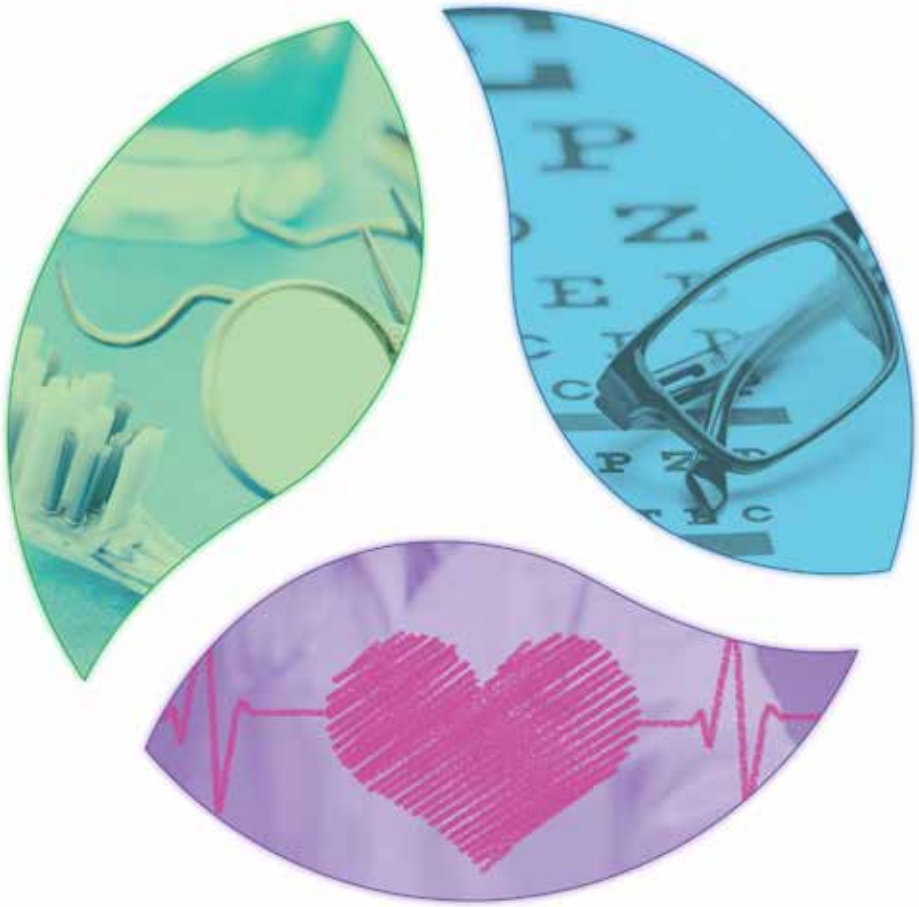
The Pension Boards
United Church of Christ, Inc.



Highlights of Your UCC Medical and Dental Benefits Plan

For individuals who are not eligible for medicare

Health Coverage **Dental Coverage** **Vision Coverage**

The Pension Boards
United Church of Christ, Inc.

WHERE FAITH & FINANCE INTERSECT

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

HEALTH PLAN MISSION

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

January 2018

Dear UCC Colleague,

We are pleased to provide you with this copy of **Highlights of Your UCC Medical and Dental Benefits Plan** *(for individuals who are not eligible for Medicare)*.

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:

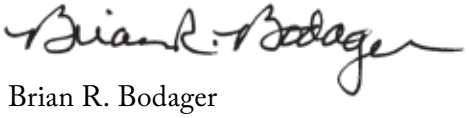
- three Health Plan options through Blue Cross Blue Shield that offer various levels of premiums, deductibles, copays, and benefits;
- a robust schedule of benefits to include all federally-mandated preventive health and essential health benefits and services;
- Healthy Stewards Wellness Rewards and 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.;
- two Dental Plan options, including a stand-alone entry-level Plan for those not previously enrolled in UCC dental coverage;
- an optional, stand-alone Vision Plan that does not require participation in the UCC Medical Plan; and
- access to nationwide Preferred Provider Organizations (PPOs) for cost-effective 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, have a significant impact on 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. 7.

