

UPMC Student *Advantage**

UPMC HEALTH OPTIONS, INC. (hereafter referred to as “UPMC Health Plan¹”),
a Pennsylvania corporation whose address is
U.S. Steel Tower, 600 Grant Street, Pittsburgh, Pennsylvania 15219

STUDENT GUARANTEED RENEWABLE/PREMIUM SUBJECT TO CHANGE

Your Right to Examine this Policy for 10 Days

You have the right to return this Policy within 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

This document is a Student Accident and Insurance Policy (hereinafter referred to as the “Policy”). This Policy establishes the terms of coverage for your health benefits. It sets forth what services are covered and what services are not covered. It explains the procedures that you must follow to ensure that the health care services that you receive will be covered under this Policy. It also describes how you can add a dependent to your plan, submit a claim, file an appeal, and other information that you may need to know to access your health benefits. The Policy sets forth your obligations as a member and the obligations of UPMC Health Plan as the administrator of this Policy. It is important to use this Policy along with your Schedule of Benefits. Your Schedule of Benefits is the document that outlines your coverage amounts and Benefit Limits. This plan does not impose any pre-existing condition exclusions. There are no annual or lifetime limits on the dollar value of benefits for anyone receiving coverage under this plan.

This Policy does not divide or give back any excess premiums to its Members.

This benefit plan has cost-sharing, which may include 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 may pay Copayments and/or Coinsurance each time you go to the doctor or pick up a prescription from the pharmacy and at other times as outlined in this Policy or the Schedule of Benefits.

This Policy allows you to get Emergency Services at the Participating Provider cost-share. This is true even if you use health care providers who are not in Your 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, if applicable, is not a provider within UPMC Health Plan’s Extended Network. For more information about Extended Network, see **Section XI. General Provisions**.

Certain in-network care and out-of-network non-emergent care must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan **and** obtain Prior Authorization **prior** to receiving services. A list of services that must be Prior Authorized is available 24/7 on our website at www.upmchealthplan.com or you can contact Member Services by calling the phone number on your ID card. Your out-

¹UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc. Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

of-network provider may also access this list at www.upmchealthplan.com or he or she may call Provider Services at 1-866-918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of receiving services for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that requires Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date of service.

All out of network non-emergent care and services that UPMC Health Plan has Prior Authorized or deemed Medically Necessary by UPMC Health Plan will be paid according to your benefit design and network. A referral is not required to access benefits from in-network providers. That means that if you need to go to a Specialist, you can go without a referral.

The terms of this Policy will be in effect for you and your dependents after you pay the premiums for the duration of time that the premium covers.

Your newborn children, whether natural born, adopted, or placed for adoption, are entitled to the health care benefits set forth in this Policy from the moment of birth to a maximum of 31 days from the date of birth. In order to continue coverage for your newborn after the 31st day, you **must** add him or her to your policy of coverage by contacting Member Services. For more information, see **Section II. Eligibility for Coverage**.

Guaranteed renewable/Premium subject to change

This Policy will remain in effect each month as long as the applicable premiums are paid. UPMC Health Plan will not terminate your coverage because of the deterioration of your mental or physical health or that of any individual covered under this Policy. This Policy shall remain in effect continually unless terminated by UPMC Health Plan in accordance with **Section X. Termination of Coverage**, you elect to disenroll in coverage, you fail to meet the eligibility requirements as determined by your school or university, or your school or university no longer contracts for coverage.

*UPMC Student *Advantage* is a product of UPMC Health Options Inc. and is administered by UPMC Health Plan Inc. Please note that throughout this document, we use the term “UPMC Health Plan” to refer to UPMC Health Options Inc. as well as to UPMC Health Plan Inc.

Diane P. Holder, President and CEO, UPMC Health Plan

Gordon Gebbens, Chief Financial Officer, UPMC Health Plan

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, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and Consolidated Appropriations Act, 2021. 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 your identification (ID) card, or write to:

