

2027

HIGHLIGHTS OF THE UCC
MEDICAL, DENTAL AND VISION PLAN
(NON-MEDICARE)

Providing Medical Coverage and Optional Dental and Vision Coverage

History

Since 1914, the Pension Boards-United Church of Christ, Inc. (PBUCC) has been a partner in ministry with those who serve the United Church of Christ (UCC). PBUCC offers comprehensive employee benefits programs for active and retired UCC clergy and lay employees and their eligible dependents, providing the highest standards of service, access, and options.

PBUCC assists those who serve the church in achieving health and economic security through:

- thought leadership regarding faith-based, socially responsible investing;
- professional investment expertise that enhances returns;
- a comprehensive mix of products and services that meet diverse needs;
- innovative application of technology; and
- outreach to all settings of the UCC and the greater church

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.

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About This Booklet

This booklet provides a general summary of certain benefits available under the UCC Medical, Dental and Vision Plan ("Plan"). It does not describe every benefit, limitation, exclusion, eligibility rule, or administrative requirement. You must meet the Plan's eligibility requirements (as determined by PBUCC) to participate in the Plan. Complete terms are contained in the official Plan document and the applicable medical, prescription drug, dental, and vision benefit documents, including the applicable Highmark benefit booklet and Summary of Benefits. If this booklet conflicts with any controlling Plan document, the controlling Plan document will govern. PBUCC reserves the right to amend or terminate the Plan or any benefit option in accordance with the Plan document. The Plan incorporates the applicable benefit components and provides that benefits are determined under the controlling Plan materials.

The Plan is designed to support eligible employees and clergy of the UCC and participating UCC-affiliated entities in performing their ministries. The Plan is self-insured and administered by the PBUCC on behalf of all participants.

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

PLAN ADMINISTRATION

The Plan's benefits are self-funded and administered by the PBUCC, 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. The PBUCC has sole and exclusive discretionary authority with respect to interpretation and application of any and all Plan provisions. The PBUCC is solely responsible for determination of, entitlements to, and payments of any amount due under this Plan. The PBUCC retains the right to modify, amend, or terminate the Plan at any time, with or without notice to participants or other persons.

Your UCC Medical And Dental Benefits Plan Coordinates Access To Health Care Services Through The Following Preferred Provider Organizations

MEDICAL SERVICES

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

myhighmark.com
Member Services: 1.866.763.9471
Precertification for Inpatient Services: 1.800.452.8507
Blues On Call 24/7 Nurse Line: 1.888.258.3428
Mobile App - Highmark (Apple) (Google Play)

Claims Processing Address
Highmark Blue Cross Blue Shield
PO Box 1210
Pittsburgh, PA 15230-1210

PHARMACY SERVICES

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

Express-scripts.com
1.800.939.3781
Mobile App - Express Scripts

Claims Processing Address
Express Scripts
ATTN: Commercial Claims
PO Box 52017
Phoenix, AZ 85072-2017

DENTAL SERVICES

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

Unitedconcordia.com
1.866.851.7195
Mobile App - UCD Mobile

Claims Processing Address
United Concordia Companies, Inc.
PO Box 69421
Harrisburg, PA 17106-9421

VISION SERVICES

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

VSP.com
1.800.877.7195
Mobile App - My VSP

Claims Processing Address
VSP
PO Box 495933
Cincinnati, OH 45249

Additional Benefits Accessed Through Vendor Partnerships Include A Member Assistance Program, Wellness Rewards Program, And Telemedicine.

HealthAdvocate℠

MEMBER ASSISTANCE PROGRAM

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

WELLNESS REWARDS PROGRAM

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

Healthadvocate.com/members
1.877.240.6863
Mobile App - Health Advocate

Well360 Virtual Health

TELEMEDICINE

Access to 24/7 virtual care visits with a board-certified physician ranging from general medical and behavioral health to dermatology concerns

myHighmark.com
1.866.763.9471
Mobile App - Teladoc

Available Plans

You are eligible to participate in the following UCC Plans if you meet the eligibility requirements listed in the Eligibility section of this booklet. The following plans are stand-alone plans, can be purchased separately, and do not require participation in any other Pension Boards benefit offerings.

MEDICAL PLANS

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

DENTAL PLAN

A comprehensive stand-alone dental plan available to all eligible employees and their eligible dependents. The annual benefit maximum is $2,400 per person. A discounted dental premium is available when combined with enrollment in the Medical Plan.

VISION PLAN

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

Eligibility for Benefits

Eligibility depends on the employee, clergy, ministry, employer, and other eligibility categories described in the official Plan document and PBUCC enrollment rules. An individual must also satisfy applicable participation requirements, complete enrollment, and make all required contributions. Contact PBUCC for the eligibility rules applicable to your circumstances.

APPLYING FOR COVERAGE

You may apply for coverage for yourself and your eligible dependent(s) by filing an **application** with the PBUCC within 90 days of your initial eligibility to participate in the 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 commencement of your domestic partnership. A completed **Health Benefit Dependent Change Form** must be sent to the Pension Boards.

Eligible employees and dependents may enroll in medical coverage for 2027 without completing a Statement of Health. All other Plan eligibility and enrollment requirements continue to apply.

