

HIGHLIGHTS OF YOUR
FLEXIBLE BENEFIT PLAN
FOR UNITED CHURCH OF CHRIST MINISTRIES
(revised January 2009)



Pension Boards
United Church of Christ

Table of Contents

| | |
|----|--|
| 2 | Introduction |
| 3 | I. Eligibility |
| 3 | 1. When May I Become a Participant in the Plan? |
| 3 | 2. What Are the Eligibility Requirements for Our Plan? |
| 3 | 3. When Is My Entry Date? |
| 3 | 4. What Must I Do to Enroll in the Plan? |
| 3 | II. Operation |
| 3 | 1. How Does This Plan Operate? |
| 4 | III. Contributions |
| 4 | 1. How Much of My Pay May My Employer Redirect? |
| 4 | 2. What Happens to Contributions Made to the Plan? |
| 4 | 3. When Must I Decide Which Accounts I Want to Use? |
| 4 | 4. When Is the Election Period for Our Plan? |
| 4 | 5. May I Change My Elections During the Plan Year? |
| 4 | 6. May I Make New Elections in Future Plan Years? |
| 5 | IV. Benefits |
| 5 | 1. What Benefits Are Available? |
| 6 | 2. Are Costs Incurred By My Same-Gender Domestic Partner Eligible For Reimbursement? |
| 7 | V. Benefit Payments |
| 7 | 1. When Will I Receive Payments For My Expenses? |
| 7 | 2. What Happens If I Don't Spend All Plan Contributions? |
| 7 | 3. Family and Medical Leave Act (FMLA) |
| 7 | 4. Uniformed Services Employment and Re-employment Rights Act (USERRA) |
| 8 | 5. What Happens If I Terminate Employment? |
| 8 | 6. Will My Social Security Benefits Be Affected? |
| 9 | VI. Plan Accounting |
| 9 | 1. Periodic Statements |
| 9 | VII. General Information About Our Plan |
| 9 | 1. General Plan Information |
| 9 | 2. Sponsor Information |
| 9 | 3. Plan Administrator Information |
| 10 | 4. Service of Legal Process |
| 10 | 5. Type of Administration |
| 10 | 6. Claims Submission |
| 10 | VIII. Additional Plan Information |
| 10 | 1. Claims Process |
| 12 | IX. Summary |
| 13 | Appendix |
| | Qualifying Medical Care Expenses |



Introduction

The Flexible Benefit Plan for UCC Ministries (“Plan”) was established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits. The benefits you may choose are outlined in this Highlights booklet, which will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join.

One of the most important features of the Plan is that the benefits offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under the Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

There are two parts to your Flexible Benefit Plan:

- The Health Care Reimbursement Account that will help with expenses related to Medical, Dental and Vision Care.
- The Dependent Care Assistance Account which will help with work-related Dependent Day Care costs.

Read this Highlights booklet carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions to the Administrator. There is a Plan Document on file which you may review if you desire. In the event there is a conflict between this Highlights booklet and the Plan Document, the Plan Document will take precedence.



I. Eligibility

1. When May I Become a Participant in the Plan?

Before you become a participant in the Plan, there are certain rules which you must satisfy. First, you must meet the eligibility requirements. After that, the next step is to actually join the Plan. You will be required to complete certain application forms to enroll in the Plan.

2. What Are the Eligibility Requirements for Our Plan?

If you are currently employed, you can only enroll during the open enrollment period at the end of the year; the effective date of your coverage will be the January 1 immediately following your enrollment.

New employees are eligible to enroll on the first of the month after they have completed one (1) month of employment. Special rules apply if your employer implements the Plan on a date other than January 1.

3. When Is My Entry Date?

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you complete one month of service with your employer.

4. What Must I Do to Enroll in the Plan?

You must complete an application to participate. The application must include your personal choice for each of the benefits offered under the Plan. You must also authorize your employer to set aside some of your earnings on a pre-tax basis to pay for the benefits you have elected.

II. Operation

1. How Does This Plan Operate?

Before the start of each year, you may elect to have some of your pay for the year contributed on a pre-tax basis to the Plan. You must make elections each year, whether you choose to keep the same benefits or not. Your contributions will be placed in special funds or accounts to pay for the benefits you have chosen. The portion of your salary that is paid to the Plan is not subject to Federal income or Social Security taxes. This allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your Federal tax return for that expense.

If your employer adopts the Plan during the year or if you become eligible during the year, you will be given 30 days to elect to participate in the Plan. If you elect to participate in the Plan, your election will be prospective only.

The Pension Boards-UCC has a special arrangement with the firm of National Associates in Cleveland, Ohio to assist with administration and to process all claims for reimbursement.