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

Table of Contents

Section I. Terms and Definitions to Help You Understand Your Coverage 5

Section II. Eligibility for Coverage 9

Section III. A Guide to Obtaining Covered Benefits 12

Section IV. Covered Services 16

 Preventive Care 16

 Pediatric Dental Services 17

 Pediatric Vision Services..... 17

 Hospital Services..... 17

 Maternity Services..... 18

 Emergency Services..... 18

 Emergency Transportation..... 18

 Surgical Services..... 18

 Inpatient Medical Services..... 19

 Outpatient Medical Care 19

 Convenience Care..... 20

 Urgent Care..... 20

 Virtual Visit..... 20

 Allergy Services 20

 Diagnostic Services 20

 Rehabilitative Therapy Services..... 21

 Habilitative Therapy Services 21

 Medical Therapy Services 21

 Cancer Treatment..... 21

 Pain Management and Rehabilitative Outpatient programs..... 22

 Behavioral Health..... 22

 Autism Spectrum Disorder Services 22

 Acupuncture..... 23

 Corrective Appliances (orthotics and prosthetics) 23

 Durable Medical Equipment (DME) 23

 Emergency Dental Services Related to Accidental Injury 24

 Fertility Testing 24

 Home Health Care..... 24

 Hospice Care..... 24

 Infertility Services 24

 Medical Nutrition Therapy..... 24

 Nutritional Counseling..... 25

 Nutritional Formulas..... 25

 Podiatry Services 25

 Skilled Nursing Facility Services..... 25

 Therapeutic Manipulation/Chiropractic Care..... 26

 Diabetic Equipment, Supplies, and Education 26

 Prescription Drugs..... 27

 Clinical Trials and Research Studies 27

 Transplantation Services 27

 Vision Services for a Medical Condition 27

 Health Management Services 27

 Member Discounts..... 28

Section V. Exclusions 29

Section VI. Care When You Are Away from Home..... 33

Section VII. Benefit Coverage and Reimbursement 35

Section VIII. Resolving Disputes with UPMC Health Plan 39

Section IX. Payment..... 45

Section X. Termination of Coverage..... 46

Section XI. General Provisions 47

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.

Administrative Denial - An Adverse Benefit Determination that involves a decision to deny authorization, coverage, or payment for a service because (a) you are not eligible for coverage; (b) you or your provider failed to submit sufficient information with which to make a coverage decision; or (c) your provider has failed to comply with an administrative policy of UPMC Health Plan.

Adverse Benefit Determination - Any of the following:

- A determination by UPMC Health Plan that a request for a benefit does not meet UPMC Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental/Investigational, such that the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit.
- UPMC Health Plan's denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination that you are ineligible for coverage, failed to submit complete information, or failed to comply with an administrative policy of UPMC Health Plan (Administrative Denials).
- A rescission of coverage determination by UPMC Health Plan (retroactive cancellation of your coverage due to fraud or intentional misrepresentation of a material fact).

Instructions regarding how to appeal an Adverse Benefit Determination are set forth in **Section VIII. Resolving Disputes with UPMC Health Plan.**

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 period for which you are eligible for coverage) 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. Refer to your Schedule of Benefits to determine Coinsurance amounts. Copayments do not apply toward Coinsurance.

Complaint — A dispute or objection by a Member or Member's authorized representative regarding a Participating Provider or the coverage (including contract exclusions and non-Covered Benefits), operations, or management policies of UPMC Health Plan. 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 behavioral or 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; and/or
- Risk of harm to the individual or others; and/or
- Serious impairment to bodily functions; and/or
- Serious dysfunction of any bodily organ or part; and/or
- 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. If you choose to receive non-emergency services from a Non-Participating Provider or facility, those services will be covered at the lesser, out-of-network rate unless UPMC Health Plan provided Prior Authorization for the services.

Essential Health Benefit (EHB) — Marketplace coverage includes 10 essential health benefits with no lifetime or annual dollar coverage limits. Plans must provide coverage for these products and services: ambulatory patient services, prescription drugs, emergency services, rehabilitative and habilitative services and devices, hospitalization, laboratory services, maternity and newborn care, preventive and wellness services and chronic disease management, mental health and substance use disorder services, including behavioral treatment and pediatric services, including oral and vision care. Please see **Section IV. Covered Services** for additional information.

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.

Extended Network — A national and/or regional provider network that UPMC Health Plan has entered into an agreement with for access to physicians and facilities located outside the UPMC Health Plan Service Area.

Explanation of Benefits — The notice UPMC Health Plan sends you that lists the costs of recent medical services and explains payments made by UPMC Health Plan for health care services you received. Your health care provider may bill you directly for any amount that you owe.

Final Adverse Benefit Determination — A decision by UPMC Health Plan to partially or fully uphold an Adverse Benefit Determination following completion of UPMC Health Plan’s internal appeal process.

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, if applicable, is not a provider with UPMC Health Plan’s Extended Network.

Out-of-Pocket Limit — The maximum dollar amount you are responsible for paying during a Benefit Period before UPMC Health Plan will pay 100% of 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, if applicable, is a provider with UPMC Health Plan’s Extended Network. All Health Plan Participating Providers are listed in our most current provider directory available online www.upmchealthplan.com or by calling the number on your ID card.