QUALIFYING LIFE EVENTS

If you do not enroll within 90 days of initial eligibility, you generally must wait until annual open enrollment or a qualifying life event, such as a marriage, birth or adoption, or loss of other coverage. Applicable deadlines and requirements vary. Contact PBUCC promptly if you think you may have experienced a qualifying life event and for the rules that apply.

WHEN COVERAGE STARTS

Plan coverage for you and your eligible dependent(s) begins on the first day of the month following receipt and approval of your enrollment application.

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

- The order of payment between the Plan and Medicare depends on the applicable Medicare coordination rules, including the size of the participating employer. Contact PBUCC before making enrollment decisions based on Medicare eligibility.
- If you continue UCC employment after age 65 and your employer has 20 or more employees, the Pension Boards recommends that you do not sign up for Medicare Part B at this time; however you must enroll in Medicare Part A. The UCC (Non-Medicare) Plan will remain the primary insurer until you retire, terminate employment with the UCC, or terminate your medical benefit coverage through the UCC Health Plan.
- If you continue UCC employment after age 65 and your employer has 19 employees or fewer, you will be required to enroll in Medicare Parts A and B in order to maintain eligibility for benefits under the UCC Plan. Your coverage will be transferred to the UCC Medicare Advantage Plan with Rx. If you do not enroll for Medicare benefits, you will no longer be eligible for benefits through the UCC Plan. The booklet, **Highlights of Your UCC Medicare Advantage Plan with Rx**, is available online at **www.pbucc.org** or by calling the Pension Boards toll-free at **1.800.642.6543.**

Newborn children are covered on the date of birth if you have timely enrolled. You must notify the PBUCC within 90 days following the birth; otherwise, you must generally wait until the next annual open enrollment period (unless an intervening election change event occurs) in order to add your child to your coverage.

WHEN COVERAGE ENDS

In general, Plan coverage continues from year to year unless you elect to terminate coverage during the Plan's annual open enrollment period, a special enrollment period, or if a mid-year election change event happens that allows you to cancel your coverage mid-year. Otherwise, coverage for you and your dependent(s) ends on the last day of the month during which any of the following occurs:

- Contributions are no longer made when due;
- You or your dependent(s) are no longer eligible for coverage, including your termination of employment;
- Your participating employer ceases to participate in the Plan; or
- The Plan terminates.

Members who wish to cancel Plan coverage can complete the applicable change-of-benefits form and return it to PBUCC. PBUCC will provide applicable continuation information after receiving timely and complete notice of the loss of coverage. Refer to the Continuation of Coverage section for more information.

COVERAGE WHILE LIVING ABROAD

Your coverage may be continued if you live outside the United States while on sabbatical, church business, or business for a UCC entity. Dependents who normally live with you in the United States and move to another part of the world may 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 or Division of Overseas Ministries.

MILITARY SERVICE

If you are called to military service while enrolled in the Plan, you will be eligible for re-enrollment in the Plan upon return to your UCC-related employment, consistent with the requirements of the Uniform Services Employment and Reemployment Right Act ("USERRA").

Continuation of Coverage

If your Plan coverage would otherwise end due to certain events, you may be eligible to continue the Plan for a limited period of time by electing continuation coverage and making premium contributions directly to the Plan. In most cases, you will be required to pay the full amount of your continuation of coverage costs (i.e., there is no employer contribution for continuation coverage).

The loss of coverage events that trigger a right to elect continuation coverage under the Plan include termination of employment (for reasons other than gross misconduct), divorce or dissolution of domestic partnership, death of the covered employee, and loss of dependent status. The Pension Boards must receive timely notice of a qualifying loss of coverage event in order for you to exercise this right to continuation of coverage. Because the Plan is a church plan, it is not subject to the federal COBRA continuation requirements. Contact the Pension Boards for additional information or to notify Pension Boards of a qualifying event.

How the Medical Plan Works

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

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 help 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 in-network or out-of-network services. In-network care is care you receive from providers in the Plan's PPO network. Out-of-network care is care you receive from providers who are not in the Plan's 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. Out-of-network providers may charge more than the Plan's allowed amount. In addition to applicable deductibles, copayments, and coinsurance, participants may be responsible for amounts exceeding the allowed 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.

If you receive services from an out-of-network provider, you may be required to submit your claim to Highmark. Contact Highmark at **1.866.763.9471** to request a claim form. Complete the form and submit online by logging into your Highmark account, or make a copy for your records and mail it to the address on the form along with your itemized receipt.

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

PREEXISTING MEDICAL CONDITIONS

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

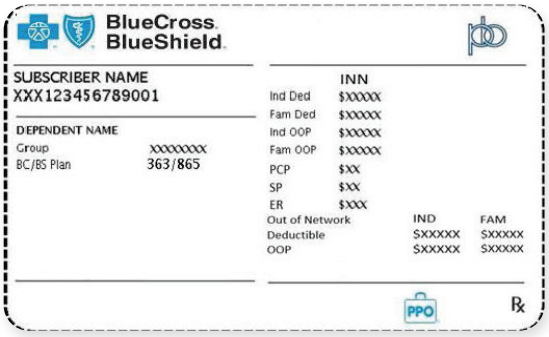
PRECERTIFICATION

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

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

Emergency Hospital Admissions–You must ensure Highmark Blue Cross Blue Shield is notified within 48 hours of an emergency situation.

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





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, cardiac care, knee and hip replacement, and spine surgery, 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 24 hours a day, 7 days a week 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**.

