



## Highlights of Your 2021 UCC Medicare Advantage Plan with Rx

Health | Optional Dental & Vision Coverage



# WHERE FAITH & FINANCE INTERSECT

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

## **HEALTH PLAN MISSION**

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

January 2021

Dear UCC Colleague,

We are pleased to provide you with this copy of **Highlights of Your UCC Medical and Dental Benefits Plan: Medicare Advantage Plan with Rx** (for individuals who are enrolled in Medicare Parts A and B).

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

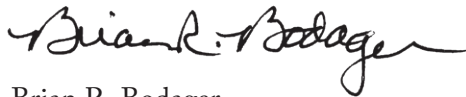
Your UCC Medicare Advantage Plan with Rx offers flexibility and choice, including:

- annual wellness visit and listing of preventive care schedule benefits covered at 100% with no additional cost;
- reimbursement of up to 96% of the amount not covered by Medicare for Medicare-eligible services;
- Optional stand-alone dental and vision plans that do not require paritipation in the UCC Medical Plan;
- Go365 Wellness Rewards Program;
- Access to fitness centers (Silver Sneakers); and,
- Medicare Part D pharmacy coverage with retail and mail order options.

We hope that you continue to be pleased with the benefits available to Plan participants, and we covenant to work with you to provide the best possible benefits at the most effective cost.

May you enjoy good health and abundant blessings.

Best regards,



Brian R. Bodager  
President and Chief Executive Officer



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# ABOUT THIS BOOKLET

The Pension Boards-United Church of Christ, Inc., is pleased to provide you and your family with a comprehensive health benefits program, offering flexibility and choice in plan selection. This booklet contains information for the UCC Medicare Advantage Plan w/Rx, as well as the Dental and Vision Benefit Plans.

The plans described in this booklet are designed to support active and retired clergy and lay employees, and their families of the UCC and UCC-affiliated entities in performing their ministries. The plans are administered by The Pension Boards-United Church of Christ, Inc., on behalf of all participants. Questions regarding the administration of the plans should be addressed to:

The Pension Boards-United Church of Christ, Inc.  
475 Riverside Drive  
Room 1020  
New York, NY 10115  
1.800.642.6543  
[www.pbucc.org](http://www.pbucc.org)



## ACCESS TO HEALTH CARE SERVICES THROUGH PREFERRED PROVIDER ORGANIZATIONS



### MEDICAL & PHARMACY SERVICES

Medical Services and pharmacy services are provided by Humana



### DENTAL SERVICES

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



### VISION SERVICES

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



### FITNESS PROGRAM

Access to exercise equipment, fitness classes, social events and more



### WELLNESS PROGRAM

Access to earn rewards for completing eligible healthy activities



## CONTACTS

### MEDICAL & PHARMACY SERVICES HUMANA

1.866.733.1872

[www.humana.com](http://www.humana.com)

#### CLAIMS PROCESSING

##### *Medical Claims*

Louisville Waterside Service Center

Humana Claims Office

PO Box 14601

Lexington, KY 40512-4601

##### *Pharmacy Claims*

Humana Pharmacy Solutions

PO Box 1410

Lexington, KY 40512-4140

### SILVER SNEAKERS

1.888.423.4632

[Silversneakers.com/StartHere](http://Silversneakers.com/StartHere)

### GO365 BY HUMANA

1.866.733.1872

Sign in at [Humana.com](http://Humana.com) and click on Go365

### DENTAL SERVICES

United Concordia Companies, Inc.

1.866.851.7576

[www.ucci.com](http://www.ucci.com)

#### CLAIMS PROCESSING

##### *Dental Claims*

United Concordia Companies, Inc.

P.O. Box 69421

Harrisburg, PA 17106-9421

### VISION SERVICES

1.800.877.7195

[www.vsp.com](http://www.vsp.com)

#### CLAIMS PROCESSING

##### *Vision Claims*

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

##### **VSP**

P.O. Box 997105

Sacramento, CA 95899-7105

### GENERAL ADMINISTRATION

The Pension Boards—United Church of Christ, Inc.