Primary Care Provider or PCP — A provider whom you choose who will supervise, coordinate, prescribe, and otherwise provide initial and basic health care services, and maintain continuity of your health care. PCPs can include pediatricians, obstetrician-gynecologists, internal medicine providers, or family practice providers.

Prior Authorization — The process in which UPMC Health Plan reviews all reasonably necessary supporting information prior to the delivery or provision of a requested health care service and makes a decision to approve or deny payment for the health care service based on whether the service is Medically Necessary. The term includes Step Therapy and step therapy exception requests. For certain treatment or services, you must obtain Prior Authorization prior to receiving a health care service by having your provider submit a Prior Authorization request that meets UPMC Health Plan’s administrative requirements for such a request and includes the specific clinical information necessary to evaluate the request.

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. A Non-Participating Provider may charge you the difference between the billed amount and the R&C amount, in addition to any Copayments, Coinsurance, or Deductibles.

Rider — A document that modifies your Policy. A Rider may expand or restrict the benefits set forth in your Policy. Common types of Riders include, but are not limited to, pharmacy, domestic partner, and vision benefit Riders. If you are unsure if you have a Rider, contact UPMC Health Plan.

Service Area — The counties in which UPMC offers Pennsylvania domiciled employer groups and individuals health insurance products. For more information, please contact Member Services by calling the phone number on your ID card.

Special Enrollment Period (SEP) — A time outside the yearly open enrollment period when you can sign up for health insurance. You qualify for an SEP if you have had certain life events, including, but not limited to, losing health coverage, moving, getting married, having a baby, or adopting a child. If you qualify for an SEP, you usually have up to 60 days following the event to enroll in a plan. If you miss that window, you must wait until the next open enrollment period to apply. For more information, please contact Member Services by calling the phone number on your ID card.

Specialist — A health care provider whose practice is not limited to primary health care services and who has additional postgraduate or specialized training, has board certification or practices in a licensed specialized area of health care (e.g., cardiology or dermatology).

Step Therapy – A course of treatment in which certain designated drugs or treatment protocols must be either contraindicated, or used and found to be ineffective, prior to approval of coverage of other designated drugs or treatment protocols. The term does not include requests for coverage of nonformulary drugs. Please see your Prescription Medication Schedule of Benefits for more information.

Your Network — The physicians, hospitals, facilities, and other providers in the network selected by you. Your Network is listed on your member ID card. Getting care from Participating Providers in Your Network is the best way to keep your Out-of-Pocket costs as low as possible.

Section II.

Eligibility for Coverage

Who is eligible for coverage?

You are eligible for coverage if you are a registered full time student as determined by the school or university. The number of credits you must carry to be considered a full-time student is determined by the school or university in its sole discretion.

An eligible student may enroll the following individuals as dependents:

- Your spouse under a legally valid existing marriage.
- Your children under the age of 26 including newborn children, stepchildren, children legally placed for adoption, and children for whom coverage is mandated by a qualified medical child support order. 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 are subject to the criteria as set forth below.
- Disabled Dependents who meet the criteria set forth in the subsection titled "Disabled Dependents," located in the "How do you enroll a dependent?" section.
- Domestic Partners: A relationship of two individuals regardless of sex or gender identity 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 spouse, domestic partner, or dependent, you may be required by UPMC Health Plan or the school or university to provide proof that the individual meets one of the above criteria.

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 60 days of the date on which the dependent becomes eligible for coverage. The Effective Date of coverage for newly enrolled dependents will be communicated to you following the receipt and acceptance of an enrollment application by UPMC Health Plan.

The following are rules for special circumstances relating to 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 (31)-day period, you must contact UPMC Health Plan to enroll the child as a dependent before the end of the initial 31-day coverage period. If you do not contact UPMC Health Plan, coverage for that child will end after the 31-day automatic coverage period.

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.

If UPMC Health Plan has been made aware that a dependent has been enrolled pursuant to a court order, UPMC Health Plan will not disenroll or eliminate coverage of such dependent unless it is provided with evidence that the court order is no longer in effect or the dependent will be enrolled in comparable health coverage through another insurer.

Disabled dependents: The disabled dependent child, as medically certified by a physician due to intellectual or 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 incapable of self-sustaining employment; and
- Be chiefly dependent 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.

