Highlights of Your 2021 UCC Non-Medicare Medical and Dental Benefits Plan

Health | Dental | Vision Coverage

The Pension Boards
United Church of Christ, Inc.

WHERE FAITH & FINANCE INTERSECT

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

HEALTH PLAN MISSION

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

January 2021

Dear UCC Colleague,

We are pleased to provide you with this copy of **Highlights of Your UCC Non-Medicare Medical and Dental Benefits Plan**.

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

Your UCC Plan offers flexibility and choice, including:

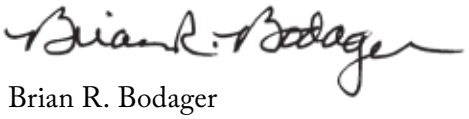
- Health Plan options through Blue Cross Blue Shield ranging from a low deductible plan to a high deductible health plan with a Health Savings Account.;
- a robust schedule of benefits to include all federally-mandated preventive health and essential health benefits and services as well as telemedicine through Teladoc and Assisted Fertilization Services;
- Healthy Stewards Wellness Rewards and Member Assistance Programs to help promote physical and mental health and well-being;
- physician and hospitalization coverage while traveling overseas;
- a pharmacy benefit offering a comprehensive nationwide formulary, low copays, and retail and mail-order services through Express Scripts, Inc.;
- an optional, stand-alone Dental Plan that does not require enrollment in the UCC Medical Plan;
- an optional, stand-alone Vision Plan that does not require participation in the UCC Medical Plan; and
- access to nationwide Preferred Provider Organizations (PPOs) for cost-effective health, 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 no-cost preventive care services offered as a way to prevent more serious health conditions has a significant 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.

Best regards,



Brian R. Bodager
President and Chief Executive Officer

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ABOUT THIS BOOKLET

The Pension Boards–United Church of Christ, Inc. is pleased to provide you and your family with a comprehensive health benefits program, offering flexibility and choice. This booklet contains information about the UCC Medical and Dental Benefits Plan ("the Plan") and applies to you if you meet the eligibility requirements stated on p. 8.

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

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

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

The UCC Medical and Dental Benefits Plan is an exempted Health Plan under The Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, an exempted Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being an exempted 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. Exempted health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

PLAN ADMINISTRATION

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

YOUR UCC MEDICAL AND DENTAL BENEFITS PLAN COORDINATES ACCESS TO HEALTH CARE SERVICES THROUGH THE FOLLOWING 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

PHARMACY SERVICES

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

DENTAL SERVICES

Access through Advantage Plus 2.0, 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

MEMBER ASSISTANCE PROGRAM

Access through Health Advocate, a leading clinical health advocacy company to a Licensed Professional Counselor or Work/Life Specialist for help with personal, family, and work issues

WELLNESS REWARDS PROGRAM

Access through Health Advocate to rewards for engaging in healthy lifestyle activities

CONTACTS

MEDICAL SERVICES

1.866.763.9471
www.highmarkbcbs.com

Blues on Call
1.888.258.3428

Precertification for Inpatient Services
Highmark Healthcare Management
1.800.452.8507

CLAIMS PROCESSING

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

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

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

PRESCRIPTIONS

Express Scripts Retail Pharmacy
1.800.939.3781

Mail Order Pharmacy
1.800.633.2662
www.express-scripts.com

CLAIMS PROCESSING

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

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

HEALTHY STEWARDS WELLNESS REWARDS AND MEMBER ASSISTANCE PROGRAM

Health Advocate
1.877.240.6863
www.healthadvocate.com

DENTAL SERVICES

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

CLAIMS PROCESSING

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

VISION SERVICES

1.800.877.7195
www.vsp.com

CLAIMS PROCESSING

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

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

TELADOC

Telemedicine Services
1.800.TELADOC (835.2362)
www.teladoc.com/Enter

AVAILABLE PLANS

You are eligible to participate in the following UCC Plans if you meet the eligibility requirements listed on p. 8 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 including medical and pharmacy coverage with the lowest out-of-pocket (deductible and coinsurance) cost.
Plan B:	A comprehensive health plan including medical and pharmacy coverage with mid-level out-of-pocket (deductible and coinsurance) cost.
Plan C:	A comprehensive health plan including medical and pharmacy coverage with a higher out-of-pocket (deductible and coinsurance) cost.
Plan HSA:	A comprehensive health plan including medical and pharmacy coverage with the highest deductible and out-of-pocket (deductible and coinsurance) cost tied to a health savings account.
Plan M:	This plan is available to individuals whose eligibility will be determined by Wider Church Ministries.

DENTAL PLAN

Dental 2000: A comprehensive stand-alone dental plan available to all eligible employees and their eligible dependents. The annual benefit maximum is $2,000 per person. A discounted dental premium is available when combined with enrollment in the Health Plan.

