Comprehensive Major Medical Preferred Provider Organization Guaranteed Renewable Policy for Individuals Utilizing the UPMC Health Options Inc., Preferred Provider Organization Network of Providers, Without a Referral Required

[UPMC *Advantage*]
Identified as [**UPMC *Advantage***]
UPMC HEALTH OPTIONS INC. (hereafter referred to as "UPMC Health Plan[1]"),
a Pennsylvania corporation whose address is
[U.S. Steel Tower, 600 Grant Street, Pittsburgh, Pennsylvania 15219]

INDIVIDUAL GUARANTEED RENEWABLE [PREMIUM SUBJECT TO CHANGE]

Your Right to Examine this Policy for Ten (10) Days

You have the right to return this Policy within ten (10) days of its delivery and to have the premium rate refunded if, after examination of the Policy, you are not satisfied for any reason.

Welcome and General Information for Members

Description: This is your Individual Policy (the "Policy"). If this Policy has been purchased on behalf of a child, references to "you" or "your" should be considered to reference the child. It describes your health care benefits and gives you details about benefits for medical expenses related to covered accidents and sicknesses. Such benefits are subject to all Deductibles, Coinsurance, Copayments, and other limitations set forth in this Policy. Your specific coverage period and premium rate will be communicated to you by letter prior to your Effective Date. For more information, see **Section II. Eligibility for Coverage.**

This benefit plan has cost-sharing, including Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limits. An Out-of-Pocket Limit puts a cap on the amount of money you can spend. Your Deductible is the amount you must pay for Covered Services before UPMC Health Plan begins to pay for Covered Services. Coinsurance is the percentage of the cost you pay for the Covered Services you receive. You will pay Copayments and/or Coinsurance each time you go to the doctor or pick up a prescription from the pharmacy, as well as at other times.

This Policy allows you to get Emergency Services at the highest benefit level. This is true even if you use health care providers who are not in our network. We know that it's not always possible to go to a Participating Provider in an emergency. If you require Emergency Services and cannot reasonably be attended to by a Participating Provider, UPMC Health Plan will pay for Emergency Services, so that you are not responsible for a greater out-of-pocket expense than if you had been attended to by a Participating Provider. A Non-Participating Provider is defined as a provider or facility licensed where required and performing within the scope of that license but is not a contracted provider with UPMC Health Plan and is not a provider within one of UPMC Health Plan's contracted Out-of-Area Networks.

All non-emergency care and services that UPMC Health Plan has Prior Authorized will be covered at the Participating Provider level. A referral is not required to access benefits from providers. That means that if you need to go to a specialist, you can go.

Your newborn children, whether natural born, adopted, or placed for adoption, are entitled to the health care benefits set

[1] In this document, the term "UPMC Health Plan" refers to benefit plans offered by UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., and/or UPMC Health Plan Inc. forth in this Policy from the moment of birth to a maximum of thirty-one (31) days from the date of birth.

UPMC Health Plan may adjust premiums after getting approval from the Pennsylvania Insurance Department. You will be notified in advance of any change in your premium. The Policy will remain in effect each month as long as you pay your premium. UPMC Health Plan will not terminate your Policy because of the deterioration of your mental or physical health or that of any individual covered under this Policy. Subject to the right of UPMC Health Plan to terminate coverage and to any amendment permitted under applicable law, this Policy will remain in effect continually until you terminate it, or UPMC Health Plan terminates your coverage in accordance with **Section X. Termination or Rescission of Coverage.**

[_____]
[Diane P. Holder, President and CEO, UPMC Health Plan]

[_____]
[Scott Lammie, Chief Financial Officer, UPMC Health Plan]

Thank you for choosing [**UPMC *Advantage***], which is a **Preferred Provider Organization** (PPO) Guaranteed Renewable plan for Individuals. Your coverage is defined by the following documents:

1. This Policy, which identifies Covered Services and the terms and conditions of coverage awarded to all covered persons eligible for guaranteed renewable coverage;
2. The Schedule of Benefits — Medical — to the Policy, which defines, among other things, your responsibilities for cost-sharing such as Copayment, Deductible, and Coinsurance amounts for Covered Services, including the Out-of-Pocket Limit liability within the Benefit Period (as applicable);
3. The Pediatric Dental Policy and Outline of Coverage, which further define the Dental coverage for members under the age of 19;
4. The Pediatric Dental Schedule of Benefits, for those enrolled members under the age of 19, which documents the Pediatric Dental benefits available under this plan;
5. The Pediatric Vision Certificate of Insurance, which further defines the Vision coverage for members under the age of 19;
6. The Pediatric Vision Schedule of Benefits, for those enrolled members under the age of 19, which documents the Pediatric Vision benefits available under this plan;
7. The Schedule of Benefits for Prescription Drugs;
8. [Information supplied on your application, which is your request for coverage]; and
9. Your identification (ID) card.

UPMC ADVANTAGE COMPREHENSIVE MAJOR MEDICAL PREFERRED PROVIDER ORGANIZATION (PPO) GUARANTEED RENEWABLE POLICY FOR INDIVIDUALS UTILIZING THE UPMC HEALTH PLAN NETWORK OF PROVIDERS, WITHOUT A REFERRAL REQUIRED

The coverage described in this Policy is at all times administered in compliance with applicable laws and regulations, including, but not limited to, the Affordable Care Act of 2010. If at any time any part or provision of this Policy is in conflict with any applicable law, regulation, or other controlling authority, the requirement of that authority prevails.

This Preferred Provider Organization (PPO) plan may not cover all your health care expenses. Please read your Policy and other plan documents carefully for complete information about benefits and exclusions. If you have any questions about your benefits, contact UPMC Health Plan's Member Services Department at the phone number on the back of your identification (ID) card, or write to:

Member Services Department
[UPMC Health Plan
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219]

UPMC *Advantage* Comprehensive Major Medical
Preferred Provider Organization (PPO) Guaranteed Renewable Policy for Individuals
Utilizing the UPMC Health Options, Inc. Network of Providers, Without a Referral Required

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Section I.

Terms and Definitions to Help You Understand Your Coverage

The following are some important and frequently used terms and definitions that UPMC Health Plan uses in this Policy and when administering your benefits.

Actuarial Value (AV) — The average share of overall costs that a health plan is expected to pay for covered benefits. For example, a health plan that was designed to pay for 70 percent of a member's covered health care costs would have an actuarial value of 70 percent. The covered member would pay the other 30 percent of his or her costs.

- Qualified Health Plans will be identified in four categories based on their actuarial value. The categories are:
  - Bronze (60%)
  - Silver (70%)
  - Gold (80%)
  - Platinum (90%)

Benefit Limit — The maximum amount that UPMC Health Plan will pay for a Covered Service. The Benefit Limit may be expressed in many ways, such as a dollar amount, number of days, or the number of services. Some Benefit Limits are discussed in this Policy, but generally are described in your Schedule of Benefits.

Benefit Period — The specified period of time (the calendar year) during which charges for Covered Services must be incurred in order to be eligible for payment by UPMC Health Plan. A charge shall be considered incurred on the date you receive the service or supply.

Coinsurance — The percentage of expenses for Covered Benefits that you are responsible to pay after meeting your Deductible, if you have one. The amount of your Coinsurance depends on the plan you select. Refer to your Schedule of Benefits to determine Coinsurance amounts. Copayments do not apply toward Coinsurance.

Complaint — A dispute or objection by an enrollee regarding a Participating Provider or the coverage (including contract exclusions and non-covered benefits), operations, or management policies of UPMC Health Plan, that has not been resolved by UPMC Health Plan and has been filed with UPMC Health Plan or the Pennsylvania Department of Health or the Insurance Department. Instructions for filing a Complaint are in **Section VIII. Resolving Disputes with UPMC Health Plan**.

Copayment — The specified dollar amount that you pay at the time of service, for certain Covered Benefits. Copayments do not apply toward your Coinsurance or Deductible. You are expected to pay Copayments at the time of service. Refer to the Schedule of Benefits to determine Copayment amounts.

Covered Benefit or Covered Services — A health care service or supply as set forth in **Section IV. Covered Services.** Such services must be Medically Necessary. Some may require Prior Authorization.

Covered Prescription Drugs — Prescription drugs ordered by an appropriately licensed health care professional by means of a valid prescription order, which UPMC Health Plan is contractually obligated to pay for or provide.

Deductible — The initial amount that you must pay each year for Covered Benefits before UPMC Health Plan begins to pay for Covered Benefits. See your Schedule of Benefits to determine which services, if any, apply to the Deductible and the Deductible amounts. Under some plans, if you have several covered dependents, you may have a family Deductible.

Effective Date — The date on which your coverage begins under this Policy as set forth in **Section II. Eligibility for Coverage.**

Emergency Services — A health care service provided after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or

more of the following:

- Placing the health of the individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Other serious medical consequences

Emergency transportation and related Emergency Services provided by a licensed ambulance service constitute an Emergency Service and will be covered at the in-network level whether the service is provided by a Participating or Non-Participating Provider.

Experimental/Investigational — The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) that is not determined by UPMC Health Plan, or its designated agent, to be scientifically validated and/or medically effective for the condition (including diagnosis and stage of illness) being treated. UPMC Health Plan will consider an intervention to be Experimental/Investigational if, at the time of service:

- The intervention does not have FDA approval to market for the specific relevant indication(s); or
- Available scientific evidence and/or prevailing peer-reviewed medical literature does not indicate that the treatment is safe and effective for treating or diagnosing the relevant medical condition or illness; or
- The intervention is not proven to be as safe or effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or
- The intervention has not been shown to improve health outcomes; or
- The effectiveness of the intervention has not been replicated outside the research setting.

If an intervention is determined to be Experimental/Investigational at the time of service, it will not be covered retroactively if, at a later date, it no longer meets the definition above.

Grievance — A request by you or your health care provider, with your written consent, to have UPMC Health Plan reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. If UPMC Health Plan is unable to resolve the matter, a Grievance may be filed regarding the decision that:

- Disapproves full or partial payment for a requested health care service.
- Approves the provision of a requested health care service for a lesser scope or duration than requested.
- Disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.

This term does not include a Complaint. Instructions for filing a Grievance are described in **Section VIII. Resolving Disputes with UPMC Health Plan.**

Lifetime Maximum — The maximum benefit that will be provided under this Policy for any member during his or her lifetime. Refer to your Schedule of Benefits to determine Lifetime Maximums.

Medical Necessity or Medically Necessary — Health care services covered under your benefit plan that are determined by UPMC Health Plan to be:

- Commonly recognized throughout the provider's specialty as appropriate for the diagnosis and/or treatment of your condition, illness, disease, or injury.

- Provided in accordance with standards of good medical practice and consistent with scientifically based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by UPMC Health Plan.
- Reasonably expected to improve your condition or level of functioning.
- In conformity, at the time of treatment, with medical management criteria/guidelines adopted by UPMC Health Plan

or its designee.
- Provided not only as a convenience or comfort measure or to improve physical appearance.
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

UPMC Health Plan reserves the right to determine whether a health care service meets these criteria. Authorization for coverage based upon Medical Necessity shall be made by UPMC Health Plan, at its discretion, with input from the treating provider. The fact that a provider orders, prescribes, recommends, or approves a health care service does not mean that the service is Medically Necessary or a Covered Benefit.

Member — A person who meets eligibility requirements specified in the Eligibility for Coverage section of this Policy and who is entitled to receive covered benefits under this Policy by virtue of having enrolled in this Policy. References throughout this Policy to "you/your" refer to the member.

Non-Participating Provider — A provider or facility licensed where required and performing within the scope of its license that is not a contracted provider with UPMC Health Plan and is not a provider with one of UPMC Health Plan's contracted Out-of-Area networks.

Out-of-Pocket Limit — The maximum dollar amount you are responsible for paying during a Benefit Period before UPMC Health Plan will pay for your Covered Benefits. See the Schedule of Benefits for Out-of-Pocket Limit amounts.

Participating Provider — A provider who has entered into an agreement with UPMC Health Plan to render Covered Services to Health Plan members or is a provider with one of UPMC Health Plan's contracted networks. All Health Plan Participating Providers are listed in our most current provider directory available online [www.upmchealthplan.com] or by calling the number on the back of your ID card.

Precertification — A process through which you must obtain approval from UPMC Health Plan before receiving any self-referred non-emergency inpatient care at a Non-Participating hospital as well as certain outpatient services. If you fail to comply with these requirements, a significant financial penalty will apply for each incident of non-compliance.

Prior Authorization — The process through which UPMC Health Plan determines whether the treatment or service is Medically Necessary and that such treatment or service will be obtained in the appropriate setting. For certain services or medication, you must obtain authorization prior to receiving such care, or a penalty may be assessed.

Qualified Health Plan — An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

Reasonable & Customary (R&C) Charge — For a Covered Benefit or Covered Service rendered by a Participating Provider, the R&C Charge is the amount agreed upon by UPMC Health Plan and the provider pursuant to a negotiated agreement. For the services authorized by UPMC Health Plan that are provided by a Non-Participating Provider, the R&C Charge is the amount that UPMC Health Plan determines is reasonable for Covered Services pursuant to industry standards. The Non-Participating Provider may charge you the difference between the billed amount and the R&C amount.

Service Area — UPMC Health Plan's primary Service Area, which consists of the counties listed in the most current version of the UPMC Health Plan Provider Directory. These are the counties in which UPMC Health Plan is licensed to do business and in which most of its Participating Providers are located.

