and behavioral counseling to reduce alcohol use.

Prevention of Obesity

Benefits for Children

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

Benefits for Adults

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 the back of your ID card.

	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.

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.

MEMBER ASSISTANCE PROGRAM/WORK-LIFE BENEFITS

At times we all experience challenges at work or at home that affect our well-being and make it difficult to concentrate on our daily tasks. The Member Assistance Program (MAP)/Work-Life Benefits provides short-term counseling and referral services to help you address these personal or familial challenges–at no cost to the participant.

MAP services are:

- Confidential
- Available around the clock, every day of the year
- Available to Plan participants and immediate household dependents
- Accessible by:
  - Toll free number: **1.800.565.4788**
  - Online: **www.achievesolutions.net/ucc**
    - ID: open
    - Password: open

SUMMARY OF BENEFITS: MENTAL HEALTH AND SUBSTANCE ABUSE CARE THROUGH ValueOptions

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.

If you receive services from an out-of-network provider, you may be required to submit your claim to ValueOptions. Contact ValueOptions at **1.800.565.4788** to request a claim form. Complete the form and return it to the address on the form.

VALUEOPTIONS

Mental Health and Substance Abuse Claims Processing Service
ValueOptions
UCC Claims
P.O. Box 1347
Latham, NY 12110-1347

Precertification through ValueOptions is required for both inpatient and outpatient care, including services for Autism Spectrum Disorder (ASD)[6]. To request precertification, call **1.800.565.4788**.

Benefit: Mental Health & Substance Abuse Treatment Services [1]	Plans A, B, & C		Plan M [2]
	In-Network	Out-of-Network [3]	Comprehensive Coverage [4]
Inpatient [5] *Including residential treatment center services*	80%	60%	85%
Outpatient [6] *Including office visits, partial hospitalization, and intensive outpatient services*	100% after $25 copayment	60%	100% after $25 copayment

Mental Health and Substance Abuse Care Footnotes:

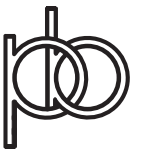
1. *Covered PPO network services and covered out-of-network services are those provided by or under the direction of a ValueOptions psychiatrist, doctoral-level psychologist, licensed pastoral counselor, licensed MSW or licensed MSN in sychiatric nursing.*
2. *Eligibility for Plan M will be determined by Wider Church Ministries.*
3. *Benefit payments are based on Reasonable and Customary (R&C) limits.*
4. *Under the comprehensive benefits program, health care benefits are provided as one integrated program. These benefits include coverage for hospital services, physician services, and many other covered services. Most benefits are subject to deductible and coinsurance provisions which require you to share a portion of the medical costs.*
5. *Benefits paid for mental health and substance abuse treatment are included in the annual maximum, annual deductible, and annual out-of-pocket maximum.*
6. *Autism Spectrum Disorder (ASD) services are limited to a benefit of $2,500 per person/year. Benefits for physical therapy, speech therapy, and/or occupational therapy for ASD treatment is covered by the Plan's current combined therapy limit of $2,000 per person/year and will not reduce the Plan's annual limit for ASD services. Claims for physical therapy, speech therapy, and/or occupational therapy should be submitted to Blue Cross Blue Shield. See pages 16-17 for additional information.*

The following is a sample copy of an **Explanation of Benefits *(EOB)*** from ValueOptions. You will receive an EOB from ValueOptions each time you or a covered family member receives treatment for mental health and for substance abuse.

ValueOptions UCC Claims
PO Box 1347
Latham, NY 12110

Electronic Service Requested

John Q. Public
700 Prospect Avenue
Cleveland, OH 44115-1110



Subscriber Name:	JOHN Q. PUBLIC
Patient ID:	12345678
Patient Name:	JOHN Q. PUBLIC
Provider Name:	ANY PROVIDER, MD
Parent Code:	UCH
Group Number:	UCH001
Claim #:	0111111080859
Check Date:	01/01/2009
Check #:	000000123

Explanation of Benefits -- This is NOT a Bill

Date of Service	Proc Code	Procedure Description									
		No. of Services	Charged Amount	Allowed Amount	Copay Amount	Co-Ins Amount	Precert Penalty	Remark Code	Deduct Amount	Other Amount	Paid Amount
0606-060608	90806	OFFICE VISIT 45-50 MIN									
		1	125.00	82.00	20.00	0.00	0.00	1	0.00	0.00	62.00
	Claim Total		125.00	82.00	20.00	0.00	0.00		0.00	0.00	62.00