In order to continue coverage for your disabled dependent after the attainment of age 19, you must submit proof of such dependent's incapacity by contacting Member Services within thirty-one days of the dependent's attainment of the limiting age. You may be asked to submit documentation annually.

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 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 enroll yourself or a dependent for whom you previously declined coverage because you or your dependent had health benefits within 30 days of the loss of such coverage if:

- 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 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 or your dependent's loss of eligibility for such coverage or the termination of an employer or plan sponsor's contribution toward the premium for the coverage. To be eligible for this special enrollment period, prior coverage must not have been terminated for cause (for example, making a fraudulent claim).

Medically Necessary leave of absence

If your coverage under this Policy is based on your status as a student enrolled at a postsecondary educational institution, your coverage may be continued during a Medically Necessary leave of absence, subject to certification by your treating physician and certain limitations as set forth in applicable law.

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 31 days (or longer time period as specified by your school or university) of becoming eligible for coverage. You will be required to provide supporting documentation to prove eligibility. 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 personal information (Social Security number, address, telephone number, etc.) and changes in family status (marriages, deaths, births, etc.) related to you or your dependents.

When will your coverage begin?

Your coverage will begin on the Effective Date communicated to you by your school or university. Note that some schools or universities set minimum waiting periods before your coverage will be effective. UPMC Health Plan must receive your enrollment application and correct premium payment by the date set by the school or university.

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 an individual policy as a separate policyholder, without evidence of insurability.

Section III.

A Guide to Obtaining Covered Benefits

This Policy is a Preferred Provider Organization (PPO) Policy. What does this mean for you? It means that 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. Your plan may have a tiered participating provider network design. Please refer to your Schedule of Benefits for more detailed information regarding the benefit levels and cost sharing responsibilities within your plan.

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. This means that, because the Health Plan does not contract with Non-Participating Providers, the provider can bill you for any amount over and above what the Health Plan covers.

There are some instances in which you may receive services from a Non-Participating Provider at a Participating Provider facility. This includes services performed by certain ancillary providers such as anesthesiologists, radiologists, and pathologists. In these cases, you are protected from surprise billing or balance billing and are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network) in accordance with the Consolidated Appropriations Act, 2021

Certain in-network and out-of-network non-emergent care must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan **and** obtain Prior Authorization **prior** to receiving services. A list of services (for example procedures, devices, medications) that must be Prior Authorized is available 24/7 on our website at www.upmchealthplan.com or you can contact Member Services by calling the phone number on your ID card. Your provider may also access this list at www.upmchealthplan.com or he or she may call Provider Services at 1-866-918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of receiving services for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that require Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date of service.

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.

UPMC Health Plan offers several network options, and it is important to understand which network your plan covers. If you have questions regarding Your Network, please contact Member Services at the phone number shown on your member ID card. 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 your ID card to have a provider directory sent to you. Please note that the provider directory will also tell you whether a particular provider is accepting new patients.

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, subject to 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.

UPMC Health Plan contracts with the types of providers listed below:

- Acupuncturists
- Audiologists
- Behavioral Health – Doctoral (PhDs) and/or master’s level psychologists, master’s level social workers, master’s level clinical nurse specialists 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 - Physician Assistants (PA), Certified Nurse Midwives (CNM), Certified Registered Nurse Practitioners (CRNP), and Certified Nurse Anesthetists (CRNA)
- Podiatrists (DPM)
- Primary care physicians include both Medical Doctors (MD) and Doctor of Osteopathy (DO) physicians
- Respiratory therapists
- Specialist 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 have your continued treatment 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 your ID card, and obtain Prior Authorization from UPMC Health Plan to receive coverage at the in-network rate for continued treatment with a Non-Participating Provider. If you are pregnant and undergoing a course of treatment for that

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 ninety (90) calendar days. If receiving an active course of treatment for a medical 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 pregnant and undergoing a course of treatment for the pregnancy, you may request to continue maternity care through the postpartum period and delivery of your child. Except during a transition of care as described above, if you continue care with a provider whose contract is terminated, coverage for that care will be provided at the lesser, out-of-network rate.

Managing your health care

In order to receive coverage for services, those services must be Medically Necessary. UPMC Health Plan's Utilization 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 Utilization Management Department decides this:

Prior Authorization: Certain Covered Services and medications require Prior Authorization. This means that you or your provider must get UPMC Health Plan's approval before you receive certain services or certain medications. Approval does not guarantee payment and you must have valid coverage at the time of services. 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.