Section II.

Eligibility for Coverage

When are you eligible for coverage?
Your coverage will begin when your completed application information and the applicable premium payment have been received. You will be notified by a Confirmation of Enrollment Letter which will include your Effective Date. **Please keep the Confirmation of Enrollment Letter with this Policy**. The Effective Date of coverage will be the first day of the month and is dependent upon the date on which UPMC Health Plan receives your enrollment application and premium payment. Failing to provide all the information requested may result in a delay of your Effective Date.

Who may be eligible for coverage?

- You are eligible if you live in the Service Area and are a U.S. citizen.
- You are eligible if you live in the Service Area and are a lawfully present immigrant. The term "lawfully present" includes immigrants who have:
    - "Qualified non-citizen" immigration status without a waiting period
    - Humanitarian status or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)
    - Valid non-immigrant visas
    - Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals)
- Your spouse under a legally valid existing marriage. A spouse who is eligible for Medicare coverage may not be eligible for this coverage.
- Your children under 26 years old, including newborn children, stepchildren, children legally placed for adoption, and children for whom coverage is mandated by a court order or for whom you have custody or guardianship as set forth in a court order or other legally binding document. See **Section VII. Benefit Coverage and Reimbursement** for information regarding coordination of benefits. Your child's coverage automatically terminates and all benefits hereunder cease, whether or not a notice to terminate is received by UPMC Health Plan, at the end of the policy year in which he or she turns 26 years old.
- Disabled Dependents, subject to the criteria as set forth below.
- Domestic Partners: A relationship of two individuals of the opposite or same sex who have an exclusive mutual commitment, similar to marriage, in which the individuals agree to be jointly responsible for each other's common welfare, living expenses, and financial obligations.

To obtain coverage for a dependent, you may be required by the Health Plan to provide proof that the individual meets one of the above criteria. Coverage is contingent on the dependent's meeting all of the eligibility criteria, UPMC Health Plan's acceptance of an application, and payment of the premium.

How do you enroll a dependent?
There are two ways you can enroll an eligible dependent. First, you may enroll an eligible dependent during your open enrollment period. Second, you may apply to enroll an eligible dependent within sixty (60) days of the date on which the dependent becomes eligible for coverage. You must complete and submit an enrollment application within the sixty (60)-day period. Coverage for newly acquired eligible dependents will be effective [the first day of the month] following the receipt and acceptance of an enrollment application by UPMC Health Plan.

The following are rules for special circumstances about the coverage of dependents:

Newborn and Adopted Children: Newborn children, whether natural born, adopted, or placed for adoption, are covered automatically from the moment of birth or from the date of legal placement for thirty-one (31) days regardless of the length of your coverage period. To obtain coverage for that child beyond the initial thirty-one (31)-day period, you must submit an application within sixty (60) days of the child's birth or adoption, along with the appropriate premium.

Court Order: Coverage for dependents who are required to be covered under a court order will be effective no later than thirty (30) days from UPMC Health Plan's receipt of the court order provided that the dependent has submitted a completed application, the application has been accepted by UPMC Health Plan, and you make the appropriate premium payment when due.

Disabled Dependents: The disabled dependent child, as medically certified by a physician due to mental retardation or a physical disability, mental illness, or developmental disability, who became so prior to the attainment of age nineteen (19) must:

- Be unmarried and remain unmarried while enrolled in UPMC Health Plan; and
- Be chiefly dependent (more than fifty percent [50%]) upon you for support and maintenance; and
- Be your child (either from birth, as a stepchild, or through legal adoption) or a child for whom you are legally obligated to provide principal support through a court order.

Military Leave: If an eligible dependent child who is a member of the Pennsylvania National Guard or any reserve component of the United States Armed Forces and a full-time student at a school, college, or university has been called to active duty (other than active duty for training) for a period of thirty (30) or more consecutive days, then that dependent is eligible for an extension of coverage for a period equal to the duration of active duty service or until the dependent is no longer a full-time student. Eligibility of the dependent who is called to active duty may not terminate by reason of age when his or her enrollment was interrupted because of military duty.

For purposes of this section, a "full-time student" is defined as a student enrolled in an approved institution of higher learning pursuing an approved program of education equal to or greater than fifteen (15) credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study.

To qualify for the active duty extension, the dependent must (1) submit a form approved by the Department of Military and Veterans Affairs notifying UPMC Health Plan that he or she has been placed on active duty; (2) submit a form approved by the Department of Military and Veterans Affairs notifying UPMC Health Plan that the dependent is no longer on active duty; and (3) submit a form approved by the Department of Military and Veterans Affairs showing that he or she has re-enrolled as a full-time student, as set forth above, for the first term or semester starting sixty (60) or more days after his or her release from active duty.

Loss of Other Health Coverage: You may have a dependent for whom you declined Health Plan coverage because that person had other health care coverage. If your dependent loses that coverage, your dependent can join UPMC Health Plan. You must enroll the dependent in UPMC Health Plan within sixty (60) days of losing the other coverage, and under the following conditions:

- When you declined the coverage, you stated in writing that you did so because the dependent had other health coverage; or
- When you declined the coverage, your dependent had COBRA coverage and that coverage has since been exhausted.
- When you declined the coverage, you or your dependent had Medical Assistance or Children's Health Insurance Program (CHIP) coverage that you have lost.
- You or your dependent(s) will be able to enroll in coverage in under this plan if you or your dependent(s): (1) are covered under Medical Assistance or CHIP but lose eligibility for that coverage; OR (2) become eligible for a premium assistance subsidy under Medical Assistance or CHIP.

The termination of the prior coverage must have occurred due to your dependent's loss of eligibility for such coverage. To be eligible for this special enrollment period, prior coverage must not have been terminated because of your dependent's failure to make timely premium payments or for cause (for example, making a fraudulent claim).

Enrolling or changing enrollment status

You may apply for enrollment or change the enrollment status for yourself or a dependent during open enrollment or within sixty (60) days of becoming eligible for coverage. For additional information, contact UPMC Health Plan. Remember that for UPMC Health Plan to properly manage your benefits and coverage, you must keep UPMC Health Plan up to date

regarding any changes in your contact information (address, telephone number, etc.) and changes in family status (marriages, deaths, births, etc.).

When will your coverage begin?
Your coverage will begin on the Effective Date stated in your Confirmation of Enrollment Letter from UPMC Health Plan. Your Effective Date is contingent upon UPMC Health Plan's receiving the applicable premium payment and your application.

What happens to your coverage if you lose eligibility?
Once enrolled, each covered person must continue to meet the applicable eligibility criteria identified in this Policy to continue to be covered under this plan. In the event that a dependent becomes ineligible for coverage under this plan due to divorce or legal separation or reaching the maximum age (for children), coverage under the plan shall terminate; however, the dependent may apply within [sixty (60) days] of loss of eligibility for conversion coverage or an individual policy as a separate policyholder, without evidence of insurability.

Section III.

A Guide to Obtaining Covered Benefits

You have chosen the Health Plan Preferred Provider Organization (PPO) Plan. What does this mean for you? It means you have the ability to self-direct your care. You have two levels of benefits. You can use Participating Providers, also called in-network providers, for all Covered Services, as well as Non-Participating Providers, also called out-of-network providers, for most Covered Services. If you obtain services from Participating Providers, you will receive the highest level of benefit coverage. If you obtain services from Non-Participating Providers, you will receive a lower level of benefit coverage.

Be sure to read this Policy to determine whether a service will be covered if you obtain it from a Non-Participating Provider. Remember, if you use Non-Participating Providers, you may receive a lower level of benefit coverage and you may be billed by the Non-Participating Provider for the difference between the provider's charges and the allowed amount. Because UPMC Health Plan does not contract with Non-Participating Providers, the provider can bill you for any amount over and above what UPMC Health Plan covers.

The UPMC Health Plan provider network

The Health Plan's network includes physicians, other professional providers, and hospitals. All of our Participating Providers are carefully evaluated before they are accepted into the network. UPMC Health Plan performs a review process, called credentialing, to make sure that providers meet UPMC Health Plan's provider participation standards.

To find a Participating Provider, refer to the provider directory. You can visit [www.upmchealthplan.com] to search our online provider directory or you can call UPMC Health Plan at the phone number on the back of your ID card to have a provider directory sent to you.

You may also obtain most Covered Services from Non-Participating Providers. Non-Participating means that UPMC Health Plan hasn't contracted with these providers.

Below is a list of the types of providers from whom you may seek care if they are Participating Providers, subject to referral and Prior Authorization, if applicable. Note that using or not using an adjective such as Participating, Preferred, Non-Participating, or Non-Preferred in modifying any Provider is not a statement regarding the ability of the Provider. Also, using or not using an adjective such as Contracting or Non-Contracting in modifying any supplier is not a statement regarding the ability of the supplier.

UPMC Health Plan contracts with the types of providers listed below:
Contracted providers are also called Participating Providers.

Contracted providers include:

- Audiologists
- Behavioral Health – Doctoral (PhDs) and/or master's level
- psychologists, master's level social workers, master's level clinical nurse specialist or psychiatric nurse practitioners, and other Behavioral Specialists
- Chiropractors (DC)
- Clinical laboratories
- Dentists (DDS or DMD) for our Dental Network
- Occupational therapists
- Physical therapists
- Physician Extenders – Certified Nurse Midwives (CNM), Certified Registered Nurse Practitioners (CRNP), and Certified Nurse Anesthetists (CRNA)

- Podiatrists (DPM)
- Primary Care Physicians (PCP) includes both Medical Doctor (MD) and Doctor of Osteopathy (DO) physicians
- Respiratory therapists
- Specialists Physicians – includes both MDs and DOs
- Speech pathologists

Facility Providers

- Alcohol abuse treatment facilities
- Ambulance services
- Ambulatory surgical centers
- Birthing facilities
- Convenience care clinics
- Drug abuse treatment facilities
- Freestanding dialysis clinics
- Freestanding nuclear magnetic resonance imaging facilities
- Home health care agencies
- Home infusion therapy providers
- Hospices
- Hospitals
- Outpatient alcohol and/or drug abuse treatment facilities
- Outpatient physical rehabilitation facilities
- Outpatient psychiatric facilities
- Psychiatric hospitals
- Rehabilitation hospitals
- Skilled nursing facilities
- Urgent care centers

Transitioning care from non-participating providers to participating providers

If you are a new member, you may be receiving care from a Non-Participating Provider. You may want to select a Participating Provider to obtain Covered Services at the network rate.

UPMC Health Plan recognizes, however, that it is not easy to change to a new provider who is not yet familiar with your medical condition, history, and other information. That is why UPMC Health Plan provides a transition of care period, so your current provider can communicate with your new provider to coordinate your care.

When you enroll, if you are currently in active ongoing treatment with a Non-Participating Provider, you may be able to continue this treatment, which will be paid at an in-network rate, for a period of up to ninety (90) calendar days from the effective date of your enrollment. You must complete and submit a Transition of Care application within thirty (30) calendar days of your effective date, available from UPMC Health Plan's Member Services Department by calling the phone number on the back of your ID card, and obtain Prior Authorization from UPMC Health Plan to continue treatment with a Non-Participating Provider. If you are in the second or third trimester of pregnancy on the effective date of your enrollment, the transition of care period extends through postpartum care related to the delivery of your child.

Provider Terminations

If you are receiving an active ongoing treatment for a medical condition with a Participating Provider and that provider's contract is terminated, you may request a transition of care period of up to sixty (60) calendar days. If receiving an active course of treatment for a chronic condition, you may request to continue treatment for up to (90) calendar days from the date that you are notified of the provider's termination. If you are in the second or third trimester of pregnancy, you may request to continue maternity care through the postpartum period and delivery of your child. You must obtain Prior Authorization from UPMC Health Plan to continue care with a provider whose contract is terminated.

Managing your health care
In order to receive coverage for services, those services must be Medically Necessary. UPMC Health Plan's Medical Management Department, made up of doctors and nurses, works to make sure you are receiving quality care in the most clinically appropriate setting. Here is how the Medical Management Department decides this:

Prior Authorization and Pre-certification: Certain Covered Services and medications require Prior Authorization, or Pre-certification. This means that you or your provider must get UPMC Health Plan's approval before you receive certain services or certain medications. Some, but not all Prior Authorization requirements are listed in this section and in the **Covered Services** section of this Policy. If you are unsure whether a service requires Prior Authorization, call UPMC Health Plan and a representative will assist you.

When you or your provider requests Prior Authorization, the Medical Management Department may ask for more information before making a decision. Such additional information includes, but is not limited to, your medical records. If you or your provider does not provide UPMC Health Plan the requested information, your request may be denied.

Concurrent reviews: Sometimes the Medical Management Department will review services that you are currently receiving. These reviews might happen while you are actually a patient in the hospital. That is what "concurrent" means. UPMC Health Plan does this to determine the Medical Necessity of (1) how long you stay in the hospital and (2) the treatment you are being provided with while you are there. UPMC Health Plan will review your treatment plan and your progress with the hospital or facility staff. Based on the information obtained, UPMC Health Plan will decide if your treatment should be longer or if it should change in some way.

Post-service reviews: Sometimes the Medical Management, Quality Audit, and Fraud and Abuse Departments will review services that were provided without the required authorization. They will also do this in cases when more information is needed to determine if a service was Medically Necessary or if the provider/facility was paid the correct amount.