Code **Message Description**

PROV ADDR: VALUEOPTIONS 433 RIVER TROY NY 12181 US

*** You, or your authorized representative, have the right to appeal if you disagree with any portion of the claim decision indicated on the Explanation of Benefits. Along with the claim determination, the Explanation of Benefits also lists the address and telephone number for contacting us. You may send your written appeal to the address shown. By calling the Customer Service number listed on the notice, you can also: (1) Request additional information that supports our decision on this claim (2) Find out more about the appeal rights for your benefit plan. If you request an appeal, you or your representative may submit any additional information you would like ValueOptions to consider in our decision. ValueOptions will notify you, or your representative, of the information we need to decide the appeal. Please note that a request for appeal is not considered complete until all necessary information has been received, at a minimum, the name of the patient for whom a denial is being appealed or a valid member number for the patient, and the dates for which a denial is being appealed. ValueOptions must receive your appeal request within 180 days from the date of the Explanation of Benefits notice, unless your benefit plan or state regulation allows a longer period to file an appeal. Appeal decisions are made within thirty *(30)* calendar days.

*** You can find a copy of ValueOptions Privacy Rules on our website at www.valueoptions.com

*** If you have questions regarding the payment of this claim, please contact ValueOptions at 1-866-670-8208 or write to us at ValueOptions UCC Claims; P.O. Box 1347, Latham, NY 12110-8847.

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. Abortions.
2. Assisted fertilization services related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization.
3. Bereavement services not provided by hospice care.
4. Case management services for care, treatment, or services that have been disallowed under the provisions of the Plan's case management system.
5. 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.
6. Confinement in a United States government or agency hospital, unless you would have to pay the expenses if you did not have coverage.
7. Corrective surgery for myopia, hyperopia or presbyopia, including radial keratotomy, LASIK, LASEK, and PRK.
8. 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 a functional impairment that results from a covered disease or injury are covered under the Plan.)*
9. Court-ordered services or services ordered by a tribunal as part of the participant's sentence.
10. Custodial care, domiciliary care, or residential care, protective and supportive care including education services and convalescent care.
11. 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.
12. Education, training, and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home.
13. 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.
14. 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. 37)*.
15. 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.
16. 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.

17. 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.
18. Genetic testing, unless medical documentation supports medical necessity.
19. Hospice services that are not provided under the supervision of a physician.
20. Inpatient admissions primarily for diagnostic studies and inpatient admissions primarily for physical therapy.
21. Light therapy products for treatment of medical and mental health disorders to include but not limited to a light box.
22. 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.
23. 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 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 which 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.
24. 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.
25. 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.
26. Nicotine cessation support programs and/or classes.
27. 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.
28. Prescription drugs for which there are over-the-counter equivalents and for which the Plan has discontinued coverage.
29. Private duty nursing care, unless required by a physician.
30. Respite care.
31. Reversal of sterilization.
32. Services for which the Enrollee has no legal obligation to pay.
33. Services provided by an immediate family member.
34. Services provided by an individual residing in the patient's home.
35. 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.

36. Services provided prior to the Enrollee's effective date of coverage.
37. 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.
38. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
39. 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.
40. Services provided by a licensed pastoral counselor, unless performed under mental health and substance abuse treatment.
41. Treatment for injury or illness suffered while committing a felony.
42. Treatment modalities for mental health and substance abuse care, to include but not limited to Prometa, Vagus Nerve Stimulation, Biofeedback *(except for the primary treatment of anxiety disorders)*, Applied Behavioral Analysis, Transcranial Magnetic Stimulation, or other modalities not specifically addressed herein that are newly developed or not generally recognized as routinely provided services.
43. 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.
44. 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.

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:

EXPRESS SCRIPTS®

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).

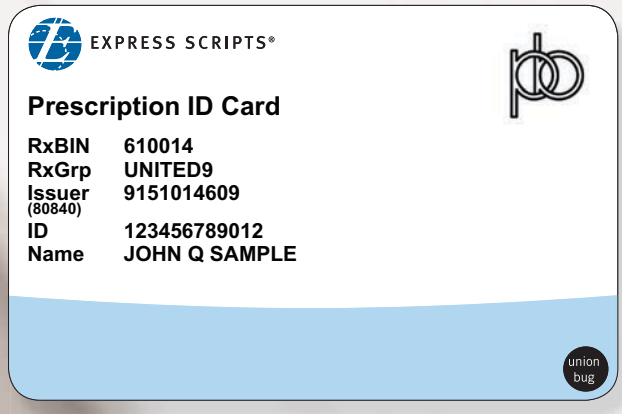
Participants enrolled in the plan prior to the Express Scripts/ Medco merger will continue to use their current ID cards.