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

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

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

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

PLAN ADMINISTRATION

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

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

MEDICAL SERVICES (INCLUDING MENTAL HEALTH AND SUBSTANCE ABUSE 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.

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.

AVAILABLE PLANS

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

HEALTH PLANS

Plan A: A comprehensive health plan with the lowest out-of-pocket (deductible and coinsurance) cost.

Plan B: A comprehensive health plan with mid-level out-of-pocket (deductible and coinsurance) cost.

Plan C: A comprehensive health plan with the highest out-of-pocket (deductible and coinsurance) cost.

Plan M: This plan is available to individuals whose eligibility will be determined by Wider Church Ministries.

DENTAL PLANS

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

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

VISION PLANS

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

ELIGIBILITY FOR BENEFITS

You are eligible to participate in the UCC Health Plan if you are a citizen or reside in the United States, 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
- Attending a seminary or other institution of higher education pursuing a degree in theology or related discipline; or
- A Member in Discernment of a UCC Association or Conference acting as an Association; 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 more than 20 employees, the Pension Boards recommends that you do not sign up for Medicare Part B at this time; however you must enroll in Medicare Part A. The UCC (Non-Medicare) Plan will remain the primary insurer until you retire, terminate employment with the UCC, or terminate your medical benefit coverage through the UCC Health Plan.
- If you continue UCC employment after age 65 and your employer has fewer than 20 employees, you will be required to enroll in Medicare Parts A and B in order to maintain eligibility for benefits under the UCC Plan. Your coverage will be transferred to the UCC Medicare Supplement Plan with Rx. If you do not enroll for Medicare benefits, you will no longer be eligible for benefits through the UCC Plan. The booklet, **Highlights of Your UCC Medicare Supplement Plan**, is available online at **www.pbucc.org** or by calling the Pension Boards toll-free at **1.800.642.6543.**

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

APPLYING FOR COVERAGE

You may apply for coverage for yourself and your eligible dependent(s) by filing a Medical Benefits Enrollment Application with the Pension Boards

within 90 days of your initial eligibility to participate in the UCC Medical and Dental Benefits Plan. You must apply for employee coverage in order to apply for dependent coverage.

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

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

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 receipt of your enrollment application if you apply for coverage within the 90-day eligibility period.

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

WHEN COVERAGE ENDS

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

Coverage for your spouse or domestic partner will end when your coverage ends or when they no longer qualify as your eligible dependent.

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

SEMINARY STUDENTS

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

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

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 of 20 or more hours per week prior to the 24-month limit, you may continue Plan coverage for up to 90 days after such employment begins. However, the 90 days may not extend beyond the 24-month overall limit.

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

In the event of your death, your spouse or 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 they become employed for 20 or more hours per week.

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 is or becomes totally disabled (as defined by the Social Security Act) at any time during the first 60 days of coverage, the continuation of coverage will be extended from 24 months to 29 months.

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. You may also visit **www.pbucc.org** to obtain a claim form.

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

There are no restricitions for preexisting conditions for participants in the Plan.

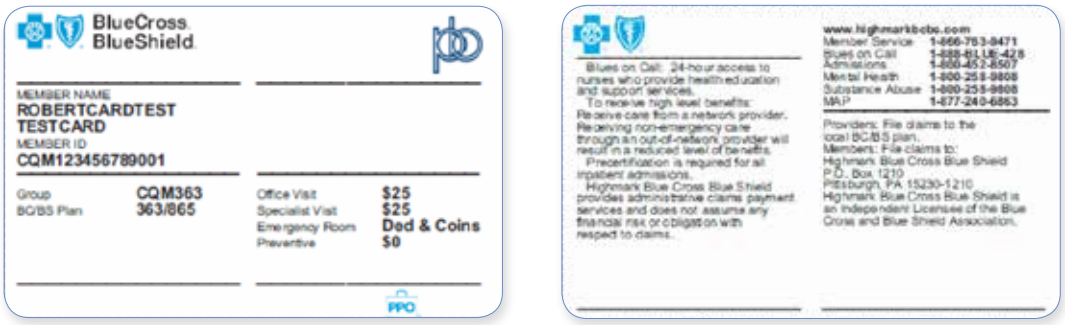
PRECERTIFICATION

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.