Discharge planning: The purpose of discharge planning is to go over your needs with you before you leave the hospital or a facility so that you will have the care you need when you leave. Your provider helps with your discharge planning, along with nursing staff and others. Information taken into consideration includes, but is not limited to:

- Your level of function before and after your admission
- Your ability to care for yourself and whether you have others to care for you
- Your living arrangements before and after your admission
- Any special equipment or safety needs
- The need to refer you to a health coaching program

Nurse Advice Line
If you would like to speak to a registered nurse about a specific health concern, call our *My*Health Advice Line 24 hours a day, 7 days a week at [1-866-918-1591]. Members may also submit email inquiries 24 hours a day/7 days a week using the Web Nurse Request system available on the UPMC Health Plan website at [www.upmchealthplan.com].Responses to email inquiries will be within 24 hours of receipt of the original message.

Health coaching: If you have a serious illness or injury, or if you have long-term or more than one health condition, you may enroll in a health coaching program. Health Plan health coaches work with you, your family, or other people in your support system. We work with your health care providers to build a plan of care that meets your needs. Health coaches can tell you about resources in your community that might be able to help you with your health care needs. They can also help you find other resources for coverage of health care services if it is determined that you may meet your Benefit Limits.

Relationship with providers
UPMC Health Plan recognizes the importance of maintaining the continuity of care rendered to you by your treating health care providers. To facilitate the management and quality of your overall treatment, UPMC Health Plan may exchange information, including claims information, with your health care providers.

Section IV.

Covered Services

UPMC Health Plan provides coverage for the following health care services when those services are Medically Necessary. Refer to your Schedule of Benefits for Copayments, Deductibles, and Coinsurance amounts, as well as any Benefit Limits related to Covered Services. You may obtain most Covered Services from either Participating or Non-Participating Providers and receive varying levels of coverage, as discussed throughout this Certificate of Coverage. However, there are certain services that will not be covered if you do not receive them from a Participating Provider. A doctor's statement that you should have certain services does not mean the services are Medically Necessary and, therefore, Covered Services under your benefit plan.

If UPMC Health Plan determines that coverage is Medically Necessary, the benefits listed below may be subject to applicable Copayments, Deductibles, and Coinsurance. Also remember that some of the services may require Prior Authorization.

Preventive services

Routine and Preventive Services: The following routine and preventive care services will be covered at no-cost sharing when performed by Participating Primary Care Providers:

- Items or services recommended with an A or B rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved.
- Immunizations for routine use in children, adolescents, and adults that the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention recommends with respect to the individual involved.
- Evidence-informed preventive care and screenings for infants, children, and adolescents that is provided in the comprehensive guidelines and supported by the Health Resources and Services Administration.
- Evidence-informed preventive care and screenings for women that is provided in the comprehensive guidelines and supported by the Health Resources and Services Administration.

A list of preventive services can be found in the Preventive Services Reference Guide available on the UPMC Health Plan website at [www.upmchealthplan.com]. Please be aware that this list may be amended from time to time to comply with recommendations from the above-mentioned entities. Some recommendations may have a future effective date. Therefore they may not be covered at no cost-sharing until plan years beginning on or after that date. A complete listing of recommendations and guidelines can always be found at [www.HealthCare.gov/center/regulations/prevention.html].

Physician office visit: For treatment of medical disease or injury, the Deductible is waived for the first three office visits.

Colorectal cancer screening
Benefits if you do not have symptoms and are age fifty (50) and over:

- An annual fecal occult blood test (or fecal immunochemical test) or
- A sigmoidoscopy, a screening barium enema, or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five (5) years or
- A colonoscopy at least once every ten (10) years

Benefits if you have symptoms:

- A colonoscopy, sigmoidoscopy, or any combination of colorectal cancer screening tests at a frequency determined by a treating physician

Benefits if you do not have symptoms but are at an increased risk for colorectal cancer and are under 50 years of age:

- A colonoscopy or any combination of colorectal cancer screening tests in accordance with current appropriate medical guidelines

Lung Cancer Screening (Low-dose Computed Tommography (CT) for Lung Cancer Screening)

- Benefits if you meet the eligibility recommendations set forth by the USPSTF, and
- Benefits if the lung cancer screening is performed at a UPMC Health Plan credentialed Center of Excellence.

Women's care

Routine gynecological examinations and Pap smears: All female members have direct access to and are covered for an annual routine gynecological examination, which includes a pelvic examination, breast examination, and Pap smear, in accordance with the recommendations of the American College of Obstetricians and Gynecologists or as otherwise required by the Affordable Care Act. See also Preventive Services Reference Guide at [www.upmchealthplan.com].

Mammograms: Beginning at age 40, all female members are covered for one annual routine mammogram. Routine Mammograms are covered for female members at any age if ordered by a physician. See also Preventive Services Reference Guide at [www.upmchealthplan.com].

Hospital services
Your benefit plan covers the following services that you receive in a hospital or other facility if such services are Medically Necessary:

- Inpatient only (Hospital)
    - Room and board
        - A semiprivate room and board
        - A private room and board when determined to be Medically Necessary
        - A bed in a special or intensive care unit when your condition requires constant attendance and treatment for a prolonged period of time
    - General nursing care
    - Ancillary services and supplies related to the inpatient stay
- Inpatient and outpatient (Hospital or Ambulatory Surgical Facility)
    - Pre-Admission Testing, including tests and studies that are required before you are admitted to the hospital
    - Drugs and medicines provided to you while you are a patient in the hospital or ambulatory surgical facility
    - Use of operating room and supplies
    - Diagnostic services and testing
    - Therapy services
    - Hospital services and supplies for inpatient and outpatient surgery, including removal of sutures, anesthesia, and anesthesia supplies and services, furnished by an employee of the hospital or other facility other than the surgeon or assistant at surgery
    - Whole blood and blood products, administration of blood and blood products, and blood processing

If you have an office visit or receive services at an outpatient clinic that is owned by a hospital, you may be responsible for a facility fee, clinic charge, or similar fee. This charge is in addition to any applicable professional fees.

Maternity services

- Your benefit plan covers services necessary to provide comprehensive care for both mothers and babies. If you believe that you are pregnant, contact your treating provider or an obstetrician or nurse-midwife. If your provider determines that you are pregnant, you are eligible for prenatal care coverage, including Medically Necessary sonograms, delivery, postpartum care, and care for your newborn while you are in the hospital.
- You will receive coverage for hospital services associated with delivery of your baby for at least forty-eight (48) hours following a vaginal delivery and for at least ninety-six (96) hours following a Cesarean section.
- You and your newborn are also covered, with no cost-sharing, for one home health care visit within forty-eight (48) hours of an early discharge from the hospital. Such discharge must occur prior to the passing of forty-eight (48) hours of inpatient care after a vaginal delivery or ninety-six (96) hours after a Cesarean section. Home health care visits shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the provider.

Emergency services
You do not need prior approval from UPMC Health Plan or your doctor to receive Emergency Services.

Use Emergency Services only when it is appropriate to do so. For situations such as a sore throat or earache, it may be better for you to contact your treating provider who knows you and your medical history. Remember that non-Emergency Services provided in an emergency department will not be covered, unless those services were authorized by your treating provider or UPMC Health Plan.
You should contact your treating provider within 24 hours of receiving Emergency Services or to obtain follow-up care. In the event of an emergency admission to a hospital or other facility, the hospital or other facility must contact UPMC Health Plan within 48 hours or on the next business day following the admission.

Ambulance services
Your benefit plan covers ambulance services by a specially designed and equipped vehicle when you are sick or injured. Ambulance services include transportation from your home or the scene of an accident or medical emergency to a hospital capable of treating your medical condition, between hospitals, and between a hospital and a skilled nursing facility.

- Non-emergency routine transportation is not a Covered Benefit for members with the exception of facility-to-facility transfers which is a Covered Benefit if Medically Necessary, such as the need for a higher level of care, and not solely for the convenience of the member or family.
- Ambulance transportation for previously scheduled and planned treatments and therapies is not a Covered Benefit (e.g., dialysis).

Physician/surgical services
Your benefit plan covers the following surgical services that you receive from a professional provider, if such services are Medically Necessary:

- Surgery performed by a professional provider, including pre- and postoperative office visits. Surgery includes the following procedures:
  - Oral surgery is covered only for the following procedures in an outpatient setting or in an inpatient setting when such setting is determined to be Medically Necessary:
    - Extraction of impacted third molars that are partially or totally covered by bone
    - Excision of malignant lesions/tumors of the mandible, mouth, lip, or tongue
    - Incision of accessory sinuses, mouth, salivary glands, or ducts
    - Manipulation of dislocations of the jaw
    - Reconstruction to repair a non-dental physiological condition that has resulted in a severe functional impairment
    - Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct bony deficits associated with extremely wide clefts that affected the alveolus
    - Surgery for temporomandibular joint disease
      - In order for surgery to be covered, documentation in the medical record must support that treatment of TMJ disorder with conventional non-surgical therapy has not resulted in adequate improvement.
    - Anesthesia for dental procedures may be covered after Medical Necessity review and Prior Authorization for services. Eligible dental patients include those who are 7 years or younger, or patients of any age who are developmentally disabled persons of any age, and for whom a superior result can be expected for treatment under general
      anesthesia, OR patients of any age with documented medical conditions including, but not limited to: sever local oral infection or certain physical or mental health conditions.
  - All other oral surgery and related services are excluded from coverage.
  - Mastectomy and Breast Cancer Reconstruction: Your benefit plan covers a mastectomy performed on an inpatient or outpatient basis as well as any surgery needed to reestablish symmetry or alleviate functional impairment. This includes:
    - 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.
    - External breast prostheses – Initial and replacement breast prosthesis are covered as per your benefit plan and UPMC Health Plan policy in accordance with the federal Women's Health and Cancer Rights Act of

1998.
    - Treatment of physical complications at all stages of the mastectomy, including lymphedema.
    - If requested by your physician, one home health care visit may be obtained within 48 hours following a hospital discharge if that discharge from the hospital occurs within 48 hours of admission for the mastectomy.
    - Prophylactic Mastectomy may be covered under your benefit plan after review for medical necessity if you have a high or moderate to high risk of developing breast cancer based on factors including, but not limited to, significant family or personal history of breast cancer; genetic predisposition or other conditions that may lead to breast cancer
- Surgical assistant services, meaning the services of a physician who actively assists the operating surgeon who is performing covered surgery, only in the event that an intern, resident, or house staff member is not available.
- A second surgical opinion from a professional provider and related diagnostic services to confirm the need for elective covered surgery. The second opinion must be from a physician other than the physician who initially recommended the elective surgery. Elective surgery is non-emergency surgery, or surgery that can be delayed.

Provider Medical Services

Inpatient medical services
Your benefit plan covers the following services that you receive from a professional provider while you are an inpatient in a hospital or other facility for a condition not related to surgery, pregnancy, or a behavioral health condition, if such services are Medically Necessary:

- Routine visits by the admitting physician to follow your care
- Intensive medical care when your condition requires constant attendance and treatment by a professional provider for a prolonged period of time
- Consultation services when requested by your attending physician
- Visits by a professional provider, to examine a newborn while the mother is an inpatient

Convenience Care
When you cannot see your family doctor right away, but you require medical attention, you may want to use convenience care. At a convenience care clinic (such as one found in a drug store), you may be seen by a certified nurse practitioner or physician assistant. You can use convenience care for an unexpected illness or injury that does not constitute an emergency medical condition or an urgent situation. Examples of convenience care conditions include motion sickness prevention, allergy symptoms, earaches, sore throats, sprains/strains, and similar problems.

Urgent care
Urgent care is care received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed. At an urgent care clinic you may be seen by a physician or a nurse practitioner, but a physician is generally always on site. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering or severe pain. These services include all of the convenience clinic treatments, plus a broader range of treatments and tests such as x-rays, setting broken bones, and stitches.

eVisits
An eVisit is a type of electronic visit that can provide access to care for many common symptoms and diagnoses, such as sinus infections, cold and flu symptoms, sore throat, and more. UPMC Health Plan utilizes AnywhereCare as the preferred provider of eVisits for adults and children 3 years old and older. After visiting [https://myupmc.upmc.com/anywhere- care], you answer a few questions about your symptoms. A UPMC medical professional will contact adult members with a diagnosis and treatment plan. For children age 3-18, you can schedule a video appointment with a pediatrician who will make a diagnosis and develop a treatment plan. If you or your child needs a prescription, UPMC AnywhereCare will send the information to your local pharmacy.

Pediatric dental services
For members under the age of nineteen (19), dental services are covered for pediatric dental care. For additional information please refer to your Pediatric Dental Certificate of Insurance and Pediatric Dental Schedule of Benefits.

Anesthesia for dental procedures may be covered after Medical Necessity review and Prior Authorization for services. Eligible dental patients include those who are 7 years or younger, or are developmentally disabled persons of any age, and for whom a superior result can be expected for treatment under general anesthesia, OR patients of any age with documented medical conditions including, but not limited to: severe local oral infection or certain physical or mental health conditions.

Pediatric vision services
For members under the age of nineteen (19), vision services are covered for pediatric vision care. For additional information please refer to your Pediatric Dental Certificate of Insurance and Pediatric Vision Schedule of Benefits.