UPMC Health Plan's network of Participating Providers represents nearly every medical specialty. However, if the service you need is not available in-network, UPMC Health Plan might cover the service at the in-network rate from a provider who is not in Your Network. If you are unable to locate a Participating Provider in your area or are unable to schedule an appointment within a reasonable period of time due to a limited number of Participating Providers in your area, please contact Member Services.

When you or your provider requests Prior Authorization, the Utilization 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 Utilization Management Department will review services that you are currently receiving. These reviews might happen while you are 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 determine if it is Medically Necessary to extend your care or suggest an alternate level of care.

Post-service reviews: Sometimes the Utilization Management, Quality Audit, and Fraud, Waste 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; and
- The need to refer you to a health coaching program

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.

SaveonSP

Your plan may include the SaveOnSP program. Please see your Prescription Medication Schedule of Benefits for more information.

Section IV.

Covered Services

UPMC Health Plan provides coverage for the following health care services in accordance with UPMC Health Plan Policies and Procedures 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 Policy. However, there are certain services that will not be covered if you do not receive them from a Participating Provider. For more information please contact Member Services by calling the phone number on your ID card. 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 care

Unless additional requirements are specifically identified below, preventive care services will be covered when performed by one of the following types of Participating Providers: Primary Care Providers, Adolescent Medicine Specialists, CRNPs, CRNPAs, Family Practice hospitalists, Gynecology Specialists, Internal Medicine Specialists, Obstetrics and Gynecology Specialists, Ophthalmology Specialists, and Pediatric Specialists. If you receive preventive services from a type of provider not listed here or a Non-Participating Provider, you may be responsible for the cost of those services. For specific information on categories of covered preventive care benefits and any applicable cost-sharing, refer to your Schedule of Benefits. The following preventive services are covered under this plan:

- 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 and consistent with state law.
- 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-based preventive care and screenings as recommended by the American Academy of Pediatrics Bright Futures for infants, children, adolescents, and preventive care and screenings for adults provided in the comprehensive guidelines and supported by the Health Resources and Services Administration.
- Routine gynecological examinations and which may include pelvic examination and breast examination. Pap tests and/or HPV tests performed for screening purposes will be covered in accordance with the recommendations of the USPSTF or as otherwise required by the Affordable Care Act. Please see the Preventive Services Reference Guide for additional information.
- Breast cancer screenings: Beginning at age 40, all Members are covered for annual preventive mammograms. Preventive screening mammograms, which include breast tomosynthesis (3D mammograms) and may include MRI/Ultrasound imaging for dense breast or other forms of imaging as required by federal and state law, are covered for Members at any age if ordered by a physician.
- Colorectal cancer screening
 - Benefits if you do not have signs or symptoms of colorectal cancer and are at average risk for colorectal cancer and are age 45 to 75:
 - High-sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year or
 - Fecal occult blood DNA or Stool DNA-FIT every (1) one to (3) three years or
 - Computed tomography (CT) colonography every (5) five years or
 - Tests include, but not limited to a screening barium enema, or a test consistent with approved medical standards and practices as determined by UPMC Health Plan to detect colon cancer or
 - Colonoscopy screening once every (10) ten years or after a positive fecal test (ex: HSgFOBT, FIT, etc.)
 - 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 high or increased risk for colorectal cancer and are 45 to 75:
 - A colonoscopy or any combination of colorectal cancer screening tests in accordance with the current appropriate medical guidelines

A list of preventive services can be found in the enclosed Preventive Services Reference Guide and is also 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.

Pediatric dental services

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

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
- 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
 - Diagnostic services and testing
 - Therapy services
 - Ancillary services and supplies
 - Use of operating and delivery rooms and supplies
 - Facility 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
 - General nursing care
 - Whole blood and blood products, administration of blood and blood products, and blood processing
- Observation Stay: Observation is a level of care in an acute care hospital setting that is appropriate when a patient is receiving ongoing short-term treatment and assessments and it is not clear if inpatient level of care is needed. Re-assessments are made during this time to determine if the patient requires inpatient admission, or may be discharged and receive follow-up in the outpatient setting.

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 members giving birth 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. Please refer to **Section II. Eligibility for Coverage**, subsection Newborn and Adopted Children for information on newborn coverage.

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 parent and neonatal physical assessments. At the parent's sole discretion, any visits may occur at the facility of the provider.

Emergency services

You do not need Prior Authorization 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 routine or non-Emergency Services provided in an emergency department will not be covered, unless your treating provider or UPMC Health Plan authorized those services.

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.