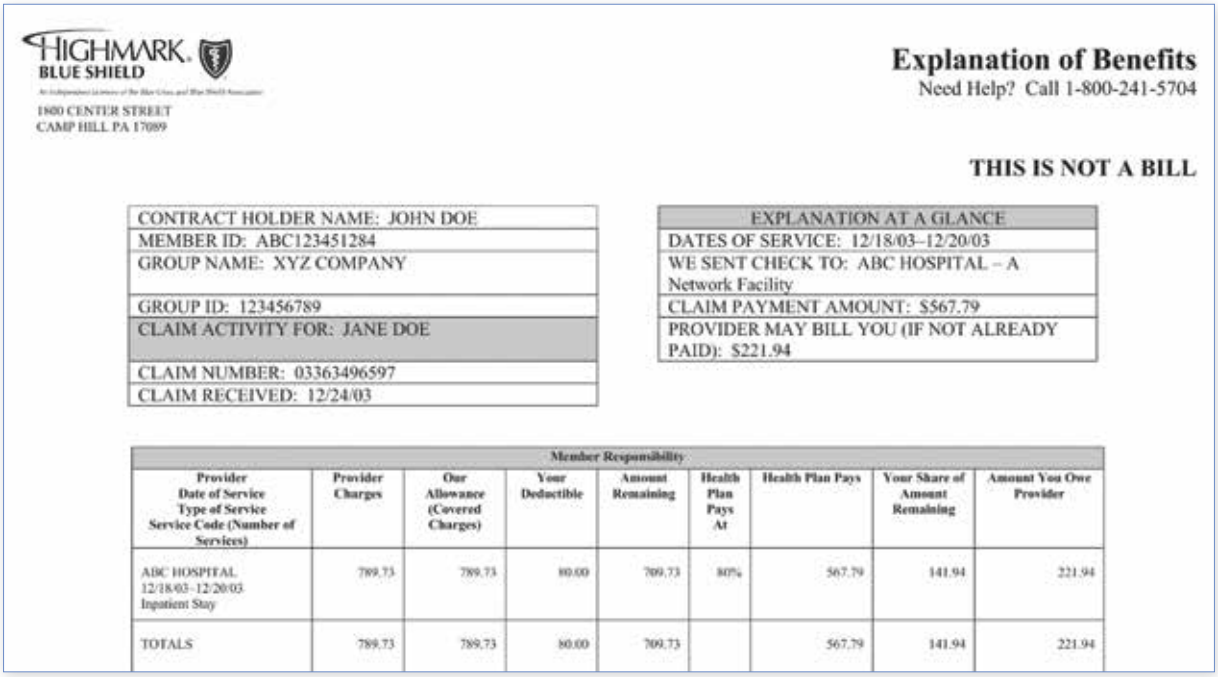
Non-Emergency Admissions–You must notify Highmark Blue Cross Blue Shield at least 24 hours prior to a non-emergency hospital admission.

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**) for more information about receiving electronic EOBs via email.



HIGHMARK. BLUE SHIELD
1800 CENTER STREET
CAMP HILL PA 17089

Explanation of Benefits
Need Help? Call 1-800-241-5704

THIS IS NOT A BILL

CONTRACT HOLDER NAME: JOHN DOE
MEMBER ID: ABC123451284
GROUP NAME: XYZ COMPANY
GROUP ID: 123456789
CLAIM ACTIVITY FOR: JANE DOE
CLAIM NUMBER: 03363496597
CLAIM RECEIVED: 12/24/03

EXPLANATION AT A GLANCE
DATES OF SERVICE: 12/18/03–12/20/03
WE SENT CHECK TO: ABC HOSPITAL – A Network Facility
CLAIM PAYMENT AMOUNT: $567.79
PROVIDER MAY BILL YOU (IF NOT ALREADY PAID): $221.94