Outpatient medical care
Outpatient medical care consists of visits to a professional provider's office, whether a treating provider or specialist, for an illness or injury not related to surgery, pregnancy, or behavioral health condition. Your benefit plan covers the evaluation, examination, services, and supplies necessary to diagnose and treat basic medical illnesses, diseases, and injuries, if such services are Medically Necessary. If you have an office visit or receive services at an outpatient clinic that is owned by a hospital, you may be responsible for a facility fee, clinic charge, or similar fee. This charge is in addition to any applicable professional fees.

Allergy services
Diagnostic testing consisting of percutaneous, intracutaneous, and patch tests, and treatment including injections and serum.

Diagnostic services
Your benefit plan covers the following diagnostic services when Medically Necessary and ordered by a professional provider and rendered by a participating laboratory or other provider:

- Diagnostic x-ray, including radiology, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine
- Diagnostic pathology consisting of laboratory and pathology tests
- Diagnostic medical procedures consisting of electrocardiogram, electroencephalogram, and other electronic diagnostic medical procedures and physiological medical testing approved by UPMC Health Plan
- Diagnostic testing to establish a diagnosis of infertility; all other services related to infertility are your financial responsibility

If you have an office visit or receive services at an outpatient clinic that is owned by a hospital, you may be responsible for a facility fee, clinic charge, or similar fee. This charge is in addition to any applicable professional fees.

Rehabilitative and habilitative therapy services
Your benefit plan covers the following therapy services that are Medically Necessary:

Physical therapy (PT), occupational therapy (OT), and speech therapy (ST)
Your provider must provide a diagnostic evaluation prior to ordering these therapy services to establish whether or not these services are Medically Necessary. The provider must anticipate that these services will result in substantial improvement to your medical condition. See your Schedule of Benefits for Benefit Limits regarding these services.

Cardiac and pulmonary rehabilitation
These services are covered when Medically Necessary and ordered by a physician. See your Schedule of Benefits for applicable Benefit Limits.

Medical therapy services
Radiation Therapy, Chemotherapy, Dialysis Treatment

Injectable, Infusion Therapy, or other Drugs Administered or Provided by a medical professional in an outpatient or office setting
Covered drugs include drugs that usually are not self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services.

Cancer treatment: Cancer chemotherapy and cancer hormone treatments, which have been approved by the United

States Food and Drug Administration for general use in the treatment of cancer, whether performed in a physician's office, in an outpatient department of a hospital, in a hospital as a hospital inpatient, or in any other Medically Necessary treatment setting, are covered.

Pain management programs
These services are covered if you are diagnosed with refractory chronic pain of at least six (6) months duration. The provider must demonstrate that he or she anticipates these services to result in substantial improvement to your medical condition.

Behavioral health services
Your benefit plan covers the following services when Medically Necessary to treat behavioral health conditions if the services are provided by a participating hospital or other facility:

- Inpatient facility services are covered as outlined in your Schedule of Benefits. These services include a semiprivate room and board; individual, group, and family psychotherapy or counseling; medications and electroconvulsive therapy; medical supplies and services; and diagnostic and other therapeutic services.
- Outpatient facility services are covered as outlined in your Schedule of Benefits.
- Psychological and neuropsychological testing is covered only if your provider obtains Prior Authorization from UPMC Health Plan for such testing.

Substance abuse services
Your benefit plan covers the following services when Medically Necessary that are obtained from a participating hospital or other facility provider:

- Inpatient and non-hospital detoxification services are covered.
- Inpatient and non-hospital residential rehabilitation therapy is covered. Covered inpatient services include room and board; physician, psychologist, nurse, and certified addictions counselor services; diagnostic x-ray; psychiatric, psychological, and medical laboratory testing; medications; equipment use; and supplies.
- Outpatient rehabilitation services are covered. Outpatient services include individual and group counseling and psychotherapy; psychiatric and psychological testing; and family counseling for the treatment of alcohol and drug abuse.

Other Medical Services

Acupuncture
[Acupuncture is only covered when it is used for the treatment of post-operative nausea, chemotherapy induced nausea, excessive nausea and vomiting associated with pregnancy, migraines, chronic low back pain, and knee osteoarthritis.]

Corrective appliances
Orthotics and prosthetics are corrective appliances or devices that restore basic bodily function. Prosthetics replace all or part of the function of a missing body part or a permanently useless or malfunctioning body part. Prosthetics may be implantable devices or an equivalent external device. Examples of prosthetics are artificial limbs, artificial eyes, external breast prosthesis, hip/knee prosthetics, and penile prosthesis. A penile prosthesis must be prior authorized by UPMC Health Plan. Orthotics are used to restrict, modify, or eliminate motion of a misaligned, weak, or diseased body part, prevent deformity or injury, and aid in proper functioning of normal activities. Orthotics are rigid or semi-rigid supportive devices. Leg braces are an example of orthotics.

Your benefit plan will cover the purchase, fitting, and necessary adjustments to orthotics and prosthetics when they are Medically Necessary.

Repair costs will be covered when the cost is less than 50% of the cost of a replacement item. Replacement coverage may be provided when the cost to repair the damaged item exceeds 50% of the price of a new item; it is Medically Necessary due to a change in your medical condition; repair of the item is not a feasible option; or the item is lost or stolen and you provide appropriate documentation of the events and circumstances of the loss. The decision to cover repair or replacement is at the sole discretion of UPMC Health Plan.

Note that your benefit plan only covers orthopedic shoes and shoe inserts if you have diabetes to prevent foot injury and/or disease.

Durable medical equipment (DME)
Your benefit plan covers the rental or, at UPMC Health Plan's discretion, the purchase of durable medical equipment for therapeutic use when prescribed by a professional provider if such services are Medically Necessary. Examples of DME are hospital beds, wheelchairs, ventilators, oxygen tanks or concentrators, crutches, walkers, canes, commodes, and suction machines.

Repairs to medically necessary DME and Corrective Appliances
When the DME, corrective appliance, or other device is under the manufacturer's warranty, repairs are the responsibility of the manufacturer. If the expense for repairs exceeds 50% of the estimated expense of purchasing replacement equipment for the remaining period of medical need, payment shall be limited to the replacement cost.

Replacements for medically necessary DME and Corrective Appliances
The replacement of the equipment before the five (5) year life expectancy can only be done if the item is irreparably damaged, for example by a natural disaster such as fire, flood, etc. Replacement due to wear and tear before the five (5) year lifetime is not covered.

Emergency dental services related to accidental injury
Your benefit plan covers dental services necessary to treat an accidental injury to sound, natural teeth that are obtained within the first seventy-two (72) hours following the accidental injury. This coverage applies only to the emergency dental services made necessary by the accidental injury itself. Emergency dental services must be obtained in an emergency department. The benefit plan does not provide coverage for any follow-up care, including, but not limited to, orthodontics, prosthodontics, and restorative procedures. Injury as a result of chewing or biting is not considered an accidental injury.

Fertility testing
Except as otherwise set forth in this Policy and pursuant to the terms specified in the Schedule of Benefits, you are covered for fertility testing only up to the diagnosis of infertility. Services required beyond the diagnosis of infertility are your responsibility.

Home health care
Your benefit plan covers the following services, which you may receive from a home health care agency or hospital program for home health care when Medically Necessary:

- Skilled nursing services provided by a registered nurse or licensed practical nurse, except for private duty nursing services
- Skilled rehabilitation services
- Physical therapy, occupational therapy, and speech therapy
- Non-disposable medical and surgical supplies provided by the home health care agency or hospital program for home health care, including oxygen
- Medical and social service consultations
- Health aid services when you are receiving skilled nursing or therapy care

Hospice care
Your benefit plan covers services provided by a hospice program or a hospital program providing hospice care services and supplies on either an inpatient or outpatient basis when Medically Necessary. Hospice care is designed to provide palliative and supporting care to terminally ill patients and their families. You are covered for hospice care when your life expectancy is 180 days or less, as determined by your attending physician. Hospice care must be ordered, directed, and approved by your attending physician and coordinated by an interdisciplinary team. Hospice care will be covered for six (6) months from the date on which you enter the hospice program. Hospice coverage may be extended if ordered and approved by your attending physician.

Nutritional counseling and medical nutrition therapy

- Nutritional Counseling consists of the assessment of a person's overall nutritional status, followed by the

assignments of an individualized diet, counseling, and/or nutrition therapies to treat a chronic illness or condition. Your benefit will cover two visits per Benefit Period with a dietitian or facility-based program that is ordered by a physician and offered by a provider.

- Medical Nutrition Therapy to treat a chronic illness or condition, which includes nutrition assessment and nutritional counseling by a dietitian or facility-based program that is ordered by a participating physician and offered by a Participating Provider. Your coverage will consist of Medically Necessary services directly related to the following specific medical conditions and subject to the following Benefit Limits:
    - Heart Disease, Symptomatic HIV/AIDS, and Celiac Disease
        - Limited to two visits per Benefit Period.
    - Morbid Obesity
        - Limited to an initial assessment and five follow-up visits for a total of six visits per Benefit Period.
    - Chronic Renal Disease, Spina Bifida, Spinal Cord Injury, Diabetes Mellitus, and High Risk Obstetrical Symptomatic Conditions.
        - Your benefit plan covers an unlimited number of visits when Medically Necessary.

Nutritional products
Nutritional products are a liquid source of nutrition, which may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements, that is administered under the direction of a physician into the gastrointestinal tract either orally or through a tube or via catheter inserted into the superior vena cava when your gastrointestinal tract does not function sufficiently to permit normal oral or enteral feedings.

Your benefit plan covers nutritional products that are specialty food products when Medically Necessary and when under the direction of a physician on an outpatient basis, for the treatment of inborn errors of metabolism and some hereditary metabolic orders. The following generalizations apply to all products and all conditions: Nutritional products which are Medically Necessary for the management of certain inborn errors of metabolism and inherited metabolic disorders are covered as state law. Coverage is independent of whether the product is administered orally or enterally.

These disorders include:

- Phenylketonuria (PKU)
- Branch-chain ketonuria
- Galactosemia
- Homocysteinuria
- Allergic reaction or malabsorption syndromes, specifically hemorrhagic colitis

*Nutritional products prescribed to meet nutritional needs that can be met using shelf nutritional products (including semisynthetic protein isolate formulas), to the extent that they are commonly available in the retail grocery market, will not be covered, even when they are the sole source of nutrition.

Podiatry care
The Health Plan will cover podiatric services that are determined by the Health Plan to be Medically Necessary, provided that you have diabetes or peripheral vascular disease, or another qualifying medical condition, which, in the Health Plan's discretion, warrants specialized podiatric care.

Skilled nursing facility services
Your benefit plan covers services rendered while you are an inpatient in a skilled nursing facility when Medically Necessary and:

- The admission is arranged or ordered by your attending physician.
- Your medical condition is such that you require skilled care twenty-four (24) hours per day.
- The skilled services are provided either directly by or under the supervision of a licensed medical professional (for example, a registered nurse, physical therapist, practical nurse, occupational therapist, speech pathologist, or audiologist) and the treatment is documented in your medical record.
- The care could not be performed by a non-medical individual instructed to deliver such services.

Skilled nursing services must be provided with the expectation that you have the potential to be restored in a reasonable and generally predictable period of time and will continue to make substantial improvement in your level of functioning. Once you reach a maintenance level and/or no further progress is being attained, the care and services provided will no longer be considered "skilled nursing." The services will instead be considered custodial care. See your Schedule of Benefits for Benefit Limits regarding the maximum number of inpatient skilled nursing facility days that are covered under your plan.

Therapeutic manipulation/Chiropractic care
Therapeutic manipulation consists of services related to attempts at restoring normal function by manipulation and treatment of the structures of the spine. This includes the relationship between the articulations of the vertebral column, as well as other specific articulations, and the neuro-musculoskeletal system and the role of these relationships in the restoration and maintenance of health. Therapeutic manipulation focuses on the detection and/or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

Your benefit plan will cover the following services directly related to therapeutic manipulation when Medically Necessary: evaluation, vertebral adjustment or manipulation, therapeutic exercise, and adjunctive procedures. Services must be obtained from a provider who is licensed to provide such services. Consult your Schedule of Benefits for Benefit Limits regarding therapeutic manipulation.

For members who are under 13 years old, the provider must obtain Prior Authorization from UPMC Health Plan for services.

Diabetic equipment, supplies, and education
Your benefit plan covers the following services when required for the treatment of diabetes, when Medically Necessary, and when prescribed by a physician who is authorized to prescribe such services under the law.

- Equipment and supplies:
    - Blood glucose monitors
    - Monitor supplies
    - Insulin
    - Injection aids
    - Syringes
    - Insulin infusion devices
    - Pharmacological agents for controlling blood sugar
    - Orthotics

The following outpatient diabetes self-management training and education services will be covered when your physician certifies that you require diabetes education as an outpatient:

- Medically Necessary visits upon the diagnosis of diabetes
- Subsequent visits when your physician (1) identifies or diagnoses a significant change in your symptoms or condition that necessitates changes in your self-management or (2) identifies a new, Medically Necessary medication or therapeutic process relating to your treatment and/or management of diabetes

An outpatient diabetes self-management training and education program is a program of self-management, training, and education, including medical nutrition therapy, for the treatment of diabetes. This program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to criteria based on the certification programs for outpatient diabetes education developed by the American Diabetes Association and the Pennsylvania Department of Health.