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 Plans described in this booklet if you are not eligible for Medicare,* and you are one of the following:

ELIGIBLE EMPLOYEE

- A full-time or part-time minister or lay employee who meets the eligibility requirements of a church or other UCC-related entity.
  - In the event your church does not cover the cost of your coverage, you may do so on a self-pay basis; or
- A Member in Discernment:
  - of a UCC Association or Conference acting as an Association
  - attending a semninary or other institution of higher education pursuing a degree in theology or related discipline; or or
- A non-UCC minister working for a UCC church or UCC-related entity; or
- A self-employed UCC minister who may be working for a non-UCC employer; or
- A UCC minister working for another denomination; or
- An Intentional UCC Interim Minister working for a UCC-related entity or a non-UCC employer.

*SPECIAL CONSIDERATION FOR MEDICARE-ELIGIBLE EMPLOYEES WHO ARE ACTIVELY WORKING

- If you continue UCC employment after age 65 and your employer has 20 or more 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 19 or less 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 Advantage 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 Advantage Plan with Rx**, is available online at **www.pbucc.org** or by calling the Pension Boards toll-free at **1.800.642.6543.**

ELIGIBLE DEPENDENTS

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

- Spouse
- Same-gender domestic partner
- Opposite-gender domestic partner
- Children up to the end of the month in which they reach age 26.
  - Your natural child(ren) or stepchild(ren);
  - Natural child(ren) or stepchild(ren) of your domestic partner, provided your domestic partner is enrolled in the Plan;
  - Children 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).
- 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;

APPLYING FOR COVERAGE

You may apply for coverage for yourself and your eligible dependent(s) by filing a Medical Benefits (Non-Medicare) 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 domestic partner within 90 days of the six-month anniversary of the commencement of your domestic partnership.

You may apply for such coverage outside of the initial 90 days of eligibility, 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.

WHEN COVERAGE STARTS

UCC Health Plan coverage for you and your eligible dependent(s) begins on the first day of the month following approval of your enrollment application. Applications must be received no later than five business days prior to the end of the month.

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 dependents ends the last day of the month that request for cancellation is made to the Pension Boards, when contributions are no longer made, or when you or your dependents are no longer eligible for coverage.

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

Upon termination of coverage, a continuation of coverage form is mailed along with corresponding rate contribution information.

COVERAGE WHILE LIVING ABROAD

Your coverage may be continued 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.

MILITARY SERVICE

If you are called to military service while enrolled in the Plan, you will be eligible for coverage upon return to your UCC-related employment. You must re-enroll within 90 days of your return. You may re-apply for coverage at a later date but satisfactory evidence of good health must be provided before coverage can begin.

CONTINUATION OF COVERAGE

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 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 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 domestic partner may continue their 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 employment begins.

For all other events that cause a loss of coverage, dependent children will continue to be covered for up to 24 months.

If you, your spouse or domestic partner, or dependent child(ren) are or become 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.

HOW THE MEDICAL PLAN WORKS

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 card.

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.

CLAIMS PROCESSING SERVICES

When you use a BlueCard PPO provider, your medical care provider will submit claims directly to their local Blue Cross Blue Shield plan.

To find a Highmark Blue Cross Blue Shield BlueCard PPO network provider:
call **1.866.763.9471**
or
visit **www.highmarkbcbs.com**

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, make a copy for your records, and mail it to the address on the form along with your itemized receipt.

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.

PREEXISTING MEDICAL CONDITIONS

Once you become a participant in the plan, there are no exclusions for preexisting conditions.

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.

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. You may also access an electronic ID card for your smartphone by visiting **www.highmarkbcbs.com**. Log in to your Highmark account for more information.

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**) to view your EOBs and claims detail.

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**.

INTERNATIONAL MEDICAL CARE

The Blue Cross Blue Shield Global Core 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 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. To learn more about Blue Cross Blue Shield Global Core, or to access an international claim form, visit **www.bcbsglobalcore.com**. See the **Summary of Benefits** (p. 16) for additional information regarding covered medical services.

Medical evacuation and repatriation of remains are not covered under this Plan. The Pension Boards recommends you purchase a separate travel policy to cover these services.

CASE MANAGEMENT SERVICES

The Plan includes case management services provided by Blues on Call. 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 at **1.888.258.3428**.

CONDITION/DISEASE MANAGEMENT

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

- assists in the management of individuals' 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.

MATERNITY BENEFITS, EDUCATION, AND SUPPORT SERVICES

Use Participating Network Providers: Please use the services of Highmark Blue Cross Blue Shield participating network providers to receive maximum benefits under your health plan. To locate a Blue Cross Blue Shield participating provider, call **1.866.763.9471**, or visit **www.highmarkbcbs.com** and click on **Find a Provider**. Please have your provider confirm benefit coverage by contacting Highmark Blue Cross Blue Shield at **1.866.763.9471**.