III. Contributions

1. How Much of My Pay May My Employer Redirect?

Each year, you may elect to have your employer contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year. The maximum that can be deferred to the Flexible Benefit Plan for each calendar year is \$5,000 to the Health Care Reimbursement Account (“Health FSA”) and \$5,000 to the Dependent Care Assistance Account.

2. What Happens to Contributions Made to the Plan?

Before each year begins or when you first become eligible, you will select the account(s) you want and how much of the contributions will go to each account. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. (See the section entitled **General Information About Our Plan**, found on **page 9**, for the definition of Plan Year.) Later, contributions to the Plan will be used to pay for the expenses as they arise during the Plan Year.

3. When Must I Decide Which Accounts I Want to Use?

Federal law requires that during the election period, before the Plan Year begins or when you first become eligible, you decide on the benefits you want and how much you want to contribute to each account.

4. When Is the Election Period for Our Plan?

Your election period will start on the date you first meet the eligibility requirements and end 30 days after your entry date. (You should review Section I on **Eligibility** to better understand the terms “eligibility requirements” and “entry date.”) Then, for each following Plan Year, the election period will be the 31-day period prior to the beginning of each Plan Year.

5. May I Change My Elections During the Plan Year?

Generally, after the beginning of the Plan Year you cannot change the elections you have made. However, there are certain limited situations when election changes are allowed. You are permitted to change elections if you have a change in status and you make an election change that is consistent with the change in status.

Currently, Federal law considers the following events to be “changes in status”:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status or any similar circumstance; and
- A change in the place of residence for you, your spouse or dependent.

In addition, if you are participating in the Dependent Care Assistance Account, there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

If the cost of dependent care increases during the year, you may change your elections; however, you may not change your election under the Dependent Care Assistance Account if the cost change is imposed by a dependent care provider who is your relative.

6. May I Make New Elections in Future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. **If you do not make new elections during the “election period” before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.**

IV. Benefits

1. What Benefits Are Available?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year:

Health Care Reimbursement Account

The Health Care Reimbursement Account (“Health FSA”) enables you to pay for expenses that are not covered by our Medical, Vision or Dental Plans and save taxes at the same time. The Health FSA allows you to be reimbursed by the Flexible Benefit Plan for out-of-pocket medical, dental and vision expenses incurred by you and your dependents. The expenses that qualify are those permitted by Section 213 of the Internal Revenue Code of 1986, as amended. A list of covered expenses is available on **page 13** of this booklet.

The maximum amount that you can contribute to your Health FSA each Plan Year is \$5,000. In order to be reimbursed for a health care expense, you must submit to the Administrator a copy of your health plan Explanation of Benefits (EOB) showing the amounts not paid, or an itemized bill from the service provider. The Plan processes reimbursement checks twice a month. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return.

Dependent Care Assistance Account

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent daycare costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 **Credit for Child and Dependent Care Expenses**. Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves.

Dependent care arrangements that qualify include:

- A dependent (day) care center, provided that, if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws.
- An educational institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An individual who provides care inside or outside your home. The individual may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of:

- (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are single or are married filing separate returns);
- (b) Your taxable compensation;
- (c) Your spouse’s actual or deemed earned income (a spouse who is a full-time student or incapable of caring for himself/herself has a deemed monthly earned income of \$250 for one dependent or \$500 for two or more dependents). Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense, as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for, even if you are not a participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser to find out which is better for you.

2. Are Costs Incurred by My Same-Gender Domestic Partner Eligible for Reimbursement?

Federal law does not recognize same gender domestic partnerships, unions or marriages. Therefore, in order to determine whether your domestic partner qualifies as your dependent and is eligible to have their medical claims reimbursed through the Health FSA, all three of the following criteria, based on Federal guidelines, must be met:

- The domestic partner must be an individual, who for the taxable year of the employee has the same principal place of residence as the employee,
- The domestic partner must be an individual who for the taxable year of the employee is a member of the employee's household, and
- Over one-half of the domestic partner's support is provided by the employee for the employee's tax year.

If any of the criteria listed above is not met, then your domestic partner does not qualify as your dependent for benefit plan purposes and you will not be reimbursed for his/her out-of-pocket medical expenses through the Health FSA.

If you will be covering your domestic partner's out-of-pocket claims through the Health FSA, please contact the Pension Boards so that you can complete the required forms, **Statement of Domestic Partnership and Financial Interdependence** and **Certification of Domestic Partner as a Dependent or Non-Dependent**.