Prescription drugs
Benefits will be provided for covered prescription drugs when prescribed by a physician, podiatrist or dentist in connection with Covered Services and when purchased at a participating network provider upon presentation of a valid ID card and dispensed on or after your Effective Date for outpatient use. Coverage is provided for injectable insulin and other

Prescription Drugs that under federal law may only be dispensed by written prescription and which are approved for general use by the Food and Drug Administration. Review your Schedule of Benefits for Prescription Drugs to determine the benefits and exclusions specific to your prescription drug coverage and your cost-sharing responsibility.

Additional Services

Clinical trials and research studies
Your benefit plan covers routine clinical services available under this benefit plan that are part of a clinical trial or research study approved by an Institutional Review Board, as well as Medically Necessary services to treat complications arising from participation in the clinical trials and studies. These services must be Prior Authorized by UPMC Health Plan, and all plan limitations apply.

Lifestyle Modification Program for Reversing Heart Disease
The Lifestyle Modification Program for Reversing Heart Disease is a comprehensive lifestyle modification program designed to assist in the management of coronary artery disease by emphasizing nutritional counseling, therapeutic exercise, stress management techniques, and regular participation in a professionally supervised support group, on an outpatient basis.

- Coverage will be provided if you meet specific benefit eligibility criteria and are certified for participation by your attending physician.
- The program requires a one-year minimum participation commitment and must be provided by a Lifestyle Modification Program Participating Provider.
- Coverage is limited to one-time enrollment in the program per lifetime, regardless of whether you complete the program.
- This program is only offered at selected participating sites; class size may be limited.

Transplantation services
Your benefit plan will cover services provided by a hospital that are directly related to organ, tissue, or bone transplantation when Medically Necessary. If a human organ or tissue transplant is provided from a living donor to a human transplant recipient:

- When both the donor and the recipient are members, each is entitled to the benefits of this Policy.
- When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this Policy subject to the following additional limitations:
  - The donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, or any government program.
  - Benefits provided to the donor will be charged against the recipient's coverage under this Policy.

- When only the donor is a member, the donor is entitled to the benefits of this Policy, subject to the following additional limitations:
  - The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Policy.
  - No benefits will be provided to the transplant recipient who is not a Health Plan member.

- If any organ or tissue is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the recipient member's Benefit Limit as set forth in the Schedule of Benefits.

Vision services for a medical condition
Prescription eyewear and the fitting and adjustment of contact lenses are covered only if you have cataracts, keratoconus, or aphakia. If one of these qualifying conditions is present, prescription lenses and contact lenses are limited to one pair of standard contact lenses OR one pair of standard eyeglasses per Benefit Period. When special lenses for presbyopia and astigmatism are used instead of traditional intraocular lenses following cataract surgery, only the cost of the traditional intraocular lens is covered. You will be responsible for any and all upgrades.

Section V.

Exclusions

Not all health care services are Covered Services. The following is a list of services that are not covered under your benefit plan. You can call UPMC Health Plan to inquire about these and other services.

1. **Alternative Medicine:** Acupressure, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation, or yoga.

2. **Assisted Fertilization:** Assisted fertilization services, including, but not limited to, GIFT, ZIFT, embryo transplants, and in vitro fertilization.

3. **Bariatric Surgery**: Bariatric Surgery is not covered under any circumstances.

1. **Behavioral Health Services:** The following behavioral health services (unless provided elsewhere in this Policy):
    a. Any psychotherapy, psychiatric care, or treatment services for mental health or substance use that are court-ordered, unless such services are Medically Necessary.
    b. Inpatient or outpatient treatment related to mental retardation or pervasive developmental disorder or autism, which extends beyond traditional medical management.
    c. Eligibility for and maintenance of Social Security disability benefits does not determine whether UPMC Health Plan will cover specific behavioral health or substance abuse treatment services. Medical necessity criteria will be used to determine whether specific treatment services are covered.
    d. Any treatment/services related to personal or professional growth/development, educational or professional training or certification, or treatment services required for investigative purposes related to employment.
    e. Any services necessary to obtain or maintain employment or insurance or for judicial or administrative proceedings, including, but not limited to, adjudication of marital, child support, or custody cases.
    f. Methadone maintenance for the treatment of chemical dependency.
    g. Marriage or family counseling, unless such services are Medically Necessary.
    h. Chronic maintenance therapy, unless such services are Medically Necessary. Medical Necessity criteria will be used to determine whether specific treatment services are covered.
    i. Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies, such as art or psychodrama, and hyperbaric or other therapy.
    j. Sex therapy without a diagnosis as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
    k. Sedative action electrostimulation therapy.
    l. Sensitivity training.
    m. Twelve-step model programs as sole therapy for conditions, including, but not limited to, addictive gambling.
    n. Treatment or consultation provided by the members' parents, siblings, children, current or former spouse or domiciliary partner.
    o. Truancy or disciplinary problems not associated with a treatable mental disorder.
    p. Psychoanalysis or other therapies that are not short-term or crisis-oriented, unless such services are Medically Necessary. Medical Necessity criteria will be used to determine whether specific treatment services are covered.
    q. Psychological and neuropsychological testing for learning disabilities or problems, other school-related issues to obtain or maintain employment, to submit a disability application for a mental or emotional condition, and any other testing that does not require administration by a behavioral health professional, including self-test reports.
    r. Intensive health coaching services, resource coordination activity, behavioral health rehabilitation services for children and adolescents, and summer camp programs are not covered services.
    s. Respite services.

4. **Blood:** Non-purchased blood or blood products, including autologous donations.
5. **Corrective Appliances:** Corrective Appliances primarily intended for athletic purposes or related to a sports medicine treatment plan, and other appliances/devices, and any related services, including, but not limited to, children's corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, and shoe inserts and orthopedics shoes except as provided in **Section IV. Covered Services**, subsection titled **Corrective Appliances (Orthotics and prosthetics)**.

6. **Cosmetic Surgery:** Surgical or other services for cosmetic purposes performed to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons, and from which no improvement in physiological function can be expected, except as such surgery or services are required to be covered by law. Excluded services include, but are not limited to, port wine stains, augmentation procedures, reduction procedures, and scar revisions. Exceptions to this exclusion are (a) surgery to correct a congenital birth defect, (b) cosmetic surgery necessitated by a covered sickness or injury, and (c) expenses otherwise covered that are necessary for repair of an accidental bodily injury.

7. **Court Ordered:** Court-ordered services when your physician or other professional provider determines that those services are not Medically Necessary.

8. **Custodial Care:** Custodial Care, domiciliary care, or protective and supportive care, including, but not limited to, respite care, rest cures, educational services, convalescent care, dietary services, homemaker services, maintenance therapy, and food or home-delivered meals.

9. **Dental Services Not Provided in this Policy:** Any other dental service or treatment, except as provided in **Section IV. Covered Services** of this Policy, any applicable Dental COI or Schedule of Benefits, or as mandated by law.

10. **Employment-Related or Employer-Sponsored Services:** For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation. Services that you receive from a dental or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.

11. **Engaged in an Illegal Act or Occupation**: For any care, treatment, or service, including coverage of prescription drugs required as a result of any loss sustained or contracted in consequence of your being engaged in an illegal act or occupation.

12. **Experimental/Investigational:** Services that are Experimental/Investigational in nature as determined by UPMC Health Plan.

13. **Food Supplements/Vitamins:** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth herein.

14. **Gender Reassignment Surgery, Procedures, and Medications:** All services, procedures, and medications related to transsexualism, including those leading to or related to gender reassignment surgery, except for sickness or injury resulting from such treatment or surgery.

15. **Genetic Counseling and Testing:** Genetic counseling and testing not Medically Necessary for treatment of a defined medical condition, except when such coverage is required by the Affordable Care Act.

16. **Growth Hormones:** Growth hormone therapy unless prescribed for Classic Growth Hormone Deficiency, Turner's syndrome, or certain other diagnoses as determined by UPMC Health Plan and authorized in accordance with applicable policy and procedure.

17. **Hearing Aids:** Hearing aids, examinations for the prescription or fitting of hearing aids, and batteries for hearing aids.

18. **Hearing Examinations:** Routine hearing examinations and related services, except as when such coverage is required by the Affordable Care Act.

19. **Home Care:** Home care for chronic conditions such as permanent, irreversible disease, injuries, or congenital conditions requiring long periods of care or observation.

20. **Home Medical Equipment:** Comfort or convenience items, for your comfort or convenience or the comfort or convenience of your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, elevators, stair gliders, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a professional provider. Medical equipment and supplies that are: (a) expendable in nature (i.e., disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and (b) primarily used for non-medical purposes, regardless of whether recommended by a professional provider.

21. **Immunizations and Drugs:** Physical examinations and immunizations required by foreign travel, school, or employment, unless coverage is required by the Affordable Care Act.

22. **Medical Services Not Provided in this Policy:** Any other medical service or treatment, except as provided in **Section IV. Covered Services** of this Policy or as mandated by law.

23. **Medically Unnecessary Services:** Services that are not Medically Necessary as determined by UPMC Health Plan.

24. **Medicare:** Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary.

25. **Mental Retardation:** Inpatient or outpatient treatment related to mental retardation or pervasive developmental disorder or autism that extends beyond traditional medical management.

26. **Military Service:** Care for military service-connected disabilities and conditions for which you are legally entitled to services, and for which facilities are reasonably accessible to you. Services that are provided to members of the armed forces and the National Health Service or to individuals in Veterans Administration facilities for military service-related illness or injury, unless you have a legal obligation to pay.

27. **Miscellaneous:** Any services, supplies, or treatments not specifically listed in the Policy as Covered Benefits, services, supplies, or treatments, unless they are preventive care services:
    a. Services and supplies which are not provided or arranged by a Health Plan physician and authorized for payment in accordance with UPMC Health Plan's medical management policies and process.
    b. Any services related to or necessitated by an excluded item or non-Covered Service.
    c. Services provided by a non-licensed practitioner.
    d. Services that are primarily educational in nature, including, but not limited to, vocational rehabilitation or recreational or educational therapy.
    e. Services rendered prior to the effective date of your coverage or incurred after the date of termination of your coverage, except as provided elsewhere in this Policy.
    f. Services for which you otherwise would have no legal obligation to pay.
    g. Charges for telephone consultations, unless otherwise allowed in accordance with Health Plan policy.
    h. Charges for failure to keep a scheduled appointment.
    i. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
    j. Charges for completion of any insurance form or copying of medical records.
    k. Services rendered by a professional provider who is a member of your immediate family. Immediate family is defined as your spouse, child, stepchild, parent, sibling, son-in-law, daughter-in-law, mother-in-law, father-in-

law, sister-in-law, brother-in-law, or grandparent.

l. Services that are submitted by two different professional providers for the same services performed on the same date for the same person.

28. **Motor Vehicle Accident/Workers' Compensation:** Treatment or services for injuries resulting from the maintenance or use of a motor vehicle to the extent that such treatment or service is paid or payable under a motor vehicle insurance policy or any injury sustained in the course and scope of performing work for which coverage is afforded under a workers' compensation policy, including, but not limited to, a qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payment in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act or equivalent law of another state. For information on coverage for injuries in excess of that paid or payable under a motor vehicle insurance policy or a workers' compensation policy, see the section of this Policy relating to "Coordination of benefits."

29. **Non-Medical Items:** Health club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a professional provider.

30. **Nutritional Supplements:** Blenderized food, baby food, or regular shelf food when used with an enteral system; milk- or soy-based infant formula with intact proteins; any formula, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance; oral semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; food additives, including, but not limited to, thickeners, vitamins, fiber supplements, calorie or protein supplements and lactose digestion products, and normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

31. **Oral Surgery:** Services, including or related to oral surgery, except as otherwise set forth in **Section IV. Covered Services**, subsections titled **Medical/surgical services** and **Emergency dental services related to accidental injury**. Exclusions include, but are not limited to (a) services that are part of an orthodontic treatment program; (b) services required for correction of an occlusal defect; (c) services encompassing orthognathic or prognathic surgical procedures; (d) removal of asymptomatic, non-impacted third molars; and (e) orthodontia and related services.

32. **Over-the-Counter Drugs:** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth in **Section IV. Covered Services**, subsection titled **Nutritional products** or when coverage is required by the Affordable Care Act.

33. **Physical Examinations:** Routine or periodic physical examinations, immunizations, or behavioral health services obtained for the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive or Medically Necessary purposes, including, but not limited to, premarital examinations, physicals for employment, school, camp, and participation in sports or travel, which are not Medically Necessary, except as set forth in **Section IV. Covered Services**, subsection titled **Routine and preventive care**, or as required by law. Physical examinations and immunizations required by foreign travel or employment.

34. **Podiatry Services:** Exclusions include palliative or cosmetic foot care, including, but not limited to, (1) treatment of weak, strained, flat, unstable, or unbalanced feet; (2) metatarsalgia or bunions (except open cutting procedures); and (3) treatment of corns, calluses, or toenails (except Medically Necessary removal of nail roots) if determined to be Medically Necessary by the Health Plan. Supportive orthotic devices for the foot are excluded unless you have diabetes or peripheral vascular disease.

35. **Pregnancy Termination (Abortion):** Abortion is not covered except for instances of rape, incest, or if the life of the mother is in jeopardy.

36. **Private Duty Nursing:** Private Duty Nursing is not covered under any circumstances.