Present Your Identification Card: Please remember to present your Blue Cross Blue Shield Identification card on your first visit to your provider. Also, please know that your pharmacy benefits are provided under Express Scripts, for which there is a separate ID card.

Benefits Provided: Listed below are the benefits, education, and support services included in your Maternity Benefit under the UCC Non-Medicare Health Plan.

PREVENTIVE CARE FOR PREGNANT WOMEN – BENEFITS COVERED AT NO COST

- Gestational diabetes screening
- Hepatitis B screening and immunization, if needed
- HIV screening
- Syphilis screening
- Smoking/alcohol cessation counseling
- One depression screening for pregnant women and one for postpartum women
- Rh typing at first visit
- Rh antibody testing for Rh-negative women
- Tdap (Tetanus, Diphtheria, Pertussis) vaccine with every pregnancy
- Urine culture and sensitivity at first visit
- Breastfeeding education

MATERNITY BENEFITS

- Prenatal care, including labs, labor and delivery, hospital stay, postnatal care, and the treatment of any pregnancy-related complications are covered.
- Deductibles will vary, depending upon the Plan (A, B, C, M, or HSA) you are enrolled in.
- Prenatal maternity office visits are covered at 100% (copay and deductible do not apply).

- Outpatient maternity services, including labs, diagnostic services, etc., are covered at 100% (after deductible).
- Inpatient maternity services, including labor and delivery room, etc., are covered at 100% (after deductible).
- The Plan covers 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.

ANTEPARTUM SERVICES

The Plan covers the following services to determine the health of the baby or if you have a high-risk pregnancy:

- Amniocentesis
- Cordocentesis
- Chorionic villi sampling
- Fetal stress test
- Electronic fetal monitoring

LABOR AND DELIVERY

The Plan covers medically-necessary services during your labor and delivery, including anesthesia, fetal monitoring, and other services required for your care during your stay.

The Plan will cover Caesarean section when needed. If you choose to have a Caesarean section instead of vaginal delivery for personal reasons, you may be responsible for some of the costs.

MATERNITY EDUCATION AND SUPPORT

Participants who become pregnant can take advantage of programs available through Highmark Blue Cross Blue Shield.

To enroll in the Baby BluePrints program, call **1.866.918.5267** for access to the following services:

- 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
- 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

BENEFITS NOT PROVIDED

- Non-medically required ultrasounds, including ultrasounds to determine gender
- Private rooms at hospitals where there are shared rooms available
- Umbilical cord collection and storage
- Non-medical support during labor and childbirth, such as a doula

Upon discharge of the mother, future services are covered at standard Plan benefit levels. Services received by the newborn while the mother remains in the hospital are covered under the maternity benefit.

In the event the newborn remains in the hospital after the discharge of the mother, services are covered at standard Plan benefit levels.

FREQUENTLY ASKED QUESTIONS

Q. In the event of miscarriage, what is the coverage for a Dilation and Curettage (D&C) procedure?

A. A D&C procedure is covered under "Global Maternity Benefits." (Deductible may apply.)

Q. What coverage is available for abortions?

A. Abortion is a covered benefit:

- All elective and voluntary services received are covered per Plan policies
- Deductibles, copays, and co-insurance may apply

Q. What if a claim has not been processed per my Plan benefits?

A. Contact a Pension Boards Health Plan Representative at **1.800.642.6543,** or contact Highmark Blue Cross Blue Shield at **1.866.763.9471**.

Q. Can my newborn grandchild be added to my health plan coverage?

A. No. Your grandchild does not qualify as a dependent under your coverage unless he/she has been adopted, or you have begun adoption proceedings. In addition, coverage for newborn grandchildren ends at the time of the mother's hospital discharge.

Q. How do I ensure my baby is added to my UCC Health Plan?

A. Please visit our website, **www.pbucc.org**, to download a copy of the Medical Benefits (Non-Medicare) Enrollment Application. You may also obtain a copy by calling **1.800.642.6543**. Return the completed application with your church or employer's signature. This should be done as soon as possible, and no later than 90 days after the birth. Please also provide the Pension Boards with a copy of your child's birth certificate and Social Security card as soon as they become available.

For additional questions, contact:

Highmark Blue Cross Blue Shield Member Service: 1.866.763.9471

Pension Boards Health Services Representative: 1.800.642.6543

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.

TELEMEDICINE

Virtual visits with a Teladoc healthcare provider are covered under the plan. Participants can connect with a board certified physician via phone, video or mobile app. Teladoc can treat many non-emergency medical conditions including cold & flu symptoms, sinus problems, dermatology and mental health. When determined necessary, medications can be prescribed.