Emergency transportation

Your benefit plan covers emergency transportation by a specially designed and equipped vehicle when you are sick or injured. Emergency transportation includes 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. Your benefit plan also covers Emergency Services when an ambulance is dispatched by a 911 call center, even if you do not require transport or refuse to be transported to a hospital. This coverage includes Medically Necessary emergency care provided to you, such as advanced life support services.

- Non-emergent routine transportation is not a Covered Benefit for members with the exception of facility-to-facility transfers which may be 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 Member's family. Services may require Prior Authorization.
- Ambulance transportation for previously scheduled and planned treatments and therapies (e.g., dialysis) is not a Covered Benefit.
- Non-emergent transportation (for example wheelchair accessible van, ambulance, or other methods of transport given medical needs) from the home to a medical facility or a provider's office for follow-up appointments following discharge from an acute setting may be a Covered Benefit, when such transportation is Medically Necessary. Services may require Prior Authorization.

Surgical services

Your benefit plan covers inpatient and outpatient surgical services, including pre- and post-operative office visits that you receive from a professional provider, if such services are Medically Necessary. Covered surgical services includes, but are not limited to, the following procedures:

- Oral surgery: Your benefit plan covers only the following oral surgery procedures in an outpatient setting or in an inpatient setting when such procedure and 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 affect the alveolus
 - Surgery for temporomandibular joint disease (TMJ)
 - 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.
 - All other oral surgery and related services are excluded from coverage
- Anesthesia for dental procedures may be covered after medical necessity review and may require Prior Authorization for services. Eligible dental patients include children who are 7 years old or younger; developmentally disabled person of any age for whom a superior result cannot be expected for treatment under general anesthesia; or patients of any age with documented medical conditions, including but not limited to, severe infection at the oral injection site or certain physical or mental health conditions.
- If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
 - 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;
 - Prostheses; and
 - Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.
- 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 or pregnancy, 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

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 or pregnancy. 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.

Convenience care

When you cannot see your Primary Care Provider 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, but are not limited to, 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.

Virtual visit

UPMC Health Plan offers live virtual visits as a covered benefit, which include telephone visits, video visits using a mobile device or computer, or visits with your provider using secure messaging.

You may also have an asynchronous, or not-live visit, in which you submit your health data (such as: a photograph, a description of symptoms or the purpose of your visit) to a provider through a secure e-mail or messaging service on a secure, cloud-based platform for the provider's review. The provider will then send a diagnosis and treatment plan back to you or your referring provider.

The following services are included:

- **UPMC AnywhereCare Virtual Urgent Care and Children's AnywhereCare:** A secure, live video visit on the UPMC AnywhereCare mobile app or website through which you have access to a provider 24/7.
- **Virtual Visit - Primary Care:** A live video, telephone or asynchronous visit with a Primary Care Provider.
- **Virtual Visit – Specialist:** A live video, telephone, or asynchronous visit with a Specialist.
- **Virtual Visit-Behavioral Health:** A live video, telephone, or asynchronous visit with a behavioral health provider.
- **eConsult:** Physician-to-physician services occurring by telephone, secure messaging, or video conference where one physician has expertise needed by the requesting/treating physician to deliver care to you. The requesting physician is required to obtain your consent before an eConsult can be conducted. Members in qualified high deductible health plans (QHDHP) may receive a bill for eConsults.

UPMC MyHealth 24/7 Nurse Line

If you have a health concern and need quick assistance, UPMC MyHealth 24/7 Nurse Line registered nurses provide prompt and efficient service. After discussing your symptoms with you, the nurse will help you determine what level of care may be appropriate. The UPMC MyHealth 24/7 Nurse Line is completely free for members and available 24 hours a day, seven days a week at 1-866-918-1591 (TTY:711).

UPMC nurses who answer calls are licensed to assist Members in Pennsylvania, West Virginia, Maryland, New York and Ohio. Members must be in one of those states when calling the UPMC MyHealth 24/7 Nurse Line. The UPMC MyHealth 24/7 Nurse Line is not a substitute for medical care. If an emergency arises, call 911 or go to the emergency department. Nurses cannot answer plan or benefit questions. Please call the Member Services phone number on your ID card for questions regarding your plan benefits.

Allergy services

Diagnostic testing consisting of percutaneous, intracutaneous, and patch tests, and treatment including injections and serum, when Medically Necessary.

Diagnostic services

Your benefit plan covers the following diagnostic services when Medically Necessary, ordered by a licensed professional provider and rendered by a participating laboratory or other Participating Provider.