IDENTIFICATION CARDS

You will receive a medical identification card from Highmark Blue Cross Blue Shield for each member of your family who is enrolled in the Medical Plan. You may also access an electronic ID card on your smartphone using the Highmark Plan App, or by logging into your Highmark account at www.myhighmark.com.

An **Explanation of Benefits (EOB)** will be mailed to you when claims are processed. An EOB is a summary of the benefits paid by Highmark to your medical care provider. It lists the date of service, the service performed, the charges submitted, and the total you may owe the provider according to the Medical Plan guidelines. You may also visit the Highmark Blue Cross Blue Shield website (www.myhighmark.com) to opt to receive EOBs electronically or view claims detail.

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 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**.

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.

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.myhighmark.com** and click on "Find a Doctor or Pharmacy." 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.

Refer to the Highmark Blue Cross Blue Shield Certificate of Coverage for specific rules regarding the Plan's covered benefits and exclusions.

FREQUENTLY ASKED QUESTIONS

Q. Are services available for Assisted Fertilization?

A. Yes. Services are available for the plan participant. A lifetime maximum of $10,000 in medical services and $10,000 in pharmacy services will apply. Contact Highmark BCBS for specific coverage details.

Q. Is surrogacy a covered benefit?

A. No. Surrogacy is not a covered plan benefit.

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

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

Q. What coverage is available for abortions?

A. Abortion is a covered benefit:

- All elective and voluntary services received are covered per Plan policies and per individual state regulations.
- Deductibles, copays, and coinsurance may apply.
- Unless otherwise prohibited by law, a travel reimbursement benefit of up to $2,500 is available for reasonable and necessary travel costs incurred during travel from a state in which abortion or contraception services are unlawful to a state in which such services are lawful.

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

A. Contact Highmark Blue Cross Blue Shield at **1.866.763.9471**. If further assistance is needed, please contact the Pension Boards at **1.800.642.6543**.

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 they have been adopted, or you have begun adoption proceedings. In addition, coverage for newborn grandchildren ends at the time of the mother's hospital discharge.

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

A. Please visit our website, **www.pbucc.org**, to download a copy of an **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.

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.

These benefits are subject to the same deductibles and coinsurance requirements applicable to other medical and surgical benefits under the Plan.

For additional information regarding WHCRA benefits available under the Plan, contact Highmark Blue Cross Blue Shield at **1.866.763.9471**.

TELEMEDICINE

Visits with a Well360 Virtual Health provider are covered under the Plan. Participants can connect with a board-certified physician via phone, video, or mobile app. Well360 Virtual Health can treat many nonemergency medical conditions such as cold and flu symptoms, sinus problems, and also offers specialty care for dermatology, and mental health. When necessary, medications can be prescribed. A $0 copay applies. Connect with Well360 Virtual Health on the My Highmark mobile app, www.myhighmark.com, or call **1-800-485-2889**. If you have a disability and require TTY accommodations, please call 711. The Plan also covers virtual visits for members who schedule appointments with their PCP or Specialist. Plan copays and coinsurance will apply, according to the schedule of benefits.

WELLNESS BENEFITS

HEALTHY STEWARDS

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

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

Visit **healthadvocate.com/members** or call **1.877.240.6863** for additional information on how participants and their covered spouse or partner can receive incentives for completion of wellness activities. All information is kept confidential.

MEMBER ASSISTANCE PROGRAM

The Member Assistance Program provides 24/7 access to confidential help with personal and work-related issues ranging from stress management to managing life's transitions. Access support by phone at **1.877.240.6863**, or at **healthadvocate.com/pbucc.**

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** for more information.

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

The Plan offers two levels of benefits. If you receive services from a provider who is in the PPO network, you will receive the higher level of benefits.

If you receive services from a provider who is not in the PPO network, you will 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.

Benefit	Plan A		Plan B		Plan C		Plan M
	In-Network	Out-of-Network[2]	In-Network	Out-of-Network	In-Network	Out-of-Network	Comprehensive Coverage
Deductible[1] Individual Family	$300 $600	$600 $1,200	$500 $1,500	$1,500 $4,500	$1,000 $3,000	$3,000 $9,000	$200 $400
Payment Level/ Coinsurance	80%	60%	80%	60%	70%	50%	85%
	after deductible until out-of-pocket maximum is met; then 100%						
Out-of-Pocket Maximums[3]	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$5,000 Individual $10,000 Family	$15,000 Individual $45,000 Family	$6,000 Individual $12,000 Family	$18,000 Individual $54,000 Family	$2,000 Individual $4,000 Family
Annual Maximum[4]	No Limit	No Limit	No Limit	No Limit	No Limit	No Limit	No Limit
Physician Office Visits	100% after $25 copayment[5]	60% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible	100% after $25 copayment
	Click here for Plan A		Click here for Plan B		Click here for Plan C		Click here for Plan M

MEDICAL PLAN FOOTNOTES

1. In-network and out-of-network deductibles cross-accumulate. Excludes prescription drug copayment, physician office 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 Limits (R&C) limits.
3. In-network and out-of-network out-of-pocket maximums cross accumulate. Excludes prescription drug copayment, physician office 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 to December of each Plan Year.
5. Not subject to deductible.