Member Responsibility								
Provider Date of Service Type of Service Service Code (Number of Services)	Provider Charges	Our Allowance (Covered Charges)	Your Deductible	Amount Remaining	Health Plan Pays At	Health Plan Pays	Your Share of Amount Remaining	Amount You Owe Provider
ABC HOSPITAL 12/18/03–12/20/03 Inpatient Stay	789.73	789.73	80.00	709.73	80%	567.79	141.94	221.94
TOTALS	789.73	789.73	80.00	709.73		567.79	141.94	221.94

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, or C) 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 as of May 15, 2017:

- 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.

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 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, ext. 2870

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

WELLNESS BENEFITS

HEALTHY STEWARDS

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

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

The program consists of three components:

- an online Wellness Profile;
- setting a health goal with a health and wellness coach or online via WebMD My Health Assistant; and
- a blood screening test via a home test kit, a LabCorp voucher, or a physician's results form.

After completing the online Wellness Profile and blood screening, participants will receive a personal score and health report. All information is kept confidential.

PREVENTIVE SERVICES

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

SUMMARY OF BENEFITS: MENTAL HEALTH AND SUBSTANCE USE CARE THROUGH HIGHMARK BLUE CROSS BLUE SHIELD

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

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

MENTAL HEALTH AND SUBSTANCE ABUSE CARE FOOTNOTES:

1. Eligibility for Plan M will be determined by Wider Church Ministries.
2. Benefit payments are based on Reasonable and Customary (R&C) limits.
3. Under the comprehensive benefits program, health care benefits are provided as one integrated program. These benefits include coverage for hospital services, physician services, and many other covered services. Most benefits are subject to deductible and coinsurance provisions, which require you to share a portion of the medical costs.

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

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
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
$40 after deductible	$40 after deductible	$40 after deductible	$40 after deductible
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply	100% - deductible does not apply
80% after in-network deductible	70% after in-network deductible	70% after in-network deductible	85% after deductible
80% after in-network deductible	70% after in-network deductible	70% after in-network deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible	100% - copay and deductible do not apply	50% after deductible	100% - after copayment
60% after deductible	100% after deductible	50% after deductible	85% after deductible
60% after deductible	100% after deductible	50% after deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
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 Limit: $2,000 per person/year	70% after deductible Limit: $2,000 per person/year	50% after deductible Limit: $2,000 per person/year	85% after deductible Limit: $2,000 per person/year
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible	70% after deductible	50% after deductible	85% after deductible
60% after deductible Limit: $2,000 per person/year	70% after deductible Limit: $2,000 per person/year	50% after deductible Limit: $2,000 per person/year	85% after deductible Limit: $2,000 per person/year
60% after deductible Limit: 60 tests per person/year	70% after deductible Limit: 60 tests per person/year	50% after deductible Limit: 60 tests per person/year	85% after deductible Limit: 60 tests per person/year
60% after deductible	70% after deductible	50% after deductible	85% after deductible
100% Limit: $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
Performed by Participant	Performed by Participant	Performed by Participant	Performed by Participant

MEDICAL PLAN FOOTNOTES:

1. In-network and out-of-network deductibles cross-accumulate. Excludes prescription drug copayments, physician office visit copayments, difference paid for brand-name drugs in lieu of available generics, penalty for failure to precertify hospital admissions, and payments over Reasonable and Customary (R&C) limits.
2. Benefit payments are based on Reasonable and Customary (R&C) limits.
3. In-network and out-of-network out-of-pocket maximums cross-accumulate. Excludes prescription drug copayments, physician office visit copayments, difference paid for brand-name drugs in lieu of available generics, penalty for failure to precertify hospital admissions, and payments over Reasonable and Customary (R&C) limits.
4. The annual maximum is the total paid in "essential health benefits" from January through December of each Plan Year.
5. Not subject to deductible.
6. Room and board charges for a semi-private or private room when medically necessary.
7. Treatment includes coverage for the correction of a physical or medical problem associated with infertility.
8. Acupuncture services are covered if medically necessary to treat a diagnosed medical condition and are provided by a physician (MD, DO), or Doctor of Chiropractic, or a licensed acupuncturist.
9. Hospice services are covered only when under the supervision of a physician.
10. Participant is required to contact Highmark Healthcare Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered, plus an additional $300 penalty.
11. Eligibility for Plan M will be determined by Wider Church Ministries.
12. Under the comprehensive benefits program, health care benefits are provided as one integrated program. These benefits include coverage for hospital services, physician services, and many other covered services. Most benefits are subject to deductible and coinsurance provisions, which require you to share a portion of the medical costs.