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 that provides participants with free information and tools needed to make positive lifestyle choices.

Visit healthadvocate.com/members for additional information on how to participate and receive incentives for completion of wellness activities.

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. 20-24) for more information.

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.

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	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 [3]	$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
Urgent Care	100% after $25 copayment	60% after deductible	100% after $25 copayment
Preventive Care *Follows Preventive Care Schedule* *Adult and Child* 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
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
Assisted Fertilization Services [7]	80% after deductible	60% after deductible	80% after deductible
Autism Spectrum Disorder	80% after deductible	60% after deductible	80% after deductible
Medical/Surgical Expenses (Except Office Visits)	80% after deductible	60% after deductible	80% after deductible
Gender Identity Services Inpatient	80% after deductible	60% after deductible	80% after deductible
Outpatient	100% after $25 copayment [5]	60% after deductible	80% after deductible
Teladoc Services	100% after $10 copayment	Not-Covered	100% after $10 copayment
Diagnostic Services (Lab, X-Ray and other tests)	80% after deductible	60% after deductible	80% after deductible
Mental Health and Substance Abuse Treatment Services Inpatient (Including residential treatment center services)	80% after deductible	60% after deductible	80% after deductible
Outpatient Including office visits, partial hospitalization, and intensive outpatient services	100% after $25 copayment	60% after deductible	100% after $25 copayment
Allergy Testing	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
Durable Medical Equipment, Orthotics, and Prosthetics	80% after deductible	60% after deductible	80% after deductible
Hearing Aids	100% Limit: $3,000 per person/every 3 years	100% Limit: $3,000 per person/every 3 years	100% Limit: $3,000 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

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. 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
60% after deductible	100% after $25 copayment	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
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
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	
Not-Covered	100% after $10 copayment	Not-Covered	100% after $10 copayment
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible	80% after deductible	60% after deductible	85% after deductible
60% after deductible	100% after $25 copayment	60% after deductible	100% after $25 copayment
86% after deductible Limit: $2,000 per person/year	70% after deductible Limit: $2,000 per person/year	85% 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
100% Limit: $3,000 per person/every 3 years	100% Limit: $3,000 per person/every 3 years	100% Limit: $3,000 per person/every 3 years	100% Limit: $3,000 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

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, and all non-covered services.
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. Lifetime maximum of $10,000 in medical services & $10,000 in pharmacy services. Contact Highmak BCBS for specific coverage details.
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.
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.

SUMMARY OF BENEFITS: ADDITIONAL ANCILLARY SERVICES

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.

Benefit	Plans A and B		Plan C		HSA		Plan M
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	Comprehensive Coverage[3]
Spinal Manipulation/ Chiropractic Services	80% after deductible	60% after deductible	70% after deductible	50% after deductible	60% after deductible	50% after deductible	85% after deductible
	Limit: $2,000 per person/year						
Physical, Speech, Occupational Therapy	80% after deductible	60% after deductible	70% after deductible	50% after deductible	60% after deductible	50% after deductible	85% after deductible
Acupuncture [8]	80% after deductible	60% after deductible	70% after deductible	50% after deductible	60% after deductible	50% after deductible	85% after deductible
	Limit: $2,000 per person/year						

SUMMARY OF BENEFITS: COVERAGE WITH A HEALTH SAVINGS ACCOUNT

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). The following medical and pharmacy schedule of benefits show what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital. The plan out-of-pocket limit includes prescription drug expenses, deductible and coinsurance. Please contact the Pension Boards for assistance in setting up your Health Savings Account.

Prescription Drugs		
Benefit	When purchased at an Express Scripts network retail pharmacy Up to a 30-day supply	When purchased through the Mail Order Pharmacy Up to a 90-day supply
Generic Drugs	60% coinsurance after deductible, max $34	60% coinsurance after deductible, max $80
Brand-name Drug, formulary	60% coinsurance after deductible, max $100	60% coinsurance after deductible, max $250
Brand-name Drug, non-formulary	60% coinsurance after deductible, max $500	60% coinsurance after deductible, max $1,000