V. Benefit Payments

1. When Will I Receive Payments for My Expenses?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered “incurred” when the service is performed, not necessarily when it is paid. The Administrator will provide you with acceptable forms for submitting requests for reimbursement. If the request qualifies as a benefit or expense that the Plan pays, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are not subject to Federal income tax or withholding, nor are they subject to Social Security taxes. Reimbursement for medical expenses is limited to the annual amount you elect. You will only be reimbursed from the Dependent Care Assistance Account to the extent that there are sufficient funds in the account to cover your request. Reimbursement checks are mailed directly to the participant’s address.

2. What Happens If I Don’t Spend All Plan Contributions?

Until recently, the Internal Revenue Service (“IRS”) required that if the participant incurred expenses during a Plan Year that were less than the amounts contributed to the Health Care Reimbursement Account (“Health FSA”), the unused contributions were forfeited. However, in May 2005, the IRS relaxed this rule by allowing an additional 2½ month “grace period” following the year. This is great news for anyone participating in the Health FSA because now a participant has through March 15 of the following year to incur claims before forfeiting Health FSA dollars.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that you have made, it is important that you carefully and conservatively decide how much to place in each account. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins or within 30 days of your first eligibility. You want to be sure that the amount you decide to place in each account will be used up entirely. Forfeited amounts are used to help pay Plan administration expenses and claims.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health FSA. If your coverage in these benefits terminates due to your revocation of the benefit while on leave, or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health FSA, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you were on leave. For example, if you elect \$1,200 for the year and are out on leave for three months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference – from \$100 per month to \$150 per month. Alternatively, your maximum reimbursable amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for three months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health FSA are not reimbursable.

If you continue your coverage during your unpaid leave, you may:

- prepay for the coverage,
- pay for your coverage on an after-tax basis while on leave, or
- arrange with your employer a schedule for you to “catch up” on your payments when you return.

4. Uniformed Services Employment and Re-employment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health FSA under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask the Administrator for further details.

5. What Happens If I Terminate Employment?

If you leave your employment during the Plan Year, your right to benefits will be determined in the following manner:

- You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate.
- If your participation in the Health Care Reimbursement Account ceases, you will be able to submit claims for health care expenses incurred prior to your date of termination.

It is your responsibility to notify the Pension Boards of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the Plan, within sixty (60) days of the event.

6. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced because tax-free benefits received under the Flexible Benefit Plan will reduce the amount of contributions that you make to the Social Security system as well as employer contributions made to the Social Security system on your behalf.



VI. Plan Accounting

1. Periodic Statements

The Administrator will periodically provide you with a statement of your account during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to claim all the money you have designated for a Dependent Care Assistance benefit by March 15 following the Plan Year and for a Health Care Reimbursement benefit by March 15 following the Plan Year.

VII. General Information About Our Plan

This Section contains some general information about the Plan that you need to know.

1. General Plan Information

Flexible Benefit Plan for United Church of Christ Ministries is the name of the Plan.

The Plan became effective on April 1, 2005, which is called the Effective Date of the Plan. The Plan has been amended and restated effective January 1, 2007.

The Plan's records are maintained on a 12-month basis. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31, except for the first Plan Year, which began when the Plan was adopted. In addition, an employer that adopts the Plan on a day other than January 1 may have an initial Short Plan Year of less than 12 months.

2. Sponsor Information

The Pension Boards' name, address, and Federal employer identification number are:

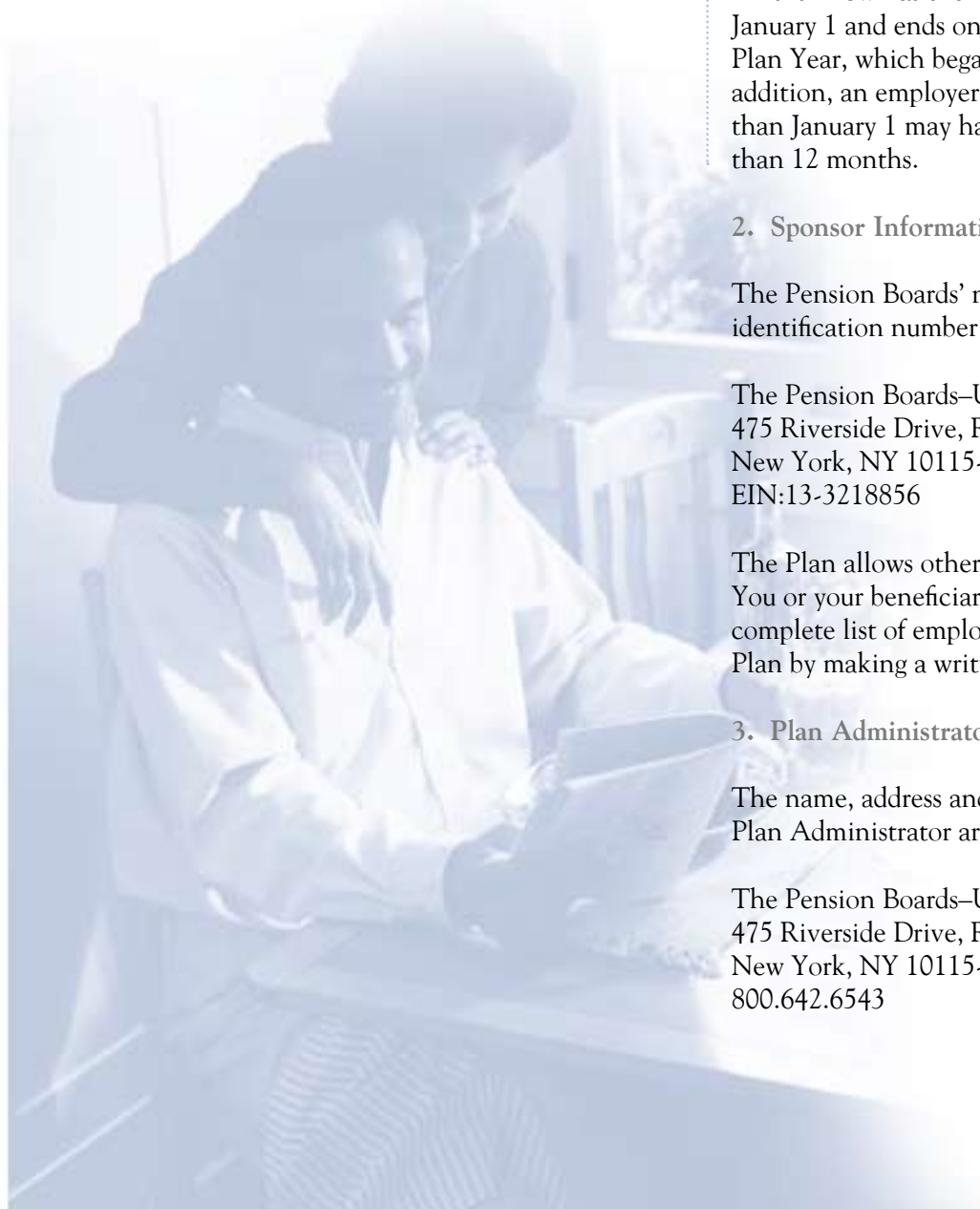
The Pension Boards—United Church of Christ, Inc.
475 Riverside Drive, Room 1020
New York, NY 10115-0059
EIN:13-3218856

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Administrator.

3. Plan Administrator Information

The name, address and business telephone number of your Plan Administrator are:

The Pension Boards—United Church of Christ, Inc.
475 Riverside Drive, Room 1020
New York, NY 10115-0059
800.642.6543



The Administrator keeps the records for the Plan and is responsible for its administration. Therefore, please feel free to contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

The Pension Boards—United Church of Christ, Inc.
475 Riverside Drive, Room 1020
New York, NY 10115-0059.

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

National Associates, Inc.
20325 Center Ridge Road
Cleveland, OH 44116
Telephone: 440.333.0222, Ext. 238
Fax: 440.333.0221

VIII. Additional Plan Information

1. Claims Process

Expenses incurred during the Plan Year (January 1 through December 31) may be submitted for reimbursement throughout the year. Expenses that you incur through March 15 of the following year may also be deemed as having been incurred during the previous Plan Year. This time after the end of the Plan Year is known as the "grace period." In order to be eligible for reimbursement of any expenses for a given Plan Year (including the grace period), you must submit your claim within 180 days after the March 15 on which the grace period ends. Any claims submitted after that time will not be considered for reimbursement. This provision will be in effect for all Plan Years.

If a claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification.

The notification will include:

- An explanation of the claims, and/or
- A description of any additional information needed to process the claim, or
- The reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based.

Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the application to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding.

Notwithstanding the foregoing, in the case of a claim for medical expenses under the Health Care Reimbursement Plan, the following timetable for claims applies:

| | |
|---|---------|
| Notification of whether claim is accepted or denied | 30 days |
| Extension due to matters beyond the control of the Plan | 15 days |
| Insufficient information on the claim: | |
| Notification of | 15 days |
| Response by participant | 45 days |
| Review of claim denial | 60 days |

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

1. The specific reason or reasons for the denial.
2. Reference to the specific Plan provisions on which the denial was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan review procedures and the time limits applicable to such procedures.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If requested, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The time period within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the claim determination;
2. Was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
3. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. Constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

IX. Summary

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. The Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings. If you have any questions, please contact the Administrator.