Preventive Schedule

HIGHMARK. Blue Cross Blue Shield

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. 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. All benefits for over the counter drugs and supplies must be purchased through in-network pharmacy providers in order to be covered.* Make sure you know what is covered by your health plan and any requirements before you receive any of these services. Recommended annual services are based on a calendar year resetting January 1 of every year.

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 your age, gender, and family history. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

Questions?

- **Call Member Service** 1.866.763.9471
- **Ask your doctor**
- **Log in to your account** Highmarkbcbs.com

Adults: Ages 19+

Female Male

GENERAL HEALTH CARE	
Routine Checkup** (This exam is not the work- or school-related physical)	• Ages 19 – 49: Every one to two years • Ages 50 and older: Once a year
Depression Screening and Anxiety Screening	Once a year
Illicit Drug-Use Screening	Once a year
Pelvic and Breast Exam	Once a year
SCREENINGS/PROCEDURES	
Abdominal Aortic Aneurysm Screening	Ages 65 – 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 five years • High-risk: More often
Colon Cancer Screening (Including colonoscopy)	• Ages 45 and older: Every one to 10 years, depending on screening test • High-risk: Earlier or more frequently
Colon Cancer Screening	Ages 45 and older: Colonoscopy following a positive result obtained within one year by other mandated screening method
Certain Colonoscopy Preps With Prescription	• Ages 45 and older: Once every 10 years • High-risk: Earlier or more frequently
Hepatitis B Screening	• Once per lifetime for adults • High-risk: More often
Hepatitis C Screening	Ages 18 – 79
Latent Tuberculosis Screening	High-risk
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 50 – 80 with 20-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 3D • Screening, follow-up MRI, or ultrasound per doctor's advice
Osteoporosis (Bone Mineral Density) Screening	Ages 65 and older: Once every two years, or younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 – 65 Pap: Every three years, or annually, per doctor's advice • Ages 30 – 65: Every five years if HPV only or combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)	• Sexually active males and females • HIV screening for adults to age 65 in the general population and those at risk, then screening over age 65 with risk factors

* For example, if the in-network pharmacy provider is located within a larger retail setting, the drug/supply must be purchased through the pharmacy provider's register (and not the general retail register) in order to be covered.

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

** USPSTF-mandated routine labs

Adults: Ages 19+

Female Male

IMMUNIZATIONS**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One two-dose series
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines
Diphtheria, Tetanus (Td/Tdap)	One dose Tdap, then Td or Tdap booster every 10 years
Flu (Influenza)	Every year
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 two-, three-, or four-dose series
Hepatitis B	• Ages 19–59: Two to four doses per doctor's advice • Ages 60 and older: High-risk per doctor's advice
Human Papillomavirus (HPV)	• To age 26: One three-dose series • Ages 27 – 45, at-risk or per doctor's advice
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
RSV Vaccine	• Ages 60 and older • Pregnant women
Shingles	• Shingrix — Ages 50 and older: Two doses • Ages 19 – 49: Immunocompromised per doctor's advice

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Aspirin	Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Chemoprevention drugs such as raloxifene, tamoxifen, or aromatase inhibitors***	At risk for breast cancer, without a cancer diagnosis, ages 35 and older
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
Low-to-Moderate Dose Select Generic Statin Drugs for Prevention of Cardiovascular Disease (CVD)	Ages 40 – 75 years with one or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater
Select PrEP Drugs and Certain Related Services for Prevention of HIV Infection	Adults at risk for HIV infection, without an HIV diagnosis

PREVENTIVE CARE FOR PREGNANT WOMEN		
Screenings and Procedures	• Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening and anxiety screening during pregnancy and postpartum • Depression prevention counseling during pregnancy and postpartum	• Rh typing at first visit • Rh antibody testing for Rh-negative women • RSV vaccine per CDC guidelines • Tdap with every pregnancy • Urine culture and sensitivity at first visit • Alcohol misuse screening and counseling • Nutritional counseling for pregnant women to promote healthy weight during the pregnancy

* Meningococcal B vaccine per doctor's advice.

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

Adults: Ages 19+

Female Male

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE		
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
Adults with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling	
Adults with BMI 40 and over	Nutritional counseling and fasting glucose screening	
ADULT DIABETES PREVENTION PROGRAM (DPP)		
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100–125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140–199mg/dl	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss	

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

CHILDREN'S PREVENTIVE SCHEDULE

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

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

Children: 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 – 18			
Ambulatory Blood Pressure Monitoring**												●
Anxiety Screening						Once a year from ages 8 – 18						
Depression Screening										Once a year from ages 12 – 18		
Illicit Drug-Use Screening												●
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	
SCREENINGS												
Hematocrit or Hemoglobin Anemia Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9 – 11 and ages 17 – 21					
IMMUNIZATIONS												
Chicken Pox		Dose 2										
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines											
Dengue Vaccine							9 – 16 years living in dengue endemic areas in U.S. Territories AND have laboratory confirmation of previous dengue infection					
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap			
Flu (Influenza)****	Ages 3 – 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9 – 14. 3 doses, all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*****									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										

* 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.

CARE FOR PATIENTS WITH RISK FACTORS	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
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												●
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)									For all sexually active individuals HIV routine check, once between ages 15 – 21			
Tuberculin Test	Per doctor's advice											

Children: 6 Months to 18 Years[1]

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride
PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE	
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
Age 18 with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling
ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140-199mg/dl	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss

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

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.