- Diagnostic advanced imaging, including but not limited to radiology, magnetic resonance imaging (MRI), CT or MRI mammograms, and nuclear medicine
- Diagnostic other imaging, including but not limited to x-ray, sonogram, standard or 3D mammograms, and ultrasound
- 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.

Participating providers are required to order diagnostic tests from a participating laboratory. If your Participating Provider does not order the tests from a participating laboratory, you will not be financially responsible for those services beyond your in-network cost share. If you or your ordering provider (if a Non-Participating Provider) choose to use a nonparticipating laboratory, you may be financially responsible for those services.

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 therapy services

Rehabilitative therapy services help you keep, restore, or improve skills and functioning for daily living and skills related to communication that have been lost or impaired due to sickness, injury, or disability. Your benefit plan covers the following rehabilitative 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.

Habilitative therapy services

Habilitative therapy services help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services assist people with disabilities in a variety of inpatient and outpatient settings. Your benefit plan covers the following habilitative 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 these services are Medically Necessary. See your Schedule of Benefits for Benefit limits regarding these services.

Medical therapy services

Radiation therapy, chemotherapy, dialysis treatment: These services are covered when Medically Necessary.

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

Chemotherapy and cancer hormone treatments and services, which have been approved by the United States Food and Drug Administration for 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 appropriate treatment setting, are covered, but they may require a Prior Authorization.

Pain management and rehabilitation outpatient 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

Behavioral Health services include services for the treatment of mental health conditions and substance use disorder conditions. Services will be classified as Behavioral Health services when primarily associated with a mental health or substance use disorder condition, as indicated by your provider, regardless of the type or location of the Covered Service.

Your benefit plan covers the following services, whether Rehabilitative or Habilitative when Medically Necessary to treat behavioral health conditions:

- **Inpatient services:**
 - Treatment in an acute care hospital or psychiatric hospital (including room and board)
 - Treatment in a residential treatment facility (including room and board). “Residential treatment” is an environment that treats patients who require daily assessment or treatment and 24-hour monitoring but do not require acute care services. In order to provide this level of care, residential treatment facilities have on-site nursing during daytime hours and 24/7 access to psychiatric, medical, and other clinical services either onsite or in close enough proximity to provide rapid response. With respect to treatment of substance use disorders, “residential treatment” is an environment equivalent to American Society of Addiction Medicine levels of care 3.5 and 3.7.
 - Hospital-based and non-hospital-based inpatient withdrawal management (detoxification) services (including room and board)
 - Ancillary services related to inpatient stay, including professional services of a physician, psychologist, nurse, certified mental health counselor, certified addiction counselor, or other trained staff; individual, group and family psychotherapy or counseling; electroconvulsive therapy; medical, psychological and laboratory testing; equipment use and supplies; and diagnostic and other therapeutic services
- **Office visits and outpatient therapy, including:**
 - Professional services of a physician, psychologist, nurse, certified mental health counselor, certified addiction counselor, or other trained staff
 - Individual, group and family psychotherapy or counseling
 - Psychological and neuropsychological testing
- **Outpatient services including:**
 - Electroconvulsive therapy
 - Intensive outpatient program
 - Partial hospitalization program
 - Outpatient detoxification/withdrawal management services
 - Other outpatient services deemed Medically Necessary for the treatment of a behavioral health condition
- **Physical therapy, occupational therapy, or speech therapy** related to treatment of a behavioral health condition.
- **Laboratory testing** related to treatment of a behavioral health condition.

Autism Spectrum Disorder services

Your benefit plan covers the diagnostic assessment and treatment of Autism Spectrum Disorder.

Covered services for the assessment and treatment of Autism Spectrum Disorder include but are not limited to:

- Applied behavioral analysis
- Rehabilitative/habilitative care and therapeutic care

In order to ensure compliance with the Mental Health Parity and Addiction Equity Act, some services may have reduced cost-sharing when provided in relation to a behavioral health condition. See your Schedule of Benefits for details.

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, chronic migraine headaches, chronic low back pain, chronic neck pain, and chronic knee osteoarthritis pain, for Members 18 years of age and older. See your Schedule of Benefits for Benefit Limits regarding this service.

Corrective appliances (orthotics and prosthetics)

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.

Note that your benefit plan only covers orthopedic shoes and shoe inserts if you have certain conditions including, but not limited to, diabetes to prevent foot injury and/or disease. Customized shoe modifications are also covered for certain conditions such as peripheral vascular disease, when prescribed by your physician and meeting UPMC Health Plan criteria. If you have questions regarding this benefit, please contact Member Services at the phone number shown on your member ID card.