475 Riverside Drive

Room 1020

New York, NY 10115

1.800.642.6543

[www.pbucc.org](http://www.pbucc.org)





## AVAILABLE PLANS

You are eligible to participate in the UCC Medicare Advantage Plan with Rx if you meet the eligibility requirements listed on p. 8. Information contained in this booklet is also available on our website at [www.pbucc.org](http://www.pbucc.org).

### HEALTH PLANS

**Medicare Advantage Plan with Rx:** The UCC's comprehensive health plan for Medicare-eligible participants.

*Participation in the health plan also includes prescription drug coverage through Humana. You may not enroll in another Medicare Part D plan while enrolled in the UCC Medicare Advantage Plan with Rx.*

### DENTAL PLANS

**Dental 2000:** A comprehensive dental plan available to all eligible participants and their eligible dependents. The annual benefit maximum is \$2,000 per person.

### VISION PLANS

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



## ELIGIBILITY FOR BENEFITS

You are eligible to participate in the UCC Medicare Advantage Plan with Rx if you reside in the United States, and you are one of the following:

### ELIGIBLE EMPLOYEE

- A retired minister or lay employee enrolled in Medicare Parts A and B who has participated in the UCC Medical Benefits Plan while an employee of a UCC church or other UCC-related entity and elects coverage under the UCC Medicare Advantage Plan with Rx immediately upon retiring; or
- A retired minister or lay employee enrolled in Medicare Parts A and B who did not previously participate in the UCC Medical Benefits Plan; or
- A minister or lay employee age 65 or over working for a UCC church or UCC-related entity with fewer than 20 employees.

### ELIGIBLE DEPENDENTS\*

Your Medicare-eligible dependent(s) may also participate in the Plan if they are enrolled in Medicare Parts A and B. They include your:

- Spouse;
- Same-gender domestic partner;
- Opposite-gender domestic partner;
- Surviving spouse or surviving domestic partner;
- Permanently disabled unmarried and unemancipated adult child(ren) if the disability began prior to their reaching age 26 and for whom you provide at least half their support.

\*Health benefits for dependents who are not Medicare-eligible are described in the booklet, *Highlights of Your UCC Non-Medicare Medical and Dental Benefits Plan*.

### APPLYING FOR COVERAGE

If you are covered under the UCC (Non-Medicare) Health Plan, you will receive information about the UCC Medicare Advantage Plan with Rx

approximately three months before you turn age 65. If you wish to participate, you will be asked to submit proof of enrollment in Medicare Parts A and B for yourself and your spouse or domestic partner, if applicable. Health coverage for your spouse or domestic partner and other dependent(s) who are not eligible for Medicare will continue under the UCC (Non-Medicare) Health Plan if they are already enrolled for coverage. You must participate in the UCC Medicare Advantage Plan with Rx in order to continue dependent coverage.

### WHEN COVERAGE STARTS

#### PARTICIPANT RETIRED

UCC Medicare Advantage Plan with Rx coverage starts on the first day of the month following receipt of evidence of your enrollment in Medicare Parts A and B.

#### WORKING

The coverage start date for working participants begins the first of the month following receipt of the Medicare Coordination of Benefits approval.

#### DEPENDENTS

Coverage starts on:

- The date you are covered if you also apply for dependent coverage at the time of your enrollment; or
- The first day of the month following receipt of application for dependent coverage.

### WHEN COVERAGE ENDS

#### PARTICIPANT

Coverage for you and your dependents ends:

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



## CONTINUATION OF COVERAGE

In the event of your death, your spouse or domestic partner may continue Plan coverage by making contributions directly to the Plan.

If you divorce or dissolve your domestic partnership, your spouse or domestic partner may continue his/her coverage by making contributions directly to the Plan. The duration of this coverage is limited to 24 months or, if earlier, until 90 days after employment begins.

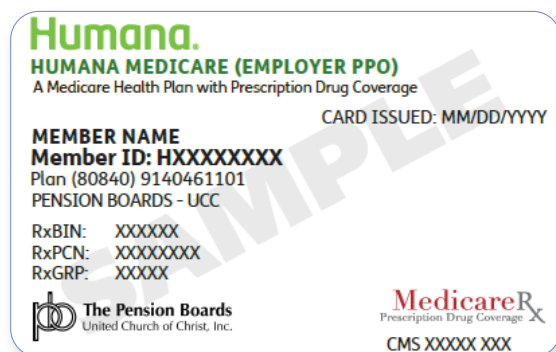
Coverage for dependent children will continue for up to a period of 24 months, or sooner if the child no longer qualifies as a dependent under the Plan.