ADULT (AGE 19+) PREVENTIVE SCHEDULE

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

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

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

Adults: Ages 19+ (Male / Female)	
General Health Care	
Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Pelvic, Breast Exam	Once a year
Screenings/Procedures	
Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Cholesterol (Lipid) Screening	• 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	High-risk
Latent Tuberculosis Screening	High-risk
Lung Cancer Screening (Requires use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years
Mammogram	Ages 40 and older: Once a year including 3-D
Osteoporosis (Bone Mineral Density) Screening	Ages 60 and older: Once every 2 years
Pap Test	• Ages 21 to 65: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)	Sexually active males and females

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

HIGHMARK® Blue Cross Blue Shield

Adults: Ages 19+ Male Female

Immunizations	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
Diphtheria, Tetanus (Td/Tdap)	• One-time Tdap • Td booster every 10 years
Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
Hepatitis A	At-risk or per doctor's advice: One 2-dose series
Hepatitis B	At-risk or per doctor's advice: One 3-dose series
Human Papillomavirus (HPV)	To age 26: One 3-dose series
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
Shingles (Zoster)	Ages 60 and older: One dose
Preventive Drug Measures That Require a Doctor's Prescription	
Aspirin	• Ages 50 to 59 to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Raloxifene Tamoxifen	At-risk for breast cancer, without a cancer diagnosis, ages 35 and older
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
Vitamin D Supplements	Ages 65 and older who are at risk for falls
Low to Moderate Dose Select Generic Statin Drugs For Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater.
Preventive Care for Pregnant Women	
Screenings and Procedures	• Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening during pregnancy and postpartum • Rh typing at first visit • Rh antibody testing for Rh-negative women • Tdap with every pregnancy • Urine culture and sensitivity at first visit
Prevention of Obesity, Heart Disease and Diabetes	
Adults With BMI 25 to 29.9 (Overweight) and 30 to 39.9 (Obese) Are Eligible For:	• 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) and** • **Overweight or obese (determined by BMI) and** • **Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.**	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

* Meningococcal B vaccine per doctor's advice.

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 With Pulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Screening							●				
Lead Screening						●					
Newborn Blood Screening	●										
Immunizations											
Chicken Pox							Dose 1				
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)**					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1		Dose 2		Dose 3						
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

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

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

Children: 3 Years to 18 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)											
Immunizations												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5			1 dose of Tdap if 5 doses were not received previously							1 dose every 10 yrs.
Flu (Influenza)******	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2 (at least 1 month apart from dose 1)										
Meningitis*******									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										
Care for Patients With Risk Factors												
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening											High-risk	
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)									For all sexually active individuals			
Tuberculin Test	Per doctor's advice											

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

Children: 6 Months to 18 Years[1]

Preventive Drug Measures That Require a Doctor's Prescription	
Oral Fluoride	For preschool children older than 6 months whose primary water source is deficient in fluoride
Prevention of Obesity and Heart Disease	
Children With a BMI in the 85th to 94th Percentile (Overweight) and the 95th to 98th Percentile (Obese) Are Eligible For:	• 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) and** • **Overweight or obese (determined by BMI) and** • **Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.**	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

INFORMATION ABOUT THE AFFORDABLE CARE ACT (ACA)

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

[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.