See page 32 for Prescription Plan exclusions

SUMMARY OF BENEFITS: HSA PLAN THROUGH HIGHMARK BLUE CROSS BLUE SHIELD

Benefit	In-Network	Out-of-Network [2] (page 18)
Deductible Individual Family	 $3,000 $6,000	 $9,000 $18,000
Payment Level/Coinsurance	60% after deductible until out-of-pocket maximum is met; then 100%	50% after deductible until out-of-pocket maximum is met; then 100%
Out-of-Pocket Maximums Individual Family	 $6,900 Individual $13,800 Family	 $20,000 Individual $40,000 Family
Annual Maximum [4] (page 18)	No Limit	No Limit
Physician Office Visits	60% after deductible	50% after deductible
Urgent Care	60% after deductible	50% after deductible
Preventive Care *Follows Preventive Care Schedule Adult and Child* Routine physical exams	 100% - deductible does not apply	 Not Covered
Eye exam	$40 after deductible	$40 after deductible
Pediatric immunizations	100% - deductible does not apply	Not Covered
Emergency Room Services	60% after deductible	60% after in-network deductible
Ambulance	60% after deductible	50% after deductible
Hospital Expenses Inpatient [6]	60% after deductible	50% after deductible
Outpatient	60% after deductible	50% after deductible
Maternity Office Visits	100% - deductible does not apply	50% after deductible
Outpatient (Labs, diagnostic services, etc.)	100% after deductible	50% after deductible
Inpatient (Labor and delivery room, etc.)	100% after deductible	50% after deductible
Assisted Fertilization Services [7]	60% after deductible	50% after deductible
Autism Spectrum Disorder	60% after deductible	50% after deductible
Medical/Surgical Expenses	60% after deductible	50% after deductible
Gender Identity Services Inpatient	60% after deductible	50% after deductible
Outpatient	60% after deductible	50% after deductible
Teladoc Services	$10 after deductible	Not Covered
Diagnostic Services (Lab, X-Ray and other tests)	60% after deductible	50% after deductible
Mental Health and Substance Abuse Treatment Services Inpatient (Including residential treatment center services)	60% after deductible	50% after deductible
Outpatient Including office visits, partial hospitalization, and intensive outpatient services	60% after deductible	50% after deductible
Allergy Testing	60% after deductible Limit: $2,000 per person/year	50% after deductible Limit: $2,000 per person/year
Durable Medical Equipment, Orthotics, and Prosthetics	60% after deductible	50% after deductible
Hearing Aids	100% after deductible Limit: $3,000 per person/every 3 years	50% after deductible Limit: $3,000 per person/every 3 years
Skilled Nursing Facility Care	60% after deductible	50% after deductible
Home Health Care	60% after deductible	50% after deductible
Private Duty Nursing	60% after deductible	50% after deductible
Hospice [9] (page 18)	60% after deductible	50% after deductible

ADULT (AGE 19+) PREVENTIVE SCHEDULE

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

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

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

Adults: Ages 19+

Female Male

GENERAL HEALTH CARE	
Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Depression Screening	Once a year
Pelvic, Breast Exam	Once a year
SCREENINGS/PROCEDURES	
Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Cholesterol (Lipid) Screening	• Ages 20 and older: Once every 5 years • High-risk: More often
Colon Cancer Screening (Including Colonoscopy)	• Ages 50 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
Certain Colonoscopy Preps With Prescription	• Ages 50 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
Hepatitis B Screening	High-risk
Hepatitis C Screening	Ages 18-79
Latent Tuberculosis Screening	High-risk
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years

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

HIGHMARK. Blue Cross Blue Shield

Adults: Ages 19+

SCREENINGS/PROCEDURES	
Mammogram	Ages 40 and older: Once a year including 3D
Osteoporosis (Bone Mineral Density) Screening	Age 65 and older: Once every 2 years, or younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 to 65 PAP: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV only or combined PAP and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)	Sexually active males and females
IMMUNIZATIONS**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
Diphtheria, Tetanus (Td/Tdap)	One dose Tdap, then Td or Tdap booster every 10 years
Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia, and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
Hepatitis A	At-risk or per doctor's advice: One 2- or 3-dose series
Hepatitis B	At-risk or per doctor's advice: One 2- or 3-dose series
Human Papillomavirus (HPV)	• To age 26: One 3-dose series • Beginning on 9/1/2020: Ages 27-45, at-risk or per doctor's advice
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
Shingles	• Zostavax - Ages 60 and older: One dose • Shingrix - Ages 50 and older: Two doses
PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Aspirin	• Ages 50 to 59, to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Chemoprevention drugs such as raloxifene, tamoxifen, or aromatase* inhibitor beginning on 10/1/2020**	At risk for breast cancer, without a cancer diagnosis, ages 35 and older
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
Low to Moderate Dose Select Generic Statin Drugs for Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater
Select PrEP Drugs for Prevention of HIV Infection	Adults at risk for HIV infection, without an HIV diagnosis
PREVENTIVE CARE FOR PREGNANT WOMEN	
Screenings and Procedures	• Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening during pregnancy and postpartum • Depression prevention counseling during pregnancy and postpartum • Rh typing at first visit • Rh antibody testing for Rh-negative women • Tdap with every pregnancy • Urine culture and sensitivity at first visit • Alcohol misuse screening and counseling
PREVENTION OF OBESITY, HEART DISEASE, AND DIABETES	
Adults With BMI 25 to 29.9 (Overweight) and 30 to 39.9 (Obese) Are Eligible for:	• Additional annual preventive office visits specifically for obesity and blood pressure measurement • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – ALT – AST – Hemoglobin A1c or fasting glucose – Cholesterol screening
ADULT DIABETES PREVENTION PROGRAM (DPP)	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140-199mg/dl	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss

* Meningococcal B vaccine per doctor's advice.
** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.
*** Aromatase inhibitors effective 10/1/2020 when the other drugs can't be used such as when there is a contraindication or they are not tolerated.