INFORMATION ABOUT CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

WHAT THE MEDICAL PLAN DOES NOT COVER

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

1. Bereavement services not provided by hospice care.
2. Case management services for care, treatment, or services that have been disallowed under the provisions of the Plan's case management system.
3. 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.
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 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.
14. Food including, but not limited to, enteral formulae, infant formulae, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.
15. Foot care, palliative or cosmetic, including flat-foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of

corns, bunions (except capular or bone surgery), calluses, toenails (except surgery for ingrown nail), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.

16. Genetic testing, unless medical documentation supports medical necessity.
17. Hospice services that are not provided under the supervision of a physician.
18. Inpatient admissions primarily for diagnostic studies and inpatient admissions primarily for physical therapy.
19. Light therapy products for treatment of medical and mental health disorders including, but not limited to, a light box.
20. Medical evacuation and repatriation of remains.
21. Mental health and substance use care considered investigational/ experimental.
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. See Subrogation section.
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 provided by an immediate family member.

31. Services provided by an individual residing in the patient's home.
32. Services provided prior to the enrollee's effective date of coverage.
33. Services that are submitted by a certified registered nurse or another professional provider for the same services performed on the same date for the same participant.
34. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
35. Surrogacy services provided to a surrogate or gestational carrier.
36. Treatment for injury or illness suffered while committing a felony.
37. Weight reduction programs, except for medical and surgical treatment of morbid obesity when determined to be medically necessary.
38. 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 participant files a claim for said benefits or compensation.

How The Prescription Drug Plan Works

The Plan includes a prescription benefit administered by Express Scripts. Neither the medical or prescription benefit may be purchased separately. 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 medical plan 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.

MAINTENANCE (LONG-TERM) PRESCRIPTION DRUG REFILLS

Your pharmacy coverage includes a refill limit for most 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.

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

EXPRESS SCRIPTS®

Attn: Commercial Claims
PO Box 52017
Phoenix, AZ 85072-2017

Mail Order Pharmacy Orders should be sent to:

Express Scripts
Mail Order Pharmacy
PO Box 66577
St. Louis, MO 63166-6564

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**.

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.

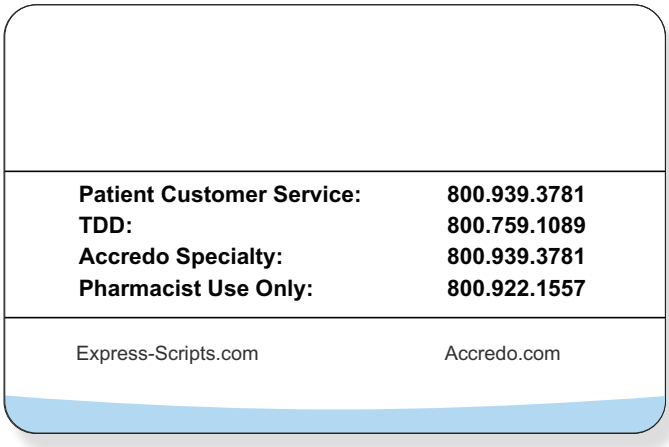
SPECIALTY MEDICATION MANAGEMENT

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, call (800) 803-2523, or visit **www.accredo.com**.

ID CARDS

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





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. See specific benefit levels on the next page.

Benefit: Prescription Drugs[1]	Plans A, B, & C	Plan M[2]
When purchased at an Express Scripts network retail pharmacy *Up to a 30-day supply*	$17 copay for a generic drug $30 copay for a brand-name drug on the formulary $45 copay for a brand-name drug not listed on the formulary	15% coinsurance up to a maximum of $50 for: • a generic drug • a brand-name drug on the formulary • a brand-name drug not listed on the formulary
When purchased through the Mail Order Pharmacy *Up to a 90-day supply*	$34 copay for a generic drug $75 copay for a brand-name drug on the formulary $115 copay for a brand-name drug not listed on the formulary	15% coinsurance up to a maximum of $125 for: • a generic drug • a brand-name drug on the formulary • a brand-name drug not listed on the formulary

PRESCRIPTION DRUG FOOTNOTES

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

EXAMPLES OF 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. The following is not an exhaustive list of exclusions:

1. Allergy sera.
2. Charges for the administration or injection of any drug.
3. Contraceptive jellies, creams, foams, non-clinical devices, or over-the-counter contraceptives.
4. Drugs used to treat impotency, unless approved following prostate surgery.
5. Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
6. Drugs labeled "Caution–limited by federal law to investigational use," or experimental drugs, even though a charge is made to the participant.

7. Durable medical equipment (see **Medical Summary of Benefits**).
8. Lost, stolen, or damaged drugs.
9. 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.
10. Non-federal legend drugs, which are not approved by the Food and Drug Administration (FDA).
11. Non-sedating antihistamines.
12. Nutritional/dietary supplements or supplies.
13. Ostomy supplies.
14. Prescription drugs for which there are over-the-counter equivalents.
15. Smoking deterrents, unless they are prescribed by your physician.
16. Therapeutic devices or appliances.

How The Dental Plan Works

The UCC Dental Plan is a stand-alone benefit that provides preventive, therapeutic, restorative, prosthetic, and 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. You may create a MyDentalBenefits account at **UnitedConcordia.com**. Once your account is created, you can access the United Concordia Dental app.