## HOW THE MEDICAL PLAN WORKS

To provide participants with quality, cost-effective health benefits, the Pension Boards has partnered with Humana.

Plan participants have access to Humana's PPO, or Preferred Provider Organization. A PPO allows participants to receive care in-network OR out-of-network. Under the UCC Medicare Advantage Plan with Rx, participants pay the same whether a provider is in-network or out-of-network. As long as a provider, specialist or facility takes Medicare and agrees to bill Humana, participants can see their provider of choice. Referrals are not needed and Humana will pay for services as long as the services are Medicare covered benefits. Participants have no costs or copay for preventive care, plus financial protection with a yearly out of pocket maximum and worldwide emergency coverage.



### SILVERSNEAKERS

Humana provides access to SilverSneakers, a total health and physical activity program that helps you get fit, and stay fit the way you want, by providing access to over 16,000 fitness locations nationwide. SilverSneakers also provides access to outdoor activities and virtual classes that can be done independently at home.

### GO365

Go365 is Humana's rewards program that helps you track and monitor your progress towards your health and well-being goals. With Go365, you can earn rewards for preventive care that you likely already receive on a regular basis like an annual wellness exam, mammogram, colorectal screening and flu and pneumonia shots.

### PREVENTIVE SERVICES

The Plan provides coverage for annual wellness exams. This benefit encourages early detection and treatment of medical conditions and is not subject to the annual deductible.

### 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.



## SUMMARY OF BENEFITS: MEDICAL PLAN THROUGH HUMANA



## Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
<b>PLAN COSTS</b>		
<b>Monthly premium</b> You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.	
<b>Medical deductible</b>	<b>\$242</b> per year for some combined in- and out-of-network services	<b>\$242</b> per year for some combined in- and out-of-network services
<b>Maximum out-of-pocket responsibility</b> The most you pay for copays, coinsurance and other costs for medical services for the year.	<b>In-Network Maximum Out-of-Pocket</b> <b>\$2,000</b> out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy, Acupuncture (Routine) ; COVID-19 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Chiropractic Services (Routine) ; Fitness Program ; Health Education Services ; Hearing Services (Routine) ; Meal Benefit ; Private Duty Nursing ; Smoking Cessation (Additional) ; Vision Services (Routine) ; Wigs (medically necessary) and the Plan Premium.  If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.	<b>Combined In and Out-of-Network Maximum Out-of-Pocket</b> <b>\$2,000</b> out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy, Acupuncture (Routine) ; COVID-19 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Chiropractic Services (Routine) ; Fitness Program ; Health Education Services ; Hearing Services (Routine) ; Meal Benefit ; Private Duty Nursing ; Smoking Cessation (Additional) ; Vision Services (Routine) ; Wigs (medically necessary) and the Plan Premium do not apply to the combined maximum out-of-pocket.  Out-of-Network Exclusions: Part D Pharmacy, Acupuncture (Routine) ; COVID-19 Testing ; COVID-19 Treatment ; Chiropractic Services (Routine) ; Hearing Services (Routine) ; Private Duty Nursing ; Vision Services (Routine) ; Wigs (medically necessary) ; Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.  Your limit for services received from in-network providers will count toward this limit.





## Monthly Premium, Deductible and Limits

IN-NETWORK	OUT-OF-NETWORK
	If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.



## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>ACUTE INPATIENT HOSPITAL CARE</b>		
Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	<b>\$272</b> per admit	<b>\$272</b> per admit
<b>OUTPATIENT HOSPITAL COVERAGE</b>		
<b>Outpatient hospital visits</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>Ambulatory surgical center</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>DOCTOR OFFICE VISITS</b>		
<b>Primary care provider (PCP)</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>Specialists</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>PREVENTIVE CARE</b>		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.	<b>Covered at no cost.</b>	<b>\$0</b> copay or <b>0%</b> of the cost for Medicare-covered preventive services <b>0%</b> of the cost for a supplemental annual physical exam
<b>EMERGENCY CARE</b>		
<b>Emergency room</b> If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	<b>4%</b> of the cost for Medicare-covered emergency room visit(s) <b>\$120</b> Maximum Out-of-Pocket per visit for emergency room services	<b>4%</b> of the cost for Medicare-covered emergency room visit(s) <b>\$120</b> Maximum Out-of-Pocket per visit for emergency room services





## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Urgently needed services</b> Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>		
<b>Diagnostic radiology</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>Lab services</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>Diagnostic tests and procedures</b>	<b>0%</b> to <b>4%</b> of the cost	<b>0%</b> to <b>4%</b> of the cost
<b>Outpatient X-rays</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>Radiation therapy</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>HEARING SERVICES</b>		
<b>Medicare-covered hearing</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>Routine hearing</b>	<ul style="list-style-type: none"> <li>• \$0 copay for fitting/evaluation, routine hearing exams up to unlimited per year.</li> <li>• \$3000 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years.</li> </ul>	<ul style="list-style-type: none"> <li>• \$0 copay for fitting/evaluation, routine hearing exams up to unlimited per year.</li> <li>• \$3000 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years.</li> <li>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</li> </ul>
<b>DENTAL SERVICES</b>		
<b>Medicare-covered dental</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>VISION SERVICES</b>		
<b>Medicare-covered vision services</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>Medicare-covered diabetic eye exam</b>	<b>0%</b> of the cost	<b>0%</b> of the cost
<b>Medicare-covered glaucoma screening</b>	<b>0%</b> of the cost	<b>0%</b> of the cost







## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Medicare-covered eyewear (post-cataract)</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>Routine vision</b>  EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.	<ul style="list-style-type: none"> <li>\$40 copay for routine exam up to 1 per year.</li> </ul>	<ul style="list-style-type: none"> <li>\$40 copay for routine exam up to 1 per year.</li> <li>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</li> </ul>
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility	<b>\$272</b> per admit	<b>\$272</b> per admit
<b>Outpatient group and individual therapy visits</b>	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>SKILLED NURSING FACILITY</b>		
Our plan covers up to 365 days in a SNF.	<b>\$0</b> copay per day for days 1-20	<b>\$0</b> copay per day for days 1-20
	<b>\$34</b> copay per day for days 21-100	<b>\$34</b> copay per day for days 21-100
No 3-day hospital stay is required.	<b>20%</b> of the cost per stay for days 101-365	<b>20%</b> of the cost per stay for days 101-365
<b>PHYSICAL THERAPY</b>		
	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>AMBULANCE</b>		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	<b>4%</b> of the cost	<b>4%</b> of the cost
<b>PART B PRESCRIPTION DRUGS</b>		
	<b>4%</b> of the cost	<b>4%</b> of the cost





## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE SERVICES		
Routine acupuncture	20% of the cost \$3000 Maximum Benefit per year	20% of the cost \$3000 Maximum Benefit per year
Medicare-covered acupuncture	4% of the cost Limit 20 visit(s) per year	4% of the cost Limit 20 visit(s) per year
ALLERGY		
Allergy shots & serum	4% of the cost	4% of the cost
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	4% of the cost	4% of the cost
Routine chiropractic visit(s)	20% of the cost \$2000 Maximum Benefit per year for routine chiropractic services	20% of the cost \$2000 Maximum Benefit per year for routine chiropractic services
COVID-19		
Testing and Treatment	\$0 copay for testing and treatment services for COVID-19	
Health Essentials Kit	Kit includes over the counter items useful for preventing the spread of COVID-19 and other viruses. Limited one per year.	
DIABETES MANAGEMENT TRAINING		
	0% of the cost	0% of the cost
FOOT CARE (PODIATRY)		
Medicare-covered foot care	4% of the cost	4% of the cost
HOME HEALTH CARE		
	4% of the cost	4% of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	4% of the cost	4% of the cost
Medical supplies	4% of the cost	4% of the cost
Prosthetics (artificial limbs or braces)	4% of the cost	4% of the cost
Wigs (medically necessary)	20% of the cost 1 item(s) every 2 years for wigs	20% of the cost 1 item(s) every 2 years for wigs
Diabetes monitoring supplies	4% of the cost	4% of the cost
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	4% of the cost	4% of the cost





## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
PRIVATE DUTY NURSING		
	20% of the cost \$5000 Maximum Benefit per year for private duty nursing	20% of the cost \$5000 Maximum Benefit per year for private duty nursing
REHABILITATION SERVICES		
Occupational and speech therapy	4% of the cost	4% of the cost
Cardiac rehabilitation	4% of the cost	4% of the cost
Pulmonary rehabilitation	4% of the cost	4% of the cost
RENAL DIALYSIS		
Renal dialysis	4% of the cost	4% of the cost
Kidney disease education services	0% of the cost	0% of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	\$0 copay	Not Covered
Specialist	4% of the cost	Not Covered
Urgent care services	\$0 copay	Not Covered
Substance abuse or behavioral health services	\$0 copay	Not Covered
FITNESS AND WELLNESS		
	SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.	
HOSPICE		
You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.		



## HOW THE PRESCRIPTION DRUG PLAN WORKS

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

Included with your **UCC Medicare Advantage Plan w/Rx** is an extensive 4 Tier Part D prescription drug coverage to serve your medication needs. Our Part D plan provides many features that may make filling your prescriptions easier.

For certain medications, Humana may require prior authorization or step therapy. If you are prescribed a medication that requires prior authorization, your doctor must provide information that indicates the medication is being used appropriately, and requests that it be covered under your prescription drug plan.

**Step therapy** requires patients to try clinically effective, lower-cost medications before “stepping up” to a higher-cost medication.

Under the UCC Medicare Plan with Rx Part D benefit, every drug that is covered by Medicare is also covered by the plan. Participants can get a 30 day or 90 day supply at a retail pharmacy, or a 90 day mail order supply. There is no deductible with the prescription plan, and there is no coverage gap, also known as the doughnut hole; you have co-pay protection all the way through to the Catastrophic Phase.

You can check your plan’s formulary online or get the same assistance by calling Humana Customer Care, to see all the medications in your **Humana** plan, and into what tier they fall.

With your plan, you have access to **Humana Pharmacy**, Humana’s own best-in-class customer satisfaction and overall customer care mail order pharmacy. With **Humana Pharmacy**, you have the convenience of free shipping, in a plain package that’s typically small enough to fit into your mailbox. We also have two pharmacists that check every order for safety and accuracy, and there is a team of pharmacists and technicians just a phone call away.

In addition, Humana Pharmacy reminds you when your prescriptions need to be refilled. You may set up an account either online at [HumanaPharmacy.com](https://www.humana.com/humana-pharmacy) or at 1.888.538.3518.

Humana’s Part D coverage is spread among four groupings based on the drug type—also called “tiers”.

**It covers every drug that is covered through Medicare.**

Tiers	Standard Retail Cost Sharing (30-day Supply)	Standard Mail Order Cost Sharing (90 Day Supply)	Common Medications that fall into each tier
<b>Tier 1</b> (Generic/preferred generic)	\$17	\$34	Levothyroxine Sodium Simvastatin Omeprazole
<b>Tier 2</b> (Preferred brand)	\$35	\$90	Synthroid
<b>Tier 3</b> (Non-preferred brand)	\$50	\$125	Zocor Prilosec
<b>Tier 4</b> (Specialty)	\$50	N/A	Enbrel Procrit



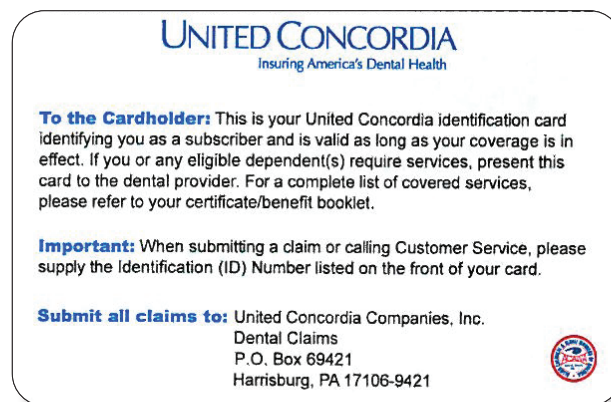
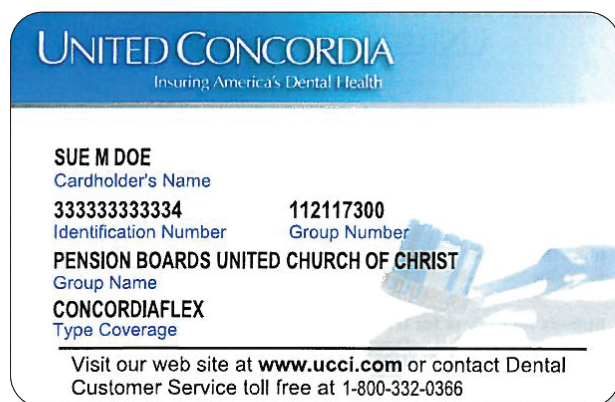
## HOW THE DENTAL PLAN WORKS