CHILDREN'S PREVENTIVE SCHEDULE

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

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

Children: Birth to 30 Months[1]

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

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

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

Children: 3 Years to 18 Years[1]

GENERAL HEALTH CARE	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												●
Depression Screening									Once a year from ages 11 to 18			
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	●
SCREENINGS												
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9–11 and ages 17–21					
IMMUNIZATIONS												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap			
Flu (Influenza)******	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9–14. 3 doses, all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*******									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										
CARE FOR PATIENTS WITH RISK FACTORS												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening											High-risk	
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)									For all sexually active individuals HIV routine check once between ages 15–18			
Tuberculin Test	Per doctor's advice											

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment. ** To confirm new diagnosis of high blood pressure before starting treatment. *** Hearing screening once between ages 11-14, 15-17, and 18-21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4, and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit. **** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network. ***** Meningococcal B vaccine per doctor's advice.

Children: 6 Months to 18 Years[1]

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride
PREVENTION OF OBESITY AND HEART DISEASE	
Children With a BMI in the 85th to 94th Percentile (Overweight) and the 95th to 98th Percentile (Obese) Are Eligible For:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100–125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140–199mg/dl	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss

INFORMATION ABOUT THE AFFORDABLE CARE ACT (ACA)

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

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

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

WHAT THE MEDICAL PLAN DOES NOT COVER

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

1. Bereavement services not provided by hospice care.
2. Case management services for care, treatment, or services that have been disallowed under the provisions of the Plan's case management system.
3. Comfort/convenience items for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical equipment, stair glides, elevators, lifts, or "barrier-free" home modifications, whether or not specifically recommended by a physician.
4. Confinement in a United States government or agency hospital, unless you would have to pay the expenses if you did not have coverage.
5. Corrective surgery for myopia, hyperopia, or presbyopia, including radial keratotomy, LASIK, LASEK, and PRK.
6. Cosmetic surgery for cosmetic purposes done to improve the appearance of any portion of the body and from which no improvement in physiological function can be expected, except as otherwise provided herein. (Surgery to correct a condition resulting from an accident, a congenital birth defect, and a functional impairment that results from a covered disease or injury are covered under the Plan.)
7. Court-ordered services or services ordered by a tribunal as part of the participant's sentence.
8. Custodial care, domiciliary care, or residential care, protective and supportive care including education services and convalescent care.
9. Dental care, except for professional services and anesthesia for removal of bony impactions of third molar(s) when performed by a doctor of dental surgery.
10. Education, training, and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home.
11. Experimental/investigative services and clinical research programs. All charges relating to a diagnosis and treatment procedures that are, in the sole determination of the Pension Boards, deemed to be experimental, investigative, unproven, for purposes of research, not medically necessary, or not generally accepted by the United States medical profession or approved by the Food and Drug Administration. The Plan does not cover services that are considered experimental by the medical profession of the United States or any other country.
12. Eyeglasses or contact lenses, except for initial pair of glasses/contact lenses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury. Benefits are available under the stand-alone Vision Plan (see p. 37).
13. Fees for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form and the preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as premarital examinations.

14. Food including, but not limited to, enteral formulae, infant formulae, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.
15. Foot care, palliative or cosmetic, including flat-foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except capular or bone surgery), calluses, toenails (except surgery for ingrown nail), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
16. Genetic testing, unless medical documentation supports medical necessity.
17. Hospice services that are not provided under the supervision of a physician.
18. Inpatient admissions primarily for diagnostic studies and inpatient admissions primarily for physical therapy.
19. Light therapy products for treatment of medical and mental health disorders to include but not limited to a light box.
20. Medical evacuation and repatriation of remains is not a covered benefit.
21. 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.
22. Military service-related losses or expenses incurred while on active duty as a member of the armed forces of any nation or losses sustained or expenses incurred as a result of any war, whether or not declared.
23. Motor vehicle accident injuries–services for treatment for injuries resulting from the maintenance or use of a motor vehicle if the services/treatment have been paid or are payable under a plan/policy of motor vehicle insurance. This includes a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefit established by state law. Payment for such injuries may be coordinated with your other insurance after those benefits have first been exhausted. The Medical Plan will then pay on a secondary basis.
24. Nicotine cessation support programs and/or classes. Coverage for prescribed smoking deterrents is available under your pharmacy (Express Scripts) benefits.
25. Physicals for school, camp, sports, travel, or any other administrative reason, that are not medically necessary and appropriate, except as provided herein or required by law.
26. Prescription drugs for which there are over-the-counter equivalents and for which the Plan has discontinued coverage.