PREFERRED PROVIDER ORGANIZATION (PPO)–ADVANTAGE PLUS 2.0

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

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



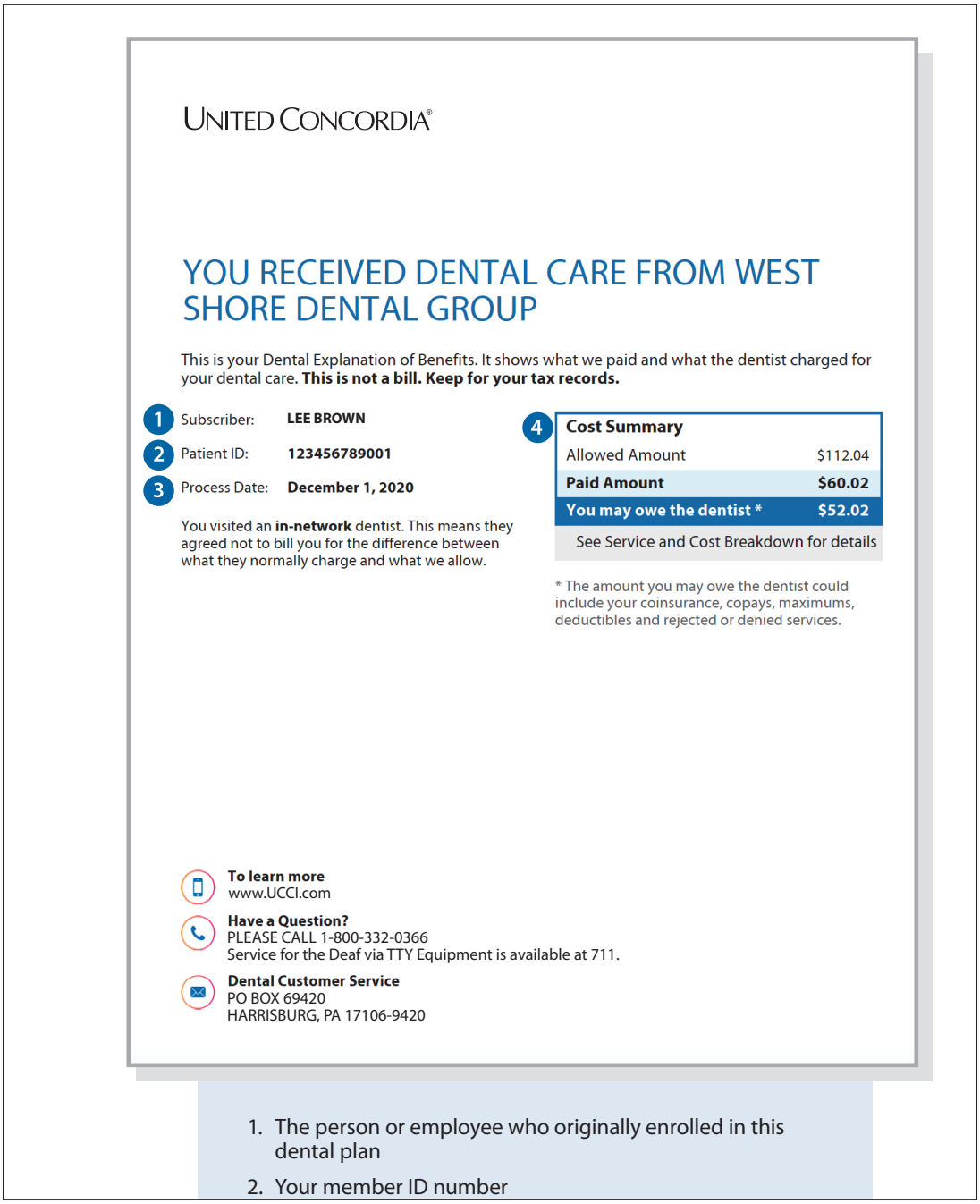


To find an
Advantage Plus 2.0 PPO
network provider:

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

Submit dental claims to:

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



UNITED CONCORDIA®

YOU RECEIVED DENTAL CARE FROM WEST SHORE DENTAL GROUP

This is your Dental Explanation of Benefits. It shows what we paid and what the dentist charged for your dental care. **This is not a bill. Keep for your tax records.**

1. Subscriber: **LEE BROWN**
2. Patient ID: **123456789001**
3. Process Date: **December 1, 2020**

You visited an **in-network** dentist. This means they agreed not to bill you for the difference between what they normally charge and what we allow.

4. **Cost Summary**

Allowed Amount	$112.04
Paid Amount	**$60.02**
You may owe the dentist *	**$52.02**

See Service and Cost Breakdown for details

* The amount you may owe the dentist could include your coinsurance, copays, maximums, deductibles and rejected or denied services.

To learn more
www.UCCI.com

Have a Question?
PLEASE CALL 1-800-332-0366
Service for the Deaf via TTY Equipment is available at 711.