37. **Rehabilitative Therapy:** Rehabilitative therapy services, including, but not limited to, physical therapy, occupational

therapy, and speech therapy provided to correct or alleviate developmental delay, school-related problems, apraxic disorders (not caused by accident or episodic illness), stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders. Physical, occupational, and speech rehabilitation therapy services provided in excess of the maximum number of visits per Benefit Period for all three therapies combined, as indicated in the Schedule of Benefits; cardiac rehabilitation services; pulmonary rehabilitation services; rehabilitation therapy services not expected to result in ongoing substantial improvement in your medical condition; and services provided after a maintenance level has been established.

38. **Reversal of Voluntary Sterilization Procedures:** Services to reverse sterilization.

39. **Smoking Programs:** Nicotine cessation programs and/or classes and prescription and non-prescription medications not otherwise included in the Preventive Services Reference Guide.

40. **Surrogate Motherhood:** Services and supplies associated with surrogate motherhood, including, but not limited to, all services and supplies relating to conception, prenatal care, delivery, and postnatal care of acting as a surrogate mother.

41. **Transportation:** Non-emergency transportation, by any means, including via ambulance provider except as set forth in **Section IV Covered Services** subsection **Ambulance Services.**

42. **Treatment Outside the United States:** Treatment for non-emergency or non-urgent services received outside of the United States.

43. **Under the Influence:** For any care, treatment, or service, including coverage of prescription drugs, required as a result of any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.

44. **Vision:** All vision-related services (except where such services are required under the Affordable Care Act), including:
    a. Adult vision examinations, as well as adult eyeglasses and contact lenses, including those for prescribing or fitting eyeglasses or contact lenses (except where you have cataracts, keratoconus, or aphakia)
    b. Services for the correction of myopia, hyperopia, or astigmatism, including, but not limited to, radial keratotomy
    c. Vision training for certain diagnoses
    d. Orthoptics

45. **Weight Reduction:** Weight reduction programs and products not included in the Preventive Services Reference Guide. Weight reduction programs, including all related diagnostic testing and other services, except when such coverage is required by the Affordable Care Act. Anti-obesity medication, including, but not limited to, appetite suppressants and lipase inhibitors.

Section VI.

Care When You Are Away From Home

UPMC Health Plan recognizes that you may get sick or suffer an injury when you are traveling away from home. That is why UPMC Health Plan covers urgent care and Emergency Services for members who are traveling outside UPMC Health Plan Service Area. Remember that if you obtain care from a Participating Provider, you will receive a higher level of benefit coverage. If you choose to use Non-Participating Providers in a non-emergent situation, you will receive a lower level of benefit coverage and the Non-Participating Provider may bill you for the amount of charges that the Health Plan does not cover.

Urgent care
If you are traveling outside the UPMC Health Plan Service area and need urgent care, you should seek that care. Contact your PCP or other treating provider within 24 hours or a reasonable time of receiving urgent care to arrange or obtain necessary follow-up care.

Emergency services
If you are traveling and suffer from an illness or injury that is a true emergency, you should go to the nearest emergency department. If the illness or injury is a true emergency, the health care services that are received from the emergency department will be paid at the highest level. If you are admitted to a facility outside the Service Area, you will not be liable for a greater out-of-pocket expense than if your care had been provided by a Participating Provider, as long as you or a family member contact UPMC Health Plan as soon as reasonably possible. If it is determined that your admission was not Medically Necessary, you may be responsible for all or some of the health care services provided to you during your admission to the out-of-network hospital. If you are admitted to an out-of-network facility after receiving Emergency Services, you may be required to transfer to a participating facility when it is medically safe to do so.

Remember, out-of-network providers are not obligated to contact UPMC Health Plan and do not have to comply with UPMC Health Plan's policies and procedures regarding Medical Necessity or billing members.

If you receive out-of-network Emergency Services that are Medically Necessary and covered under the benefit plan, such services and treatment will be reimbursed at the Participating Provider reimbursement level.

Travel assistance program
When you are traveling more than one hundred (100) miles away from your home, you have access to UPMC Health Plan's travel assistance program. The travel assistance program can help you obtain Emergency Services or urgent care when traveling. Services include making appointments with nearby physicians, providing translation services, making arrangements for medical evacuations, and returning mortal remains. Contact UPMC Health Plan for more information regarding the travel assistance program.

Coverage for dependents up to age 26 while living outside of the service area
Your dependents can obtain the care they need while living outside of the service area by visiting providers within one of the Health Plans contracted networks; however, UPMC Health Plan encourages you to schedule appointments for health care services within the western Pennsylvania service area if possible. Covered Services will be paid at the appropriate benefit level according to the type of provider from whom your dependent obtains care. For specific questions or additional information about your dependent's coverage while living outside of the service area, contact Member Services at the number on the back of your member identification card.

Section VII.

Benefit Coverage and Reimbursement

How to submit a claim
You must notify UPMC Health Plan in writing within twenty (20) days after the occurrence or beginning of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given either by you or on your behalf should be addressed to Claims Department, UPMC Health Plan, Inc., P.O. Box 2999, Pittsburgh, PA 15230-2999. You also may call UPMC Health Plan at the phone number on the back of your ID card, or any authorized agent of UPMC Health Plan and provide them with enough information so that they can identify you.

If you receive care from a Participating Provider, you will not have to submit a claim to UPMC Health Plan. UPMC Health Plan will pay the provider directly. However, if you obtain Medically Necessary Covered Services from a Non-Participating Provider, you may have to file a claim yourself. To submit a claim, just follow the steps below:

STEP 1: **REVIEW THIS POLICY** to make sure that the services you received are covered under your benefit plan.

STEP 2: **GET AN ITEMIZED BILL** from the provider. The bill must be an original (copies will not be accepted) and must contain the following information:

- The member's full name
- The name and address of the provider/facility that provided the service(s)
- A description of the service provided
- The date of service
- The amount charged
- The diagnosis or nature of illness or injury
- For durable medical equipment, the certification of the ordering provider
- If you have already made payment, proof of payment or a receipt

Be sure to make copies of the itemized bill. Original itemized bills will not be returned. Note that cancelled checks and cash register receipts will not be accepted as itemized bills.

STEP 3: **COMPLETE A CLAIM FORM**. Claim forms are available from our Member Services Department by calling the phone number on the back of your ID card. You can also download claim forms from our website at [www.upmchealthplan.com]. Make sure that you sign and date the claim form.

STEP 4: **MAIL THE CLAIM FORM AND ITEMIZED BILL** to the address below within **one year** of the date of service. UPMC Health Plan will not accept any member claims for reimbursement more than one year after the end of the Benefit Period in which the benefits were payable.

Mail your completed claim form, proof of payment, and itemized bill to:

Claims Department
[UPMC Health Plan Inc.
P.O. Box 2999
Pittsburgh, PA 15230-2999]

Remember, a request for payment of a claim will not be reviewed and no payment will be made unless all of the information described above has been submitted to UPMC Health Plan. UPMC Health Plan reserves the right to require additional information and documents, if necessary, to support your claim.

Payment to providers
Health Plan members authorize us to make payments directly to providers from whom they receive Covered Services. The

portion of the Covered Services for which UPMC Health Plan is responsible is the percentage of the Reasonable & Customary (R&C) Charge as outlined in **Section I. Terms and Definitions to Help You Understand Your Coverage.** UPMC Health Plan applies all your Deductibles, Copayments, and Coinsurance amounts to the Reasonable & Customary Charge to determine the benefit amount payable by UPMC Health Plan. In addition to all Deductibles, Coinsurance, and Copayments, you will also be responsible for any difference between the Non-Participating Provider's billed charge and UPMC Health Plan's payment.

UPMC Health Plan reserves the right to establish threshold amounts at which UPMC Health Plan will pay a Non-Participating Provider's billed charges. UPMC Health Plan further reserves the right to negotiate a one-time rate with the Non-Participating Provider for a particular Covered Service. In the event of a one-time rate negotiation, you will incur no liability beyond applicable Deductibles, Coinsurance, and Copayments for that Covered Service. However, UPMC Health Plan reserves the right to make the payments directly to you, if necessary. You cannot assign or transfer your right to receive payment for Covered Services under this Policy.

If UPMC Health Plan pays a provider directly, you will receive an Explanation of Benefits that describes the services that you received and how much we paid for those services. The Explanation of Benefits will also tell you the amount that you may owe for Copayments, Deductibles, or Coinsurance for that service.

UPMC Health Plan will not honor a request to take back payment made to a provider for Covered Services. UPMC Health Plan will have no liability to any person because of its rejection of such a request.

Remember, even if UPMC Health Plan pays your provider for Covered Services directly, you still must pay any applicable Copayment, Deductibles, or Coinsurance to that provider.

Coordination of benefits

In the event that you become eligible for coverage under more than one health care plan, UPMC Health Plan will coordinate your benefits with those plans. UPMC Health Plan does this to make sure that your benefits will be paid appropriately while preventing duplicate payments. This is how coordination of benefits works for your benefit plan:

- When your other coverage does not mention coordination of benefits, then that coverage pays first.
- Benefits paid or payable by that coverage will be taken into account when UPMC Health Plan determines if additional benefit payments can be made under this plan.
- When you are covered under any group health plan, that coverage pays first.
- When a dependent child is covered under two plans, the plan covering the parent whose birthday occurs earlier in the calendar year pays first. If both parents have the same birthday, then the plan under which one parent was covered longest pays first.
- If the dependent child's parents are separated or divorced and:
  - The parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
  - The parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent's coverage, if any, pays before the coverage of the parent without custody.
  - There is a court order that specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- When you are covered as an individual under this plan and also covered under a state funded Medicaid policy, the Medicaid policy is the payor of last resort.

- When none of the above circumstances applies, the coverage that you have had the longest applies first, as long as:
  - The benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person, and
  - The other plan does not have a provision regarding laid-off or retired employees and, therefore, the benefits of each plan are determined after the other, then the provisions listed above shall not apply.

If you or your provider receives more than you should have after your benefits are coordinated, either you or your provider will be expected to repay the overpayment to UPMC Health Plan.

It is the policy of UPMC Health Plan to review all other insurance coverage prior to releasing a claim for payment. If other insurance coverage is found after a payment has been made, a review will determine which plan pays first and what action will be taken in regard to any claims in question. Whenever payments should have been made by UPMC Health Plan, but the payments have been made under another benefit plan, UPMC Health Plan has the right to pay to the benefit plan that has made such payment any amount that UPMC Health Plan determines to be appropriate under the terms of this Policy. Any amounts paid shall be considered to be benefits paid in full under this Policy.

In the event that UPMC Health Plan makes payment for Covered Services in excess of the proper amount, regardless to whom those amounts were paid, UPMC Health Plan has the right to recover the excess amount from any person or entity to or for whom such payments were made. Upon reasonable request by UPMC Health Plan or its agent, you must execute and deliver the required documents and do whatever else is reasonably necessary to secure UPMC Health Plan's rights to recover the excess payments.

In the event that a motor vehicle insurance policy or workers' compensation policy is deemed to be the primary payor for treatment or services under the terms of this Policy, UPMC Health Plan will make payment for Covered Services that you incur in excess of the maximum allowable coverage under the motor vehicle insurance policy or workers' compensation policy, subject to the terms and limitations set forth herein.

UPMC Health Plan is not required to determine whether you have other health care benefits or insurance or the amount of benefits payable under any other health care benefits or insurance. UPMC Health Plan is only responsible for coordination of benefits to the extent that we gather information regarding your other insurance either from you, another insurance company, or any other entity or person authorized to provide such information.

Subrogation
If you incur health care expenses for injuries due to an accident caused by another person or organization, the person or organization causing the accident may be responsible for paying these expenses. For example, if you are in an accident caused by another person and suffer injuries, UPMC Health Plan has the right to seek repayment from the other person or his or her insurance company for any benefits paid related to or arising out of that injury. If you recover directly from the other person's insurance company, you will be responsible to reimburse UPMC Health Plan for benefits that it paid to the extent provided by law, even if that means you will not be fully compensated or made whole for the injuries caused.

You and/or your dependents must fully cooperate with UPMC Health Plan or its agent so that it may exercise all of its subrogation rights. You may be asked to assist UPMC Health Plan or its agent to produce documents or take other actions in subrogation efforts. You must not do anything that may impede or prevent UPMC Health Plan's subrogation recovery. UPMC Health Plan will not be responsible for any attorney's fees or other expenses you may incur to obtain the funds needed to reimburse UPMC Health Plan during the subrogation process. In the event that you do not cooperate with UPMC Health Plan in exercising its subrogation interest, UPMC Health Plan may use any legal remedies available to it to obtain full and complete reimbursement.

Subrogation does not apply to an individual insurance policy that you purchase for yourself or your dependents or where it is specifically prohibited by law. All Covered Services provided under this Policy are subject to this section to prevent duplicative benefit payments.

Notice of claim/proofs of loss/claim forms
Notice of Claim: UPMC Health Plan will not be liable under this Policy unless proper notice is provided to UPMC Health Plan that Covered Services in this Policy have been rendered. Written notice must be given to UPMC Health Plan within twenty (20) days of the date on which you received the Covered Services or as soon as reasonably possible after the date you received the Covered Services. You can give notice to UPMC Health Plan in writing to: Claims Department, [UPMC Health Plan, Inc., PO Box 2999, Pittsburgh PA 15230-2999]. Or you can give notice by calling UPMC Health Plan at the phone number on the back of your ID card. The notice must include the data necessary for UPMC Health Plan to determine benefits. A charge shall be considered incurred on the date you receive the service or supply.