27. Private duty nursing care, unless required by a physician.
28. Respite care.
29. Reversal of sterilization.
30. Services for which the enrollee has no legal obligation to pay.
31. Services provided by an immediate family member.
32. Services provided by an individual residing in the patient's home.
33. Services that are not medically necessary and appropriate as determined by the Plan or have been disallowed under the provisions of the Plan's case management system.
34. Services provided prior to the enrollee's effective date of coverage.
35. Services that are submitted by a certified registered nurse or another professional provider for the same services performed on the same date for the same enrollee.
36. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
37. Treatment for injury or illness suffered while committing a felony.
38. Mental health and substance use care treatment modalities including Prometa, or other modalities that are newly-developed or not generally recognized as routinely-provided services.
39. Weight reduction programs, except for medical and surgical treatment of morbid obesity when determined to be medically necessary.
40. 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

The UCC Medical Benefits Plan includes a prescription benefit administered by Express Scripts. Neither the medical or prescription benefit may be purchased separately. 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 30-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

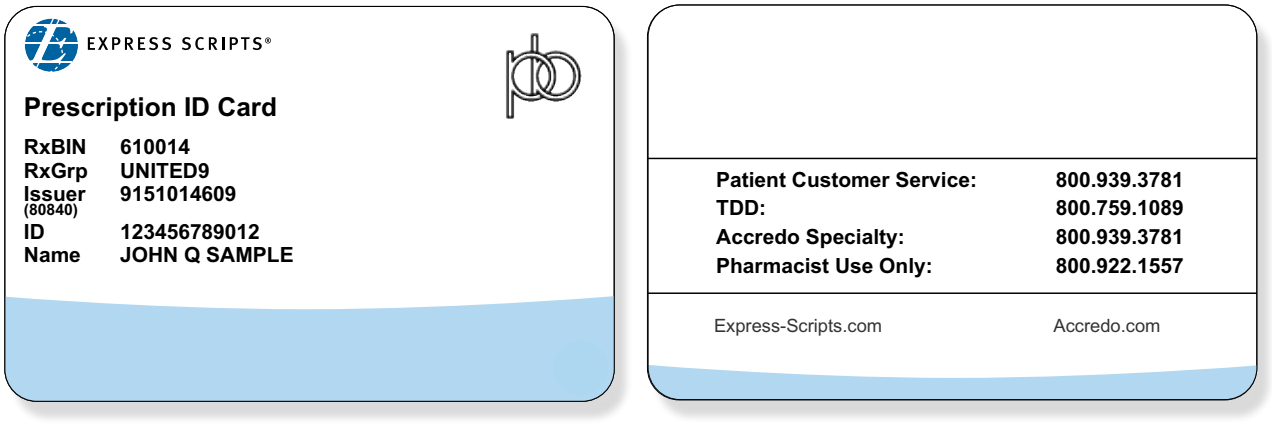
Prior authorization is a program that lets you get the effective medicine that you and your family need and helps your plan sponsor maintain affordable prescription drug coverage for everyone your plan covers. When your pharmacist tells you that your prescription needs a prior authorization, Express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

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**.

ID CARDS

You will receive prescription ID cards for you and your covered dependent(s) from Express Scripts upon enrollment in the Medical Plan. You may also access an electronic ID card for your smartphone by visiting **www.express-scripts.com**. Log in to your Express Scripts account to learn more.



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. See specific benefit levels on the next page.

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 copay for a generic drug $30 copay for a brand-name drug on the formulary $45 copay 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 copay for a generic drug $75 copay for a brand-name drug on the formulary $115 copay 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, non-clinical 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. Glucowatch/blood glucose sensors.
10. Lost, stolen, or damaged drugs.
11. 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.
12. Non-federal legend drugs, which are not approved by the Food and Drug Administration (FDA).
13. Non-sedating antihistamines.
14. Nutritional/dietary supplements or supplies.
15. Ostomy supplies.
16. Smoking deterrents, unless those prescribed by your physician.
17. Therapeutic devices or appliances.
18. Prescription drugs for which there are over-the-counter equivalents and for which the Plan has discontinued coverage.

HOW THE DENTAL PLAN WORKS

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

PREFERRED PROVIDER ORGANIZATION (PPO)–ADVANTAGE PLUS 2.0

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

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

To find an
Advantage Plus 2.0 PPO
network provider:

call **1.866.851.7576** or
visit **www.ucci.com**

Submit dental claims to:

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

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 DO120	(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

The above 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.