Dental Customer Service
PO BOX 69420
HARRISBURG, PA 17106-9420

1. The person or employee who originally enrolled in this dental plan
2. Your member ID number

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

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

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

Benefit		
Dental Services	Dental	
Annual Deductible	$100/person or $200/family	
Annual Benefit Maximum/per person	$2,400	
Type of Service	In-Network[1]	Out-of-Network[2]
Preventive Services and Supplies[3]: • Cleaning and routine oral examination–two times per calendar year • Fluoride application to child's teeth, age 16 and under–two times per calendar year • Dental sealants, under age 16 • Space maintainers, under age 16	100%	100%
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 • Emergency care[4] • Extractions • Treatment of gums • Root canals • General anesthetics for oral surgery • Injectable antibiotics	80%	80%
Restorative Services and Supplies: • Fillings[5] • Crowns[5]	80% 50%	80% 50%
Prosthetic Services and Supplies[6]: • Full or partial dentures or fixed bridges • Repair or rebasing of dentures or bridges	50%	50%
Orthodontics up to a $2,000 per person lifetime maximum	50% after separate deductible per person	50% after separate deductible per person

DENTAL PLAN FOOTNOTES

1. Advantage Plus 2.0 PPO network provides access to dental care at a lower cost than out-of-network providers.
2. Benefit payments are based on Reasonable and Customary (R&C) limits. Reimbursements are based on United Concordia's schedule of maximum allowable charges (MACs). Network dentists agree to accept UCCI's allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between UCCI allowance and their fee.
3. Preventive Services do not apply towards the plan's annual maximum.
4. Treatment received for the unexpected onset of severe pain or other symptoms, which, if not treated immediately, could reasonably be expected to result in serious health threat or impair the health of the individual.
5. Crowns will only be covered on the same tooth once every five (5) years unless the need for replacement is due to poor quality of the existing restoration.
6. Implants: Have your dental provider contact United Concordia for information regarding predetermination of services.

WHAT THE DENTAL PLAN DOES NOT COVER

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

1. Charges for reline/rebase of dentures or bridges are not covered more than once every 36 months. Repair of dentures is not covered more than once per arch per 36-month period.
2. Implants, except in limited circumstances for members 18 and over. Please contact United Concordia Dental for review.
3. Motor vehicle accident injuries–services for treatment for injuries resulting from the maintenance or use of a motor vehicle if the services/treatment have been paid or are payable under a plan/policy of motor vehicle insurance. This includes a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefit established by state law. Payment for such injuries may be coordinated with your other insurance after those benefits have first been exhausted. The Dental Plan will then pay on a secondary basis.

4. Oral surgery for bony impactions of third molars (wisdom teeth). Contact Highmark BCBS for benefits available under the Medical Plan.
5. Orthodontic services that occurred before enrollment in this Plan or after enrollment is terminated.
6. Procedures, restorations, and appliances to increase vertical dimension or to restore occlusion.
7. Replacement of an existing crown or gold filling will not be covered unless for tooth decay.
8. Training in or supplies used for dietary counseling, oral hygiene, or plaque control.
9. 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.
10. 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 participant files a claim for said benefits or compensation.

How The Vision Plan Works

This is a summary of the Vision Plan that is administered by VSP. The Vision Plan is a stand-alone benefit. You will not receive identification cards from VSP; The ID number is the employee/member/policyholder's SSN. Vision providers may use dependents' respective SSNs when they complete a pre-certification prior to services. If you have questions regarding your vision benefits or to locate a VSP Signature Network Provider, contact VSP at **1.800.877.7195**.

PREFERRED PROVIDER ORGANIZATION (PPO)–VSP SIGNATURE

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

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

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

VSP will not provide ID cards at the time of enrollment. A confirmation letter from the Pension Boards will be sent to the participant once their initial application has been processed. Participants can provide their personal information to VSP providers at the time of service in lieu of an ID card. If the provider requests the group number, it is **VSP group number 12335985.**

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



SUMMARY OF BENEFITS: VISION BENEFITS THROUGH VSP

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

VSP SIGNATURE PLAN

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 for exam and glasses Up to $39	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME[+]	• $190 Featured Frame Brands allowance • $170 frame allowance • 20% savings on the amount over your allowance • $170 Walmart/Sam's Club frame allowance • $95 Costco frame allowance	Combined with exam	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $170 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every calendar year
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam. • Get 20% off eyewear on eyeconic.com just for being a VSP member.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

Your plan provides the following out-of-network reimbursements:

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

Maximize your benefits at an in-network location. Log in to **vsp.com** to choose an in-network doctor near you, including our large network of private practice and retail locations.

Coordination Of Benefits

Plan benefits may be reduced if you or your dependent(s) have coverage for the same benefits under another plan. If you have coverage under two 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 and pay benefits.

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). Additional rules and conditions for coordination of benefits may be found in the corresponding provisions of the formal Plan document.

SUBROGATION AND REIMBURSEMENT

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. Additional rules and conditions for subrogation and reimbursement may be found in the corresponding provisions of the formal Plan document.

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, including efforts to enforce the Plan's rights to subrogation and reimbursement.

Your Rights To Appeal

You are entitled to a fair and reasonable claims and appeals process for benefits under this Plan. Specific details regarding the claims and appeals process for each benefit provided under this Plan are described in the materials prepared by the claims' administrator for that benefit. The following provides highlights of the Plan's claims and appeals rules. Contact the applicable claims administrator or the Pension Boards for additional information.

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 and appeal. 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. In certain circumstances a denied appeal is entitled to external review. The claims administrator will explain this right and how to exercise it at the time of an appeal denial.

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 or oral appeal within 180 days after receiving your Explanation of Benefits Statement. To file an appeal, please contact **1.866.763.9471**. Written appeals can be submitted to: Member Service, PO Box 1210, Pittsburgh, PA 15230.