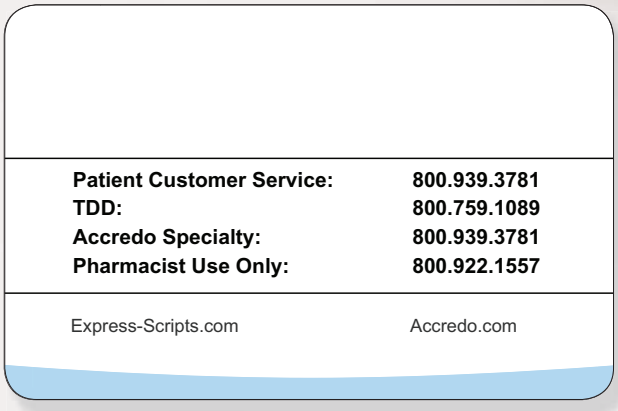
Specialty Medication Management

Your prescription drug program requires that certain specialty medications be accessed through Accredo Health Group, Inc., Express Scripts' specialty pharmacy. Specialty medications are drugs that are used to treat complex conditions and illnesses, such as growth hormone deficiency, hemophilia, hepatitis C, rheumatoid arthritis, etc. To confirm whether a medication you take is part of the specialty program, call Express Scripts at **1.800.939.3781** or visit **www.express-scripts.com**. To learn more about specialty medications, visit **www.accredo.com**.

You will receive prescription ID cards for you and your covered dependent(s) from Express Scripts upon enrollment in the Medical 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.

New participants enrolled after the Express Scripts/Medco merger will receive Express Scripts ID cards as pictured below.





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: Prescription Drugs [1]	Plans A, B, & C	Plan M [2]
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	15% coinsurance up to a maximum of $50 for: • a generic drug • a brand-name drug on the formulary • 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	15% coinsurance up to a maximum of $125 for: • a generic drug • a brand-name drug on the formulary • 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.*
2. *Eligibility for Plan M will be determined by Wider Church Ministries.*

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. 16)*.
9. Fertility drugs *(injectables)*.
10. Glucowatch/blood glucose sensors.
11. Immunization agents and vaccines. *(see **Adult Preventive Care Schedule**, p. 19 and **Children's Preventive Care Schedule**, p. 22-23). 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**.*
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. Mifeprex–RU486 *(also known as the pregnancy termination pill)*.
15. Non-federal legend drugs, which are not approved by the Food and Drug Administration *(FDA)*.
16. Non-sedating antihistamines.
17. Nutritional/dietary supplements or supplies.
18. Ostomy supplies.
19. Smoking deterrents.
20. Therapeutic devices or appliances.
21. Prescription drugs for which there are over-the-counter equivalents and for which the Plan has discontinued coverage.

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 family member 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 Oral 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. 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, 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.

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.

To find a VSP provider:

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

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

Plan benefits may be reduced if you or your dependent(s) have medical or dental benefits under another plan. If you have coverage under two medical plans, you may file claims under both. You will not be reimbursed more than 100% of the expense and no plan will pay more than it would have without a coordination provision. Certain rules govern which plan pays benefits first, but generally, the plan under which the individual is covered as an employee is the primary plan, and pays benefits first. The secondary plan may then pay the remainder of the claim. However, if the other plan does not have a coordination of benefits provision, it will be the primary plan.

If you and your spouse or same-gender domestic partner both carry children on your plans, generally the children's primary coverage is through the plan of the parent whose birthday comes first in the calendar year. For instance, a parent born on July 1 would have the primary plan if the other parent was born on August 1. If parents are divorced, special rules apply.

Effect of Coordination of Benefits: Benefits paid under this Plan for allowable expenses during a calendar year will be reduced to the extent necessary so that the sum of the benefits payable for the allowable expenses under this Plan and any other plan will not exceed the benefit amount normally payable under this Plan in the absence of other coverage.

SUBROGATION

If a covered employee 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 the third party 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, ValueOptions, 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.

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.

Mental Health/Substance Abuse Claim
If you wish to appeal denial of a mental health or substance abuse claim by ValueOptions, you should submit a written request for review to: ValueOptions Inc., The Pension Boards–United Church of Christ, Inc. Mental Health Care Plan, P.O. Box 1347, Latham, NY 12110-8847. You have 180 days following the denial of the claim to submit your appeal.

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, mental health/substance abuse claim by ValueOptions, 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. 39 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.

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

DEFINITIONS AND RELATED INFORMATION *(cont'd.)*

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. 35)*.

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 employee'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 of Medical/Surgical 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

MENTAL HEALTH/SUBSTANCE ABUSE CARE

*

1.800.565.4788
www.achievesolutions.net/ucc

CLAIMS PROCESSING

Mental Health/Substance Abuse Claims
ValueOptions–UCC Claims
P.O. Box 1347
Latham, NY 12110-1347

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

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

* **Preferred Provider Organizations**

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.

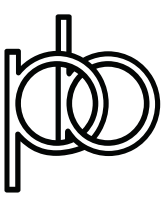
PROTECTED HEALTH INFORMATION *(PHI)*

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**.



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11/2014