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

### PREFERRED PROVIDER ORGANIZATION (PPO)–ADVANTAGE PLUS 2.0

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

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



To find an  
Advantage Plus 2.0 PPO  
network provider:  
call 1.866.851.7576 or  
visit [www.ucci.com](http://www.ucci.com)

Submit dental claims to:  
United Concordia Companies, Inc.  
Dental Claims  
P.O. Box 69421  
Harrisburg, PA 17106-9421



**UNITED CONCORDIA**

**DENTAL  
EXPLANATION OF BENEFITS**  
KEEP FOR YOUR TAX RECORDS

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

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Subscriber: John Doe

ID Number: 999 99 9999

Page: 1 of 2

Patient: John Doe

Claim Number: 01260354768

Date: 09/27/01

Provider: PACO FRALICK DDS INC  
(000848516)

PROCEDURE DESCRIPTION PROCEDURE CODE (NUMBER OF SERVICES)	SERVICE DATE(S)	PROVIDER'S CHARGE	ALLOWANCE	AMOUNT PAID	AMOUNT NOT PAID	REMARKS
PERIODIC EVALUATION (001)	09/10/01	25.00	23.00	23.00	2.00	Q1030
DO120						
PROPHYLAXIS ADULT (001)	09/10/01	51.00	47.00	47.00	4.00	Q1030
D1110						
BITEWINGS FOUR FILMS (001)	09/10/01	34.00	30.00	30.00	4.00	Q1030
D0274						
	TOTALS	110.00	100.00	100.00	10.00	

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

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

**UNITED CONCORDIA**  
America's Premier Dental Insurer

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

THIS IS NOT A BILL

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



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

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

Benefit		
<b>Dental Services</b>	<b>Dental 2000</b>	
Annual Deductible	\$100/person or \$200/family	
Annual Benefit Maximum/per person	\$2,000	
<b>Type of Service</b> <i>Applies to both Dental 2000 and Dental 750 Plans</i>	<b>In-Network<sup>2</sup></b>	<b>Out-of-Network<sup>3</sup></b>
<b>Preventive Services and Supplies<sup>4</sup>:</b> <ul style="list-style-type: none"> <li>Cleaning and oral examination—two times per calendar year</li> <li>Fluoride application to child's teeth, age 16 and under—two times per calendar year</li> <li>Dental sealants, age 16 and under</li> <li>Space maintainers, age 16 and under</li> </ul>	100%	Plan pays 100% up to R&C limits
<b>Diagnostic and Therapeutic Services and Supplies:</b> <ul style="list-style-type: none"> <li>Periodontal cleanings—two times per calendar year</li> <li>Full mouth X-rays—once in a three-year period</li> <li>Bite-wing X-rays—two times in a calendar year</li> <li>Oral examination—two times in a calendar year</li> <li>Emergency care<sup>5</sup></li> <li>Extractions</li> <li>Treatment of gums</li> <li>Root canals</li> <li>General anesthetics for oral surgery</li> <li>Injectable antibiotics</li> </ul>	80%	Plan pays 80% up to R&C limits
<b>Restorative Services and Supplies:</b> <ul style="list-style-type: none"> <li>Fillings<sup>6</sup></li> <li>Crowns<sup>6</sup></li> </ul>	80% 50%	Plan pays 80% up to R&C limits Plan pays 50% up to R&C limits
<b>Prosthetic Services and Supplies:</b> <ul style="list-style-type: none"> <li>Full or partial dentures or fixed bridges</li> <li>Repair or rebasing of dentures or bridges</li> </ul>	50%	Plan pays 50% up to R&C limits
<b>Orthodontics up to a \$1,500 per person lifetime maximum</b>	50% after separate deductible per person	50% up to R&C limits after separate deductible per person