Claims Forms: You must submit proof of loss for benefits under this Policy on the appropriate claim form**.** Once UPMC Health Plan receives notice of a claim, it will provide you the appropriate claim forms for filing proof of loss within fifteen (15) days. If claim forms are not provided to you within fifteen (15) days after you give notice of a claim, you shall be

deemed to have complied with the requirements of this subsection as to filing a proof of loss when you submit, within ninety (90) days, itemized bills for Covered Services as described below. The proof of loss may be submitted to UPMC Health Plan at the address that appears on your ID card.

Proofs of Loss: Written proof of loss must be furnished to UPMC Health Plan within ninety (90) days after the date of such loss. Failure to give notice to UPMC Health Plan within the time required will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no case, except in the absence of legal capacity, will UPMC Health Plan be required to accept notice later than one year after the end date in which the Covered Service was rendered.

Time of payment of claims
All claims payable under this Policy will be paid immediately, as long as UPMC Health Plan has received written proof of loss as described above. For submitted claims, UPMC Health Plan will not be liable under this Policy unless proper notice is furnished to UPMC Health Plan that Covered Services have been rendered.

Section VIII.

Resolving Disputes with UPMC Health Plan

At times, you may not be satisfied with a decision that UPMC Health Plan makes regarding coverage or with the health care services received. You have the right to file a Complaint or a Grievance.

The complaint process
If you have a dispute or objection regarding a coverage denial, policy termination, or a provider; or the coverage, operations, or management policies of UPMC Health Plan, you may submit a Complaint to UPMC Health Plan. Complaints may be submitted about issues including, but not limited to, quality of care or services, benefits exclusions, claims denials, or coordination of benefits.

You may file a Complaint over the phone with UPMC Health Plan or in writing to [PO Box 2939, Pittsburgh, PA 15230-2939]. You may also send any other written information that you have to support your Complaint. Include in the Complaint the remedy, resolution, or corrective action that you want from UPMC Health Plan.

At any time during the Complaint process, you may choose to designate a representative to act on your behalf. You must notify UPMC Health Plan in writing that you are designating someone to represent you. Also, at any time during the Complaint process, upon your request, UPMC Health Plan can make available, at no charge, a Health Plan employee to assist you or your representative in preparing the Complaint. This employee will not have previously participated in any of UPMC Health Plan's decisions regarding your Complaint.

You must submit your Complaint within 180 days of the date on which the incident occurred. For example, if your Complaint is because UPMC Health Plan did not pay a claim to a provider on your behalf, you must file the Complaint within 180 days of the date of the Explanation of Benefits document that you received. UPMC Health Plan will send you a letter to let you know that we received the Complaint.

A Complaint Review Committee will investigate the allegations in your Complaint. If the Committee relies on or considers new information or additional evidence in reviewing your Complaint or develops a new or additional rationale in denying your claim, it will provide that information to you free of charge. The Committee will also give you a reasonable opportunity to respond before issuing a decision. The Committee will notify you of its decision in writing within thirty (30) days of receipt of your Complaint. The notification letter will explain the Committee's decision and any additional appeal rights you may have.

The grievance process
Sometimes UPMC Health Plan will not cover a requested service because it is not Medically Necessary. If you have a dispute or objection regarding a service that was denied in full or in part because it was not Medically Necessary, you may file a Grievance. A Grievance is different from a Complaint. You, your designated representative, or your provider who has your written consent may file a Grievance. We will refer to a provider who has your written consent to file a Grievance as your provider. If you have given written consent to file a Grievance, please read the section below, which is titled "Important information regarding your written consent for your provider to file a Grievance," for more information.

Important information regarding your written consent for your provider to file a grievance

- Your provider may request written consent to pursue a Grievance at the time of treatment — but not as a condition of providing that treatment.
- You and your provider cannot file separate Grievances for the same treatment or service.
- Once you give written consent to a provider to file a Grievance, the provider has ten (10) days from the receipt of denial notification to file the Grievance. Your provider does not need to inform you when he/she files the Grievance; however, your provider must inform you if he/she decides NOT to file the Grievance.
- Your consent is automatically rescinded if your provider fails to file a Grievance within the appropriate time frames.
- If you wish to file a Grievance but already gave written consent to your provider, you must rescind your consent in order to proceed with your Grievance.

You may either file a Grievance over the phone with the Health Plan by calling the number on the back of your ID card or you may send a written Grievance to [UPMC Health Plan at PO Box 2939, Pittsburgh, PA 15230-2939]. You may also send any other written information to support your Grievance. You may include in the Grievance the remedy, resolution, or corrective action that you want from UPMC Health Plan.

At any time during the Grievance process, you may choose to designate a representative to act on your behalf. You must notify UPMC Health Plan in writing that you are designating someone to represent you. Also, at any time during the Grievance process, upon your request, UPMC Health Plan can make available, at no charge, a Health Plan employee to assist you or your representative in preparing the Grievance. This employee will not have previously participated in any of UPMC Health Plan's decisions regarding your Grievance.

You must submit your Grievance within 180 days of the date on which the denial occurred. For example, if your Grievance is regarding denial of pre-authorization for a service, you must file the Grievance within 180 days of the date on the letter you received informing you of that denial. While it is preferable that you file a Grievance in writing, you may call UPMC Health Plan to request assistance and file a Grievance orally. UPMC Health Plan will send you a letter to let you know that we received your Grievance.

A Grievance Review Committee will investigate the allegations set forth in the Grievance. The Committee will seek input from a physician or, where appropriate, a licensed psychologist with experience in the same or similar specialty that typically manages or consults regarding the disputed health care service. We will refer to such personnel throughout as "qualified clinical personnel." If the Committee relies on or considers new information or additional evidence in reviewing your Grievance or develops a new or additional rationale in denying your claim, it will provide that evidence to you free of charge. The Committee will also give you a reasonable opportunity to respond before issuing a decision.

The Committee will notify you and your representative of its decision within thirty (30) days of receipt of your Grievance. The notification letter will explain the Committee's decision and any additional appeal rights.

The external grievance review process

If you and/or your provider are still dissatisfied with UPMC Health Plan's decision regarding your Grievance, you may file a request for an external Grievance review. You, your representative, or your provider may file a request for an external Grievance with UPMC Health Plan within 120 days of the date on the Committee's decision letter. External Grievances are reviewed by an Independent Review Organization (IRO). External Grievances should involve a question of medical necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, or whether a treatment or service is experimental or investigational. If your provider is filing the request for an external Grievance review, your provider must submit a copy of your written consent. The request must contain any materials, supporting information, or necessary justification for the external Grievance.

When the request for an external Grievance is received, UPMC Health Plan will complete a preliminary review of the request within five (5) days. The purpose of the preliminary review is to determine whether (1) you are or were covered at the time the service/item was requested; (2) the adverse benefit determination relates to your failure to meet the requirements for coverage; (3) you exhausted internal appeals; and (4) you provided all information and forms necessary to process the external Grievance.

Within one (1) day after completion of the preliminary review, UPMC Health Plan will issue a notification to you in writing as to whether or not your Grievance is eligible for an external review. We will tell you if we need additional information to determine eligibility for an external review. If we need additional information, we will tell you what we need and allow you to submit the additional information within the four-month filing period or within the 48-hour period following your receipt of notification, whichever is later. If your Grievance is eligible for external review, we will notify you of the IRO name, address, and phone number.

Within five (5) days of determining that your appeal is eligible for external review, UPMC Health Plan will forward a copy of all written documentation regarding the adverse benefit determination to an IRO. Documentation will include the correspondence concerning the decision, all reasonable supporting documentation, and a summary of the clinical rationale for the adverse determination. At the same time, UPMC Health Plan will provide you, your representative, or

your provider with the list of documents that are being forwarded to the IRO for the external Grievance review.

You, your representative, or your provider may supply additional information to the IRO to consider in the external appeal within five (5) business days of notification that your Grievance is eligible for external review. If a provider supplies additional information to the IRO, the provider must simultaneously provide a copy of the same information to UPMC Health Plan.

The IRO will review all information provided by UPMC Health Plan and you, your representative, or your provider. The IRO will determine whether the service in question is/was Medically Necessary under the terms established by UPMC Health Plan. The IRO will issue a decision within forty-five (45) days of receipt of the external Grievance. The decision will be issued in writing to UPMC Health Plan, you, your representative, or your physician. The decision notification will include the basis and clinical rationale for the decision, the credentials of the individual reviewer, and a list of information considered in the decision.

You are entitled to receive, upon request, reasonable access to and copies of all documents relevant to your Grievance. Documentation includes the benefit provision, guideline, diagnosis codes, or treatment codes on which the decision was based. If you have any questions, please call the number on the back of your ID card.

Expedited grievance review process
If you believe that your life, health, or ability to regain maximum function may be jeopardized due to the delay in the time frames for an internal Grievance, you may request an expedited Grievance review. To request an expedited Grievance review, you should contact UPMC Health Plan and explain the need for an expedited Grievance review. You must obtain written certification from your treating provider that your life, health, or ability to regain maximum function would be placed in jeopardy by the delay inherent in the regular time frames of the internal Grievance process. The certification must include a clinical rationale and facts to support your provider's position. You must provide any additional information for consideration in an expedited manner so we can comply with the requirements for an expedited review. UPMC Health Plan will then arrange to have the Grievance reviewed within 72 hours. UPMC Health Plan will inform you of the decision orally and in writing within 72 hours of receipt of the request for review and the provider certification.

Expedited external grievance review process
If you believe that your life, health, or ability to regain maximum function may be jeopardized due to the time frames set forth in an expedited internal Grievance, you may request an expedited external Grievance review. To request an expedited external Grievance review, you should contact UPMC Health Plan and explain the need for an expedited external review. You must obtain written certification from your treating provider that your life, health, or ability to regain maximum function would be placed in jeopardy by the delay inherent in the regular time frames of the external review process. The certification must include a clinical rationale and facts to support your provider's position. You must provide any additional information for consideration in an expedited manner so we can comply with the requirements for an expedited review. UPMC Health Plan will submit your appeal to an IRO, which will provide you with notice of its decision as quickly as possible, but not later than 72 hours after our receipt of your request for the expedited external Grievance review. If notice of the IRO's decision is not in writing, the IRO will provide written confirmation of its decision within 48 hours after the date of the notice of the decision.

Expedited Pharmacy Review Process
An expedited pharmacy request may be initiated during an exigent circumstance when you, your designee, or your physician believes that waiting for a decision under the standard time frame may place your life, health, or ability to regain maximum function in serious jeopardy or when you are undergoing a current course of treatment using a non-formulary drug. Either you, your designee, or your physician may submit an expedited pharmacy request based on exigent circumstances in writing, electronically, or telephonically. The prescribing physician should support the request including an oral or written statement that an exigency exists and the basis for the exigency (that is, harm that could reasonably come to you if the requested drug were not provided within the standard timeframes), and a justification supporting the need for the non- formulary drug to treat your condition, including a statement that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects.

Additional appeal to government agency
If you are dissatisfied with UPMC Health Plan's decision and/or your adverse benefit decision does not meet the criteria for

an external review by an IRO, the Pennsylvania Insurance Department or the Pennsylvania Department of Health may be able to help to resolve the dispute. Generally, the Department of Health reviews appeals that concern quality of care or quality of service issues, and the Insurance Department reviews appeals that concern problems relating to contract exclusions, coverage disputes, and other insurance-related issues, such as subrogation.

The denial letter will provide you with instructions and addresses to file your appeal. The contact information for each Department is below:

- [Pennsylvania Department of Health, Bureau of Managed Care, PO Box 90, Harrisburg, PA 17108-0090 (1-888-466-2787)]
- [Pennsylvania Insurance Department, Bureau of Consumer Services, 1209 Strawberry Square, Harrisburg, PA 17120 (1-877-881-6388)**]**

Your request for an appeal to a governing agency should be in writing, although each agency will make staff available to transcribe an oral appeal. Each agency requires that you provide the following information when requesting an appeal:

- Your name, address, and telephone number
- Name of the managed care plan
- Your identification number
- A brief description of the issue being appealed
- A copy of the adverse decision letter that we sent you
- If you will be represented by an attorney

Section IX.

Payment

Payment of premiums
You must pay your first month's premium to UPMC Health Plan before the Effective Date set forth in your Confirmation of Enrollment Letter It is important that you keep your Confirmation of Enrollment Letter with this Policy. Only a member for whom UPMC Health Plan actually receives the required premium, and who has met all other applicable provisions of this Policy, is entitled to coverage under this Policy and only for the months for which UPMC Health Plan received premiums. The only exception is with respect to newborn coverage, which is automatically provided under this plan for the first thirty-one (31) days, as set forth in **Section II. Eligibility for Coverage**.

Time of payment
You must pay your first month's premium before the Effective Date of this plan, and you must pay succeeding premiums on or before the due date indicated on the invoice for each succeeding month in order for benefits to be provided, subject to the grace period provisions specified in the following subsection titled Grace period.