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

WHAT THE MEDICAL PLAN DOES NOT COVER

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

1. Assisted fertilization services related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization.
2. Bereavement services not provided by hospice care.
3. Case management services for care, treatment, or services that have been disallowed under the provisions of the Plan's case management system.
4. 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.
5. Confinement in a United States government or agency hospital, unless you would have to pay the expenses if you did not have coverage.
6. Corrective surgery for myopia, hyperopia, or presbyopia, including radial keratotomy, LASIK, LASEK, and PRK.
7. 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.)
8. Court-ordered services or services ordered by a tribunal as part of the participant's sentence.
9. Custodial care, domiciliary care, or residential care, protective and supportive care including education services and convalescent care.
10. 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.
11. 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.
12. 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.
13. 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. 34).
14. 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.

15. 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.
16. 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.
17. Genetic testing, unless medical documentation supports medical necessity.
18. Hospice services that are not provided under the supervision of a physician.
19. Inpatient admissions primarily for diagnostic studies and inpatient admissions primarily for physical therapy.
20. Light therapy products for treatment of medical and mental health disorders to include but not limited to a light box.
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 by the Pension Boards, or its medical advisors, 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

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

PRESCRIPTION DRUG BENEFITS–EXPRESS SCRIPTS

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

RETAIL PHARMACY PRESCRIPTION DRUG PURCHASES

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

MAINTENANCE (LONG-TERM) PRESCRIPTION DRUG REFILLS

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

If you need to start a maintenance drug treatment immediately, ask your physician to write two prescriptions – one for a 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.

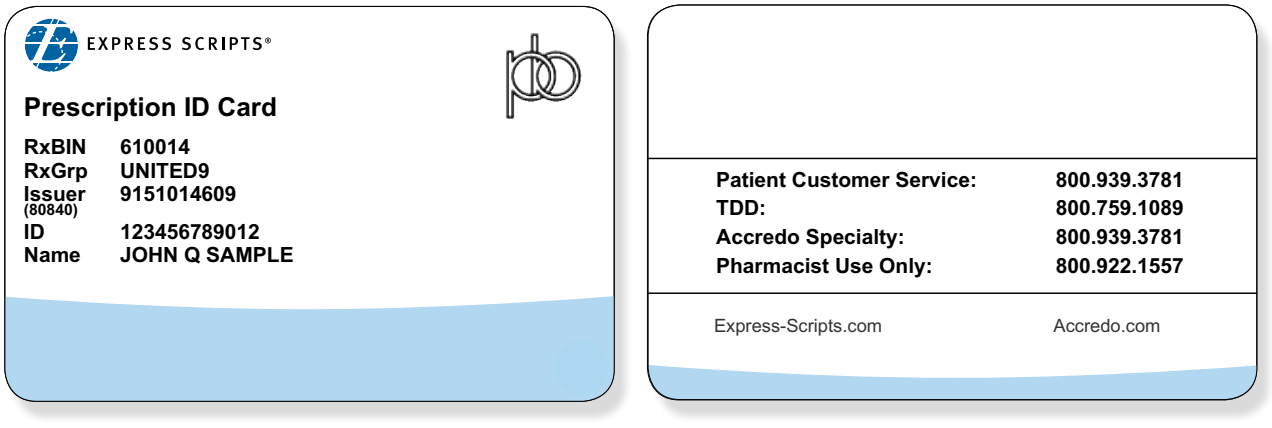
PRIOR AUTHORIZATION

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**.

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 for a generic drug $30 for a brand-name drug on the formulary $45 for a brand-name drug not listed on the formulary	15% coinsurance up to a maximum of $50 for: • a generic drug • a brand-name drug on the formulary • a brand-name drug not listed on the formulary
When purchased through the Mail Order Pharmacy *Up to a 90-day supply*	$34 for a generic drug $75 for a brand-name drug on the formulary $115 for a brand-name drug not listed on the formulary	15% coinsurance up to a maximum of $125 for: • a generic drug • a brand-name drug on the formulary • a brand-name drug not listed on the formulary

PRESCRIPTION DRUG FOOTNOTES:

1. Coinsurance for prescription drugs is not included in the annual medical deductible or annual medical out-of-pocket maximum.
2. Eligibility for Plan M will be determined by Wider Church Ministries.