**DENTAL PLAN FOOTNOTES:**

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



### WHAT THE DENTAL PLAN DOES NOT COVER

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

1. Charges for reline/rebase of dentures or bridges are not covered more than once every 36 months. Repair of dentures is not covered more than once per arch per 36-month period.
2. Facings on pontics or crowns posterior to the second bicuspid.
3. Implants, except in limited circumstances. Please contact United Concordia Dental for review.
4. Motor vehicle accident injuries—services for treatment for injuries resulting from the maintenance or use of a motor vehicle if the services/treatment have been paid or are payable under a plan/policy of motor vehicle insurance. This includes a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefit established by state law. Payment for such injuries may be coordinated with your other insurance after those benefits have first been exhausted. The Dental Plan will then pay on a secondary basis.
5. 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. Services and supplies furnished in a U.S. governmental hospital for which you would not be required to pay if there were no coverage.
9. Services and supplies in connection with illness and injury caused by war whether declared or not, or by international armed conflict.
10. Services and supplies partially or wholly cosmetic in nature.
11. Training in or supplies used for dietary counseling, oral hygiene, or plaque control.
12. 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.
13. Workers' compensation-related illness or bodily injury, if benefits or compensation are available, in whole or in part, under the provisions of any federal, state or local government workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not the enrollee files a claim for said benefits or compensation.





## HOW THE VISION PLAN WORKS

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

### PREFERRED PROVIDER ORGANIZATION (PPO)–VSP

VSP's network consists of over 36,000 providers to provide professional vision care for persons covered under this Plan. When you want to obtain services, call a VSP provider to make an appointment. While you may obtain services from any eye care provider of your choice, you will receive your maximum eye care benefits from a VSP provider.

Vision services are covered on a "Service Year" basis. This means you will be eligible for your next covered benefit 12/24 months from the date of your last service: 12 months for exams, 24 months for frames. For example: If you had an eye exam on May 1, 2020, you will not be eligible for another eye exam until May 1, 2021. If you received eyeglass frames on July 1, 2020, you will not be eligible for new frames until July 1, 2022.

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

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

VSP will not provide ID cards at the time of enrollment. A confirmation letter from the Pension Boards will be sent to the participant once their initial application has been processed.

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

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



## SUMMARY OF BENEFITS: VISION BENEFITS THROUGH VSP

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

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
<b>YOUR COVERAGE WITH A VSP PROVIDER</b>			
<b>WELLVISION EXAM</b>	<ul style="list-style-type: none"> <li>Focuses on your eyes and overall wellness</li> </ul>	\$10 for exam and glasses	Every 12 months
<b>PRESCRIPTION GLASSES</b>			
<b>FRAME</b>	<ul style="list-style-type: none"> <li>\$150 allowance for a wide selection of frames</li> <li>\$170 allowance for featured frame brands</li> <li>20% savings on the amount over your allowance</li> <li>\$80 Costco, Walmart and Sam's Club frame allowance</li> </ul>	Combined with exam	Every 24 months
<b>LENSES</b>	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Polycarbonate lenses for dependent children</li> </ul>	Combined with exam	Every 12 months
<b>LENS ENHANCEMENTS</b>	<ul style="list-style-type: none"> <li>Standard progressive lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> <li>Average savings of 35-40% on other lens enhancements</li> </ul>	\$50 \$80 - \$90 \$120 - \$160	Every 12 months
<b>CONTACTS (INSTEAD OF GLASSES)</b>	<ul style="list-style-type: none"> <li>\$150 allowance for contacts and contact lens exam (fitting and evaluation)</li> <li>15% savings on a contact lens exam (fitting and evaluation)</li> </ul>	\$0	Every 12 months
<b>DIABETIC EYECARE PLUS PROGRAM</b>	<ul style="list-style-type: none"> <li>Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</li> </ul>	\$20	As needed
<b>EXTRA SAVINGS</b>	<b>Glasses and Sunglasses</b> <ul style="list-style-type: none"> <li>Extra \$20 to spend on featured frame brands. Go to <a href="http://vsp.com/offers">vsp.com/offers</a> for details.</li> <li>30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.</li> </ul>		
	<b>Retinal Screening</b> <ul style="list-style-type: none"> <li>No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam</li> </ul>		
	<b>Laser Vision Correction</b> <ul style="list-style-type: none"> <li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li> <li>After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor</li> </ul>		
<b>YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS</b>			
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.			
Exam .....	up to \$50	Lined Bifocal Lenses .....	up to \$75
Frame .....	up to \$70	Progressive Lenses .....	up to \$75
Single Vision Lenses .....	up to \$50	Lined Trifocal Lenses .....	up to \$100
		Contacts .....	up to \$105
<small>Coverage with a retail chain may be different or not apply. Once your benefit is effective, visit <a href="http://vsp.com">vsp.com</a> for details. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.</small>			