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:
Prior Authorization Denial Appeal: Express Scripts, PO Box 66571, St. Louis, MO 63166-6571, Attn: Prior Authorization Dept., Phone (800) 753-2851

Clinical Appeals: Express Scripts, PO Box 66588, St. Louis, MO 63166-6588

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 69420, Harrisburg, PA 17106-9420.

Vision Claim

If you wish to appeal the denial of a vision claim by VSP you should contact VSP at **1.800.877.7195** or submit a written request to: Vision Service Plan, Attn: Appeals Dept., PO Box 2350, Rancho Cordova, CA 95741.

SECOND LEVEL

If you wish to appeal the decision related to a first level appeal you should submit a written request for a second level appeal within 180 days following the date of the denial to: Director of Health Plan Operations, Pension Boards–UCC, 475 Riverside Drive, Room 1020, New York, NY, 10115 or via email to info@pbucc.org. Your request should include all information pertinent to your appeal.

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, Dental and Vision Plan and is committed to maintaining the privacy of your personal health information under the Plan in accordance with HIPAA privacy standards. 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, for treatment by a health care practitioner, and in other special circumstances permitted or required by law, as described in the Notice. Uses or disclosures requiring your authorization will be made only with your written authorization, which you may revoke in writing subject to the limitations described in the Notice. An authorization form is available online at **www.pbucc.org** or by calling Member Services at **1.800.642.6543**.

Subject to the limitations described in the Notice, you may request access to or amendment of certain PHI, an accounting of certain disclosures, restrictions on use or disclosure, and confidential communications. You may also file a privacy complaint without retaliation.

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 Continuation of Coverage section 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.

Copay: The amount an insured person is expected to pay for an office visit at the time of the visit under the medical plan. For the purposes of the pharmacy plan, a flat rate applied to prescriptions based upon tier level.

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 Eligibility section 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.

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.

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**. 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: Any member or dependent who meets eligibility requirements for whom contribution rates have been paid and is covered by the plan.

Plan: The UCC Medical, Dental and Vision Benefits Plan.

Plan Year Benefit Maximum: The maximum amount the Dental Plan will pay in a Plan Year per covered individual.

Preventive Services: Medical services that protect against or reduce the likelihood of health emergencies. These services are covered at no out-of-pocket cost to plan participants and are encouraged to help keep health care costs low.

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. The Medical Plan PPO is designated as BlueCard, the Dental Plan PPO is designated as Advantage Plus 2.0, and the Vision Plan PPO is designated as Signature.

Preferred Provider Organization (PPO): 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.

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

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

Schedule of Benefits: List of services covered under a health insurance plan, along with the associated fees.

Service Year: For purposes of the Vision Benefit, the Service Year is considered 12 months from the date of your last service.

Spouse: A person to whom a participant is legally married.

Important Disclaimers

General Summary Only
This booklet provides a general summary of benefits under the United Church of Christ Medical, Dental and Vision Plan (the "Plan"). It does not describe every benefit, limitation, eligibility rule, claims procedure, or other such Plan requirement. Complete terms are contained in the official Plan document and applicable benefit materials, as amended from time to time. If this booklet or any other summary conflicts with the controlling Plan materials, the controlling materials govern.

Eligibility and Enrollment
PBUCC determines eligibility, enrollment, effective dates, and required contributions under the Plan. Coverage is not effective unless all applicable requirements are met. Statements about qualifying events, dependent coverage, Medicare coordination, continuation coverage, and other such matters are summaries only.

Benefits, Networks, and Claims
Coverage, exclusions, cost sharing, network rules, prior authorization, medical necessity, claims, appeals, and other such requirements are governed by the Plan materials. Out-of-network providers may charge more than the Plan's allowed amount, and participants may owe amounts not paid by the Plan. A provider recommendation, authorization, estimate, prior payment, or customer-service response does not guarantee coverage or payment.

Vendors and Plan Administration
PBUCC may use Highmark Blue Cross Blue Shield, Express Scripts, United Concordia, VSP, and other service providers for claims and other administrative services. Vendor materials and communications do not amend the Plan or guarantee benefits and must be read with the controlling Plan materials.

Participant Responsibility
Participants are responsible for complying with enrollment, contribution, authorization, claims, appeal, notice, and other such requirements. They should confirm provider participation, provide accurate information, report eligibility changes, and meet applicable deadlines. Noncompliance may result in delayed or denied benefits or loss of coverage.

Medicare, Other Coverage, and Privacy
Medicare and coordination-of-benefits rules may depend on individual circumstances. Contact PBUCC before making coverage decisions based on Medicare or other coverage. The Plan, PBUCC, and service providers may use and disclose health and personal information as permitted or required by HIPAA, applicable law, Plan documents, and privacy notices.

No Professional or Employment Advice
This booklet is not medical, tax, legal, financial, employment, or other professional advice. Participation does not create or alter an employment or ministry relationship or guarantee continued employment or compensation.

Amendment and Termination
Subject to applicable law and the Plan documents, PBUCC may amend, suspend, or terminate the Plan or any benefit, vendor arrangement, contribution requirement, or other Plan feature. Only benefits in effect under the controlling Plan materials at the relevant time are available.

The Pension Boards
United Church of Christ, Inc.

11/02/2026