WHAT THE PRESCRIPTION PLAN DOES NOT COVER

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

1. Allergy sera.
2. Anti-obesity medications.
3. Charges for the administration or injection of any drug.
4. Contraceptive jellies, creams, foams, 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. Fertility drugs (injectables).
10. Glucowatch/blood glucose sensors.
11. Lost, stolen, or damaged drugs.
12. Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the participant.
13. Non-federal legend drugs, which are not approved by the Food and Drug Administration (FDA).
14. Non-sedating antihistamines.
15. Nutritional/dietary supplements or supplies.
16. Ostomy supplies.
17. Smoking deterrents, unless those prescribed by your physician.
18. Therapeutic devices or appliances.
19. 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

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

UNITED CONCORDIA

DENTAL
EXPLANATION OF BENEFITS
KEEP FOR YOUR TAX RECORDS

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

Subscriber: John Doe | ID Number: 999 99 9999 | Page: 1 of 2

Patient: John Doe | Claim Number: 01260354768 | Date: 09/27/01

Provider: PACO FRALICK DDS INC
(000848516)

PROCEDURE DESCRIPTION / PROCEDURE CODE / (NUMBER OF SERVICES)		SERVICE DATE(S)	PROVIDER'S CHARGE	ALLOWANCE	AMOUNT PAID	AMOUNT NOT PAID	REMARKS
PERIODIC EVALUATION D0120	(001)	09/10/01	25.00	23.00	23.00	2.00	Q1030
PROPHYLAXIS ADULT D1110	(001)	09/10/01	51.00	47.00	47.00	4.00	Q1030
BITEWINGS FOUR FILMS D0274	(001)	09/10/01	34.00	30.00	30.00	4.00	Q1030
		TOTALS	110.00	100.00	100.00	10.00	

Q1030 These services were performed by a Participating Provider. This Provider has agreed not to bill you for the difference between the PROVIDER'S CHARGE and the ALLOWANCE for this service.

The Provider has been paid the amount shown in the AMOUNT PAID column.

UNITED CONCORDIA
America's Premier Dental Insurer

HAVE A QUESTION?
PLEASE CALL 1-800-299-1910
Business Hours: 8am-8pm E.T.
Service for the Deaf via TDD Equipment is available at 1-800-345-3837

THIS IS NOT A BILL

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

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

Benefit		
Dental Services	**Dental 1800**	**Dental 750[1]**
Annual Deductible	$100/person or $200/family	$100/person or $200/family
Annual Benefit Maximum/per person	$1,800	$750
Type of Service *Applies to both Dental 1800 and Dental 750 Plans*	**In-Network[2]**	**Out-of-Network[3]**
Preventive Services and Supplies: • Cleaning and oral examination–two times per calendar year • Fluoride application to child's teeth, age 16 and under–two times per calendar year • 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[4] • Extractions • Treatment of gums • Root canals • General anesthetics for oral surgery • Injectable antibiotics	80%	Plan pays 80% up to R&C limits
Restorative Services and Supplies: • Fillings[5] • Crowns[5]	 80% 50%	 Plan pays 80% up to R&C limits Plan pays 50% up to R&C limits
Prosthetic Services and Supplies: • Full or partial dentures or fixed bridges • Repair or rebasing of dentures or bridges	50%	Plan pays 50% up to R&C limits
Orthodontics for dependent children age 16 and under, up to a $1,500 lifetime maximum	50% after separate deductible per child	50% up to R&C limits after separate deductible per child

DENTAL PLAN FOOTNOTES:

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

WHAT THE DENTAL PLAN DOES NOT COVER

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

1. Charges for 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.

Vision

Benefits Overview:

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in-network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical and Visionworks.
- Take advantage of our service agreement with Walmart and Sam's Club—they check your eligibility and process claims even though they are out-of-network.