Grace period
Members who receive the Advance Premium Tax Credit: A grace period of thirty (30) days from the premium due date will be granted for payment of the required premium. During the grace period, the Policy will remain in force. If the required premium payment is not received within ninety (90) days of the premium due date, the policy will automatically terminate effective at the end of the thirty (30)-day grace period. No benefits will be paid for services incurred after the thirty (30)-day grace period.

All other members: A grace period of thirty (30) days from the due date will be granted for payment of the required premium. During the grace period, the Policy will remain in force; however, any claims paid during this grace period may be your responsibility if you do not pay the amount due by the end of the grace period. If the required premium payment is not received by the end of the thirty (30)-day grace period, the policy will automatically terminate as of the then current paid-through date.

Unpaid premium
If you are terminated due to an unpaid premium, all claims paid by UPMC Health Plan after the termination date will be retracted from the provider and funds will be recovered by UPMC Health Plan. This could result in the provider of service billing you directly for the full cost of the service(s) rendered.

Reinstatement for on-Marketplace members
If your coverage through the Federally Facilitated Marketplace has been terminated for failure to pay premiums, a decision as to whether or not your coverage may be reinstated is determined solely by the Marketplace. The Health Plan is not able to reinstate your Marketplace coverage. Premium payments submitted to the Health Plan after the date of termination do not entitle you to reinstatement. Any such payments will be processed by the Health Plan and refunded to you.

Reinstatement for off-Marketplace members
If your coverage under this Policy has been terminated for failure to pay premiums, UPMC Health Plan will reinstate your coverage as long as the premium due is paid in full within 30-calendar days after the end of the grace period. The reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Legal actions
No action in law or in equity will be brought to recover on this coverage prior to the expiration of sixty (60) days after written proof of loss for Covered Services has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three (3) years after the time written proof of claims for Covered Services was required to be furnished.

Section X.

Termination or Rescission of Coverage

Termination of your coverage under this Policy
There are a few reasons why your coverage with UPMC Health Plan may terminate. In addition, there are a few specific reasons for which your coverage with UPMC Health Plan may be rescinded. Please note that your coverage under this Policy will not be terminated or rescinded because of your health status or requirements for health services. This plan is guaranteed renewable and can only be terminated or rescinded by UPMC Health Plan in certain circumstances, including but not limited to those listed below:

- You may terminate your own coverage if you provide UPMC Health Plan with written notice of your intent to terminate. Termination may be effective on the last day of the month in which you make the request, or the last day of the next month. Requests for retroactive terminations will not be accepted.
- UPMC Health Plan may terminate this Policy in the following instances:
  - You are no longer an eligible dependent. In this case, your coverage will terminate at the end of the policy year.
  - You fail to pay your required premium contribution to UPMC Health Plan, subject to the grace period.
  - You no longer live in UPMC Health Plan's Service Area.
  - UPMC Health Plan intends to discontinue service in your Service Area and provides you with 180 days' written notice.
  - UPMC Health Plan has credible evidence that you committed fraud or made a material misrepresentation in information submitted to UPMC Health Plan or in obtaining or using services under this Policy. This includes improper use of your ID card, such as allowing another person to use your ID card to obtain health care services.
- UPMC Health Plan may rescind this Policy only where it has credible evidence that you (or a dependent) have committed fraud or intentionally misrepresented a material fact.

If rescission of your coverage is appropriate, you will receive a rescission notice setting forth the reasons for rescission and your right to appeal the rescission within thirty (30) days of the date of the notice. If no appeal is requested, the coverage will be rescinded on the date set forth in the rescission notice.

This is not an exhaustive list of all possible scenarios for termination of your coverage. If you have questions about when your coverage or eligibility may terminate, contact UPMC Health Plan's Member Services Department at the phone number on the back of your ID card.

Benefits after termination of coverage
If you are an inpatient in a facility on the day this Policy is terminated for reasons other than fraud or intentional misrepresentation of a material fact, and you incur charges during this time, you are entitled to benefits after the Coverage Period under the terms of this Policy. Benefits will be provided for charges incurred for the inpatient confinement, until the earlier of:

- The maximum amount of benefits has been paid; or
- The end of the inpatient confinement.

Continuation of benefits after the date this Policy is terminated is conditional upon your continuous inpatient status. You also must provide supporting documentation as required by UPMC Health Plan to demonstrate your continued inpatient status.

- If you are pregnant on the date coverage terminates, unless such termination is the result of non-payment of premiums, fraud, or intentional misrepresentation of a material fact, benefits will be provided for Covered Services related to that pregnancy to the same extent that such benefits would have been payable had the Policy continued in force.
- A newborn child is eligible for continuing benefits beyond the first thirty-one (31) days under this Policy, in accordance with the first paragraph of this subsection titled **Benefits after termination of coverage**, provided the newborn child is an inpatient in a facility on the day this Policy is terminated.

Application and statements

Applicants for coverage under this plan shall complete and submit such [application] or other forms or statements as UPMC Health Plan may reasonably request. Applicants for coverage under this plan represent that all information contained in such [application forms], or statements submitted for enrollment under this Policy or the administration hereof shall be true, correct, and complete to the best of their knowledge or belief, and all rights to benefits hereunder are subject to the condition that such information shall be true, correct, and complete. A person who knowingly and with intent to defraud UPMC Health Plan by completing forms containing false information or by omitting relevant information commits a fraudulent insurance act, which is a crime and may be subject to criminal and civil penalties or the termination of coverage hereunder. Please see the **Time limit on certain defenses** (below) provision regarding information you submitted.

Misstatement of age

If your age has been misstated, all amounts payable under the plan shall be the premium amount owed if the plan had been purchased at the correct age. UPMC Health Plan shall notify you of the correct premium amount on immediately following its discovery of the error. The correct premium amount shall also be applied retroactively, which may result in you owing additional premium amounts as of the effective date of your policy.

If UPMC Health Plan accepts payment of a premium for coverage extending beyond the date determined in the subsection titled **Time limit on certain defenses** (below), then coverage will continue, except if the acceptance of premium was based on a misstatement of age.

Time limit on certain defenses

No misstatements, except fraudulent misstatements, made by the applicant in the application for such coverage shall be used to void this plan or to deny a claim commencing after the expiration of three years from the date of issue of this Policy. UPMC Health Plan will not reduce or deny any claim for loss that you may incur from the date your plan started on the grounds that a disease or physical condition existed before the date your plan started, unless the disease or physical condition was excluded from coverage by name or by a specific description that was in effect on the date of loss. Material misrepresentations will, at the option of UPMC Health Plan, render this plan void from inception, provided that such material misrepresentations are discovered by UPMC Health Plan within three (3) years of the Effective Date. In the event UPMC Health Plan elects to void this Plan, you forfeit any charges paid to the extent of any liability incurred by UPMC Health Plan.

Section XI.

General Provisions

Your contract with UPMC Health Plan
Remember, this Policy acts as a contract between you and UPMC Health Plan. By enrolling in UPMC Health Plan or accepting benefits hereunder, you are agreeing to all terms and conditions of this Policy. UPMC Health Plan's liability under this Policy is limited to payment for the Covered Benefits described herein.

You have no entitlements or privileges under this Policy except as specifically set forth in **Section IV. Covered Services**. Except with regard to Medically Necessary covered transplantation services, as described herein, no one other than you and/or eligible enrolled dependents are entitled to receive benefits under this Policy. Your right to benefits and coverage under this Policy is not transferable or assignable. UPMC Health Plan shall have the right to assign this policy, and its rights and obligations hereunder, to an affiliate or subsidiary.

As a Health Plan member, you and/or your eligible enrolled dependents understand and agree that information related to your health/claims may be shared among the various UPMC Insurance Services Division entities for all lawful purposes.

Fraud and abuse
According to Pennsylvania statutes:

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

UPMC Health Plan is committed to the integrity of, provision of, and payment for health care services to our members. In the event that you suspect that a UPMC Health Plan member or a provider is committing fraud or abuse, call or email our Special Investigations Unit at [1-866-FRAUD01 (372-8301) or specialinvestigationsunit@upmc.edu.]

UPMC Health Plan's relationship with providers
The relationship between UPMC Health Plan and Participating Providers is that of independent contractors and neither UPMC Health Plan nor any Participating Provider shall be considered an agent or representative of the other for any purpose.

UPMC Health Plan makes no express or implied warranties or representations concerning the qualifications or continued participation of any Participating Provider. The choice to use a particular provider is solely your own. Participating Providers may be terminated at UPMC Health Plan's sole discretion. You may be required to choose another Participating Provider if the provider rendering services to you terminates or is terminated from participation during the term of your enrollment, unless otherwise set forth herein or as required by state or federal law or regulation.

UPMC Health Plan does not provide or render Covered Services, but only makes payment or provides coverage for Medically Necessary Covered Services that you receive. Participating Providers are solely responsible for any health services rendered to you and their other patients. UPMC Health Plan is not liable for any act or omission of any provider who renders health care services to you. UPMC Health Plan has no responsibility for a provider's failure or refusal to render health care services to you

Release of information
Each member agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under the Policy may furnish to UPMC Health Plan, upon its request, any information (including copies of records) relating to the illness or injury. In addition, UPMC Health Plan may furnish similar information regarding claims and charges that providers submitted to UPMC Health Plan to other entities that provide similar benefits at the entity's request. Each member further agrees that approval by UPMC Health Plan of any benefits for services rendered under the Policy is contingent upon furnishing such information or records or copies of records.

Amendment
Anything contained herein to the contrary notwithstanding, UPMC Health Plan shall have the right, for the purpose of complying with the provisions of any law or any lawful order of a regulatory authority, to amend the Policy or any attachment hereto or to increase, reduce, or eliminate any of the benefits provided for in the Policy for any one or more eligible members enrolled under the Policy, and each party hereby agrees to any amendment of the Policy which is necessary in order to accomplish such purpose.

Entire contract; changes
This Policy, [your application], your Confirmation of Enrollment Letter, Medical Schedule of Benefits, and current ID card constitute the entire Policy between you and UPMC Health Plan. A Dental Policy, Outline of Coverage and Schedule of Benefits and a Vision Certificate of Insurance and Schedule of Benefits are also included for members under the age of 19. No agent or representative of UPMC Health Plan other than a Health Plan officer may otherwise change this Policy or waive any of its provisions. All statements you made will, in the absence of fraud, be deemed representation and not warranties and no such statement will be in defense to a claim under this Policy, unless it is contained in a written instrument signed by and furnished to you.

Benefits to which you are entitled
- The liability of UPMC Health Plan is limited to the benefits specified in this Policy.
- Except as provided under Covered Services, in the subsection titled Transplantation Services, no person other than you is entitled to receive benefits under this Policy. Your right to benefits and coverage is not transferable.
- Benefits for Covered Services specified in this Policy will be provided only for services and supplies that are rendered by a Participating Provider specified in the Definitions section of this Policy and regularly included in such Participating Provider's charges

Governing law
This Policy is entered into and is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions hereof in no way affects the validity or enforceability of any other terms or provision. The waiver by either party of a breach or violation of any of any provision of this Policy shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

Reports and records
Each member, in connection with the administration, delivery, or receipt of benefits under this Policy:
- Authorizes any insurer, employer, organization, or health care service provider to release to UPMC Health Plan all personal health information relating to past, present, and future health care examinations, treatments, and diagnoses.
- Authorizes UPMC Health Plan to release the personal health information described above, including medical records, claims, benefits, and other administrative data to insurers, health care service providers, and outside vendors. The information will only be released in connection with the following purposes: treatment decisions, appeals, complaints and grievances, coordination of care, quality assessment and measurement, quality improvement, preventive measures, audits, utilization management, case management, pharmacy management, physician review, research, fraud investigations, reviews by regulatory and accrediting bodies, claims processing, billing, and reimbursement.
- Further agrees that approval by UPMC Health Plan of benefits for any services rendered under this Policy is contingent upon furnishing such information or records or copies of records.
- Is responsible for maintaining all claims information and correspondence. If you request claims information from UPMC Health Plan with an incurred date of more than twelve (12) months prior to the request, it will be your responsibility to pay for the cost of retrieval of such information.

Provider network
UPMC Health Plan manages and provides coverage through its own comprehensive network in western Pennsylvania. This provider network includes UPMC (University of Pittsburgh Medical Center) facilities and providers as well as community providers. In addition, UPMC Health Plan has entered into agreements with two national and/or regional provider networks in order to better serve you when you need medical care.

If you need care in Ohio, the SuperMed network is available through Medical Mutual of Ohio. The SuperMed network includes more than 200 hospitals and 6,900 primary care physicians across all of Ohio. If you need care outside of western Pennsylvania and Ohio, the Private Healthcare Systems (PHCS) network and the complementary MultiPlan network is available through MultiPlan, Inc. These networks offer access across the country to more than 550,000 health care professionals and more than 4,000 hospitals. Providers in these networks accept their contracted rate as payment in full in addition to any applicable Copayment, Deductible, and Coinsurance amounts as specified in your plan design.

All Emergency Services at Non-Participating Providers will be covered at the Participating Provider level. If you require emergency health care services and cannot reasonably be attended to by a Participating Provider in UPMC Health Plan Service Area, UPMC Health Plan shall pay the emergency services so that you are not liable for a greater out-of-pocket expense than if a Participating Provider had attended to you. In addition, all non-emergency care and services in the UPMC Health Plan Service Area and outside the UPMC Health Plan Service Area that UPMC Health Plan has Prior Authorized UPMC Health Plan will also be covered at the Participating Provider level.