## COORDINATION OF BENEFITS

### MEDICARE

UCC Medicare Advantage Plan with Rx benefits are coordinated with your Medicare Part A and Part B benefits.

### SUBROGATION

If a covered participant 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 a third-party suit or settlement, or otherwise, of an amount up to and including the value of any such health services or supplies covered by the Plan, the participant is obligated to reimburse the Plan for the value of such benefits paid by the Plan.

### PARTICIPANT'S COOPERATION

In some circumstances, the participant's help will be requested to assist with the administration of the Plan. Enrollment in the Plan constitutes an agreement by the participant and by his or her covered dependents to cooperate with the Plan's administration requirements and efforts to enforce the Plan's rights to subrogation and reimbursement.

### PLAN ADMINISTRATION

The UCC Medical and Dental Benefits Plans are self-funded plans administered by The Pension Boards—United Church of Christ, Inc., an affiliated ministry of the United Church of Christ. The Pension Boards has engaged Humana, Express Scripts, United Concordia Companies, Inc., and VSP to provide claims administration services. Claims administration services do not insure benefits under the Plan. Final interpretation of any and all Plan provisions is the responsibility of the Pension Boards.



## YOUR RIGHTS TO APPEAL

If you have additional information for the reconsideration of a claim, please send it with your request. You are entitled to obtain copies of documents related to the claim. In some cases, approval may be needed to release confidential information such as medical records. 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. Appeals must be initiated within 12 months of the date of service in question.

### *Medical & Pharmacy Claims*

#### *Standard Appeal*

Humana Grievances and Appeals Dept.  
PO Box 14165  
Lexington, KY 40512-4165

You may request a Fast Appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

#### *Fast Appeal*

Phone 1.800.867.6601  
Fax 1.800.949.2961

### *Dental Claim*

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

### *Vision Claim*

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



## DEFINITIONS AND RELATED INFORMATION

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

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

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

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

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

**Coordination of Benefits:** When coverage exists under two health plans, benefits may be paid under both plans. Certain restrictions and guidelines apply with regard to reimbursement amount, which plan is primary, etc. See p. 34 for additional information.

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

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

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

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

**Domestic Partner:** A person who meets the financial, cohabitation and other requirements

established by the Pension Boards. To apply for benefits, you must submit a Statement of Domestic Partnership after you have been in the domestic partnership for at least six months.

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

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

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

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

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

**Medically Necessary:** Services or supplies that are appropriate and consistent with a diagnosis in accordance with accepted medical standards as described in the Plan **Summary of Benefits** (see p. 13-14). Medical necessity, when used in relation to services, shall have the same meaning as medically necessary services. All services are subject to the medical necessity requirement and to the exclusions and limitations described in this Plan.



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

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

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

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

**Plan:** The UCC Medical and Dental Benefits Plan.

**Plan Year Benefit Maximum:** The maximum amount the Dental Plan will pay in a Plan Year per covered individual. The amounts can be found on the Dental **Summary of Benefits** (see p. 30).

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

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

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

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

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



## PRIVACY PRACTICES

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

### PROTECTED HEALTH INFORMATION (PHI)

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

The Plan is required by law to:

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

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















**The Pension Boards**  
United Church of Christ, Inc.