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 Annual Deductible Annual Benefit Maximum/per person	**Dental 2000** $100/person or $200/family $2,000	
Type of Service *Applies to both Dental 2000 and Dental 750 Plans*	**In-Network[2]**	**Out-of-Network[3]**
Preventive Services and Supplies[4]: • Cleaning and oral examination–two times per calendar year • Fluoride application to child's teeth, age 16 and under–two times per calendar year • Dental sealants, age 16 and under • Space maintainers, age 16 and under	100%	Plan pays 100% up to R&C limits
Diagnostic and Therapeutic Services and Supplies: • 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[5] • 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[6] • Crowns[6]	80% 50%	Plan pays 80% up to R&C limits Plan pays 50% up to R&C limits
Prosthetic Services and Supplies[7]: • Full or partial dentures or fixed bridges • Repair or rebasing of dentures or bridges	50%	Plan pays 50% up to R&C limits
Orthodontics up to a $1,500 per person lifetime maximum	50% after separate deductible per person	50% up to R&C limits after separate deductible per person

DENTAL PLAN FOOTNOTES:

1. Advantage Plus 2.0 PPO network provides access to dental care at a lower cost than out-of-network providers.
2. Benefit payments are based on Reasonable and Customary (R&C) limits.
3. Preventive Services do not apply towards the plan's annual maximum.
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.
6. Implants: Have your dental provider contact United Concordia for information regarding predetermination of services.

WHAT THE DENTAL PLAN DOES NOT COVER

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

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

HOW THE VISION PLAN WORKS

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

PREFERRED PROVIDER ORGANIZATION (PPO)–VSP

VSP's network consists of nationwide 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, 2020, you will not be eligible for another eye exam until May 1, 2021. If you received eyeglass frames on July 1, 2020, you will not be eligible for new frames until July 1, 2022.

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 the Pension Boards will be sent to the participant once their initial application has been processed. Participants can provide their personal information to VSP providers at the time of service in lieu of an ID card.

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

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

SUMMARY OF BENEFITS: VISION BENEFITS THROUGH VSP

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

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10 for exam and glasses	Every 12 months
PRESCRIPTION GLASSES			
FRAME	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco, Walmart and Sam's Club frame 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 ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$50 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every 12 months
DIABETIC EYECARE PLUS PROGRAM	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a 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

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Exam ..... up to $50	Lined Bifocal Lenses ..... up to $75	Progressive Lenses ..... up to $75
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $100	Contacts ..... up to $105
Single Vision Lenses ..... up to $50		

Coverage with a retail chain may be different or not apply. Once your benefit is effective, visit vsp.com for details. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

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 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 (e.g., Court Order).

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 their covered dependent(s) to cooperate with the Plan's administration requirements and efforts to enforce the Plan's rights to subrogation and reimbursement.

YOUR RIGHTS TO APPEAL

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

FIRST LEVEL:

Medical Claim

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

Pharmacy Claim

If you wish to appeal the denial of a pharmacy claim by Express Scripts, you should submit a written request for a review to: Express Scripts, Attention: Admministrative Appeals Department, P.O. Box 66587, St. Louis, MO 63166-6587.
Phone #: **800.946.3979**

Dental Claim

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

Vision Claim

If you wish to appeal the denial of a vision claim by VSP you should contact VSP at **1.800.877.7195** or submit a written request to: VSP, P.O. Box 997105, Sacramento, CA 95899-7105.

SECOND LEVEL:

If you wish to appeal the decision related to the request for a review, you should submit a written request for the appeal within 180 days following the date of the denial of a medical claim by Highmark, pharmacy claim by Express Scripts, dental claim by United Concordia, or vision claim by VSP to: Director of Health Plan Operations, Pension Boards–UCC, 475 Riverdside 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.

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

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

Coordination of Benefits: When coverage exists under two health plans, benefits may be paid under both plans. Certain restrictions and guidelines apply with regard to reimbursement amount, which plan is primary, etc. See p. 39 for additional information.

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

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

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

Dependent: An eligible spouse, domestic partner, or child(ren). See p. 8 for additional information.

Domestic Partner: A person who meets the financial, cohabitation, and other requirements established by the Pension Boards. To apply for benefits, you must submit a Statement of Domestic Partnership after you have been in the domestic partnership for at least six months.

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

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

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

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

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

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

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

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

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

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

Plan: The UCC Medical and Dental Benefits Plan.

Plan HSA: A high deductible consumer driven health plan which includes a health savings account.

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. 33).

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 a participant's child(ren).

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

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

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

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**.

Notes

The Pension Boards
United Church of Christ, Inc.

09-2020