In-network value added features:

Additional lens enhancements:
In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.[1]

Savings on glasses and sunglasses:
Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.[1]

Laser vision correction: [2]
Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

We're here to help

Find a Vision provider at
www.metlife.com/vision

Download a claim form at
www.metlife.com/mybenefits

For general questions go to
www.metlife.com/mybenefits or call
1-855-MET-EYE1
(1-855-638-3931)

ADF# V1130.16

In-network benefits

There are no claims for you to file when you go to an in-network vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

Frequency

Eye exam — Once every **12** months

- Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a **$10** copay.
- Retinal imaging: Up to a **$39** copay on routine retinal screening when performed by a private practice.

Frame — Once every **24** months

- Allowance: **$140** after **$0** eyewear copay
- Costco: **$75** allowance after **$0** eyewear copay

You will receive an additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco.

Standard corrective lenses — Once every **12** months

- Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after **$0** eyewear copay.

Standard lens enhancements[1] — Once every **12** months

- Ultraviolet (UV) coating, Polycarbonate (child up to age 18): Covered in full.
- Progressive Standard, Progressive Premium/Custom, Polycarbonate (adult), Scratch-resistant coatings, Tints, Anti-reflective and Photochromic: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at www.metlife.com/mybenefits.

Contact lenses (instead of eye glasses) — Once every **12** months

- Contact fitting and evaluation: Covered in full with a maximum copay of **$60**.
- Elective lenses: **$140** allowance.
- Necessary lenses: Covered in full after eyewear copay.

Diabetic Eyecare Plus Program

Provides additional coverage for members who have been diagnosed with type 1 or type 2 diabetes and have specific ophthalmological conditions. It also provides benefits for those with glaucoma and age-related macular degeneration (AMD). In addition, members who have diabetes but don't show signs of diabetic eye disease are eligible to receive preventive retinal screenings. Not available at retail chains including Costco.

- Exam: Covered in full after **$20** copay.
- Special Ophthalmological services: Covered in full.

Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **in-network benefits** apply. Once you enroll, visit www.metlife.com/mybenefits for detailed out-of-network benefits information.

• Eye exam: up to **$45**	• Single vision lenses: up to **$30**	• Progressive lenses: up to **$50**
• Frames: up to **$70**	• Lined bifocal lenses: up to **$50**	
• Contact lenses:	• Lined trifocal lenses: up to **$65**	
- Elective up to **$105**	• Lenticular lenses: up to **$100**	
- Necessary up to **$210**	• Diabetic Eyecare Plus Program: Exam and other ophthalmological services	
	- The lesser of the provider's usual fee or 80% of the Medicare allowable charge.	

Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments

SERVICES AND EYEWEAR

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Worker's Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state, and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
- Plano lenses (lenses with refractive correction of less than ± 0.50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

TREATMENTS

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

MEDICATIONS

- Prescription and non-prescription medications.

[1] All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco to confirm your availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.
[2] Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

Important: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

M140D-10-O

MetLife Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

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).

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

SUBROGATION

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

PARTICIPANT'S COOPERATION

In some circumstances, the participant's help will be requested to assist with the administration of the Plan. Enrollment in the Plan constitutes an agreement by the participant and by 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, 8111 Royal Ridge Parkway, Irving, TX 75063.

Dental Claim

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

SECOND LEVEL:

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

DEFINITIONS AND RELATED INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan: The UCC Medical and Dental Benefits Plan.

Plan Year Benefit Maximum: The maximum amount the Dental Plan will pay in a Plan Year per covered individual. The amounts can be found on the Dental **Summary of Benefits** (see p. 32).

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

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

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

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

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

CONTACTS

MEDICAL SERVICES

1.866.763.9471
www.highmarkbcbs.com

Blues on Call
1.888.258.3428

Precertification for Inpatient Services
Highmark Healthcare Management
1.800.452.8507

CLAIMS PROCESSING

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

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

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

PRESCRIPTIONS

Express Scripts Retail Pharmacy
1.800.939.3781

Mail Order Pharmacy
1.800.633.2662
www.express-scripts.com

CLAIMS PROCESSING

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

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

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

*** Preferred Provider Organizations**

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

GENERAL ADMINISTRATION

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

PRIVACY PRACTICES

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

PROTECTED HEALTH INFORMATION (PHI)

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

The Plan is required by law to:

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

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