Repairs to Medically Necessary corrective appliances: Repair costs are covered up to 50% of the replacement cost when necessary to make the appliance serviceable. If the appliance is still 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 corrective appliances: 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; or repair of the item is not a feasible option. Replacement due to wear and tear before the five (5) year life expectancy of the item is not covered.

The decision to cover repair or replacement is at the sole discretion of UPMC Health Plan.

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 include, but are not limited to in-home hospital beds, wheelchairs (including power mobility devices), ventilators, oxygen tanks or concentrators, crutches, walkers, canes, commodes, and suction machines. Prior Authorization may be required for some durable medical equipment.

Repairs to Medically Necessary DME: When the DME 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: The replacement of the equipment before the five (5) year life expectancy may be covered 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 life expectancy of the item is not covered.

The decision to cover repair or replacement is at the sole discretion of UPMC Health Plan.

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, you are covered for fertility testing up to the diagnosis of infertility. See Infertility services for a description of Covered Services beyond the diagnosis of infertility.

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. Prior Authorization may be required. See your Schedule of Benefits for Benefit Limits regarding this service.

- 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
- Home infusion therapy
- Respiratory therapy

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.

Infertility services

Your benefit plan covers assisted fertilization procedures, which includes artificial insemination only. This includes services performed for the promotion of fertilization of a recipient's own ova (eggs) by the introduction of mature sperm from partner or donor into the recipient's vagina or uterus, with accompanying simple sperm preparation, sperm washing and/or thawing.

To be eligible for coverage for infertility services and diagnostic procedures, the member(s) must meet the following criteria:

- Evidence that the Member is premenopausal and reasonably expects fertility as a natural state or, if the Member is menopausal, such menopause is experienced at an early age.

Eligibility for coverage (infertility) may arise from gender-specific factors (e.g. pelvic adhesions, ovarian dysfunction, endometriosis, prior tubal ligation, abnormalities in sperm production, function or transport, or prior vasectomy), a combination of factors, or unknown causes.

Medical nutrition therapy

Medical nutrition therapy helps individuals with certain diseases better manage their health. Relevant conditions include, but are not limited to:

- Pediatric obesity
- Morbid obesity
- Malnutrition
- Cardiovascular disease
- Symptomatic HIV/AIDS
- Inflammatory bowel disease
- Celiac disease
- Chronic renal disease
- Spina bifida
- Spinal cord injury
- Diabetes mellitus
- High risk obstetrical conditions
- Eating disorders (e.g., anorexia nervosa, bulimia, binge-eating)

This therapy includes nutritional assessment and counseling services directly related to those conditions, when provided by a dietitian or facility-based program. Your benefit plan will cover medical nutrition therapy services directly related to a medical condition when Medically Necessary. Medical Necessity (including limits on medical nutrition therapy services) may vary by condition.

Nutritional counseling

Nutritional counseling consists of the assessment of a person's dietary intake and overall nutritional status, followed by the counseling, educational materials, and assignment of an individualized diet. Your benefit will cover nutritional counseling services that are provided by a dietitian or facility-based program. See your Schedule of Benefits for Benefit Limits regarding the maximum number of visits that are covered under your plan.

Nutritional formulas

Your benefit plan covers nutritional formulas as Medically Necessary for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia, and homocystinuria as administered under the direction of a physician.

Your benefit plan covers amino acid-based elemental medical formula (made of 100% free amino acids as the protein source) when ordered/prescribed by a physician for documented Medical Necessity to infants or children (under 18 years old) administered orally or enterally for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders, and short-bowel syndrome.

Podiatry Services

Your benefit plan covers routine foot care services, when performed by a provider, that are determined by UPMC Health Plan to be Medically Necessary provided that you have diabetes, metabolic, neurologic 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 following criteria are met:

- You or your provider receives Prior Authorization
- 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 or rehabilitation. The services will instead be considered custodial care and will not be covered.

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. Chiropractic services performed repetitively to maintain a level of function, or when no expectation of additional functional improvement is likely to occur are considered maintenance care and will not be covered. See your Schedule of Benefits for Benefit Limits regarding the maximum number of visits that are covered under your plan.

For members who are under 7 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

Outpatient diabetes self-management training and education services will be covered:

- Upon initial diagnosis of diabetes
- Subsequent visits when you or 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. Please refer to the Preventive Services Reference Guide at www.upmchealthplan.com for information on gestational diabetes.

Prescription drugs

Benefits will be provided for Covered Prescription Drugs when prescribed by an appropriately licensed health care