Qualifying Medical Care Expenses

Qualifying medical expenses include only those expenses incurred for:

1. Yourself.
2. Your spouse.
3. All dependents you list on your Federal tax return.
4. Any person that you could have listed as a dependent on your return if that person has not received \$3,400 or more of gross income or has not filed a joint return. This amount is adjusted each year for cost of living.

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your Federal income tax return (without regard to the 7.5% of adjusted gross income limitation). IRS Publication 502, **Medical and Dental Expenses**, has a checklist of medical expenses that can be deducted and therefore reimbursed under this Plan, and those that cannot. However, regardless of any statements in Publication 502 to the contrary, expenses under this Plan are treated as being “incurred” when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged or when you pay for the medical care.

Qualifying medical expenses include expenses you have incurred for:

1. Medicine, drugs, and vaccines that your doctor prescribed.
2. Medical doctors, dentists, eye doctors, orthodontists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
3. Medical examination, X-ray and laboratory service, insulin treatment and whirlpool baths prescribed by a physician.
4. Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.

5. Hospital care (including meals and lodging), clinic costs and lab fees.
6. Medical treatment at a center for substance abuse.
7. Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
8. Ambulance service and other travel costs to get medical care. If you use your own car, you can claim what you spend for gas and oil to go to and from the place you receive the care; or you can claim 14 cents a mile. Add parking and tolls to the amount you claim under either method.

You cannot obtain reimbursement for:

1. The basic cost of Medicare insurance (Medicare A).
2. Life insurance or income protection policies.
3. Accident or health insurance for you or members of your family.
4. The hospital insurance benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax.
5. Nursing care for a healthy baby.
6. Illegal operations or drugs.
7. Travel your doctor told you to take for rest or change.
8. Cosmetic surgery.
9. Long-term care expenses.

Special Information Regarding Over-the-Counter Medicines

Over-the-Counter Medicines Eligible for Reimbursement

Over-the-counter medicines that have been purchased in reasonable quantities may be reimbursed even if you do not have a medical doctor's note. These include but are not limited to:

| | |
|--------------------------------|--|
| Allergy medicine | Menstrual cycle products for pain and cramp relief |
| Antacids | Motion sickness pills |
| Bactine | Nasal sinus sprays |
| BAND-AID® Bandages | Nasal strips |
| Anti-diarrhea medicine | Nicotine gum or patches for stopping smoking |
| Bug bite medication | Pain reliever |
| Calamine lotion | Pedialyte® for ill child's dehydration |
| Carpal tunnel wrist supports | Pregnancy test kits |
| Cold medicines | Products for muscle pain or joint pain, i.e., BENGAY®, Tiger Balm®, etc. |
| Cold/Hot packs for injuries | Reading glasses |
| Condoms | Rubbing alcohol |
| Contact lens cleaning solution | Sinus medications |
| Cough drops | Sleeping aids used to treat occasional insomnia |
| Diaper rash ointments | Special ointment or cream for sunburn |
| First aid cream | Spermicidal foam |
| First aid kits | Thermometers |
| Hemorrhoid medication | Throat lozenges |
| Incontinence supplies | VISINE® and other such eye products |
| Laxatives | Wart removers |
| Liquid adhesive for small cuts | |

Over-the-Counter Medicines Covered in Special Circumstances

Some over-the-counter medicines may be reimbursed if they are accompanied by a note from a medical doctor indicating they are being purchased to treat a specified illness or condition. These include but are not limited to:

| | |
|---|---|
| Acne treatment – only to treat a specific medical condition such as acne vulgaris | Pills for persons who are lactose intolerant |
| Dietary supplements or herbal medicines to treat a specific medical condition in narrow circumstances | Prenatal vitamins |
| Fiber supplements under narrow circumstances | St. John's wort for depression |
| Glucosamine/Chondroitin for arthritis or other medical condition | Sunscreen |
| OTC hormone therapy and treatment for menopause to treat symptoms such as hot flashes, night sweats, etc. | Weight-loss drugs to treat a specific disease (including obesity) |

Over-the-Counter Medicines not Covered

Certain over-the-counter medicines are not eligible for reimbursement. These include but are not limited to:

| | |
|------------------------------|---------------------|
| Face cream, moisturizers | One-a-Day® vitamins |
| Lip moisturizers | Suntan lotion |
| Medicated shampoos and soaps | |

Notes



Pension Boards
United Church of Christ

475 Riverside Drive, Room 1020
New York, NY 10115-0059
www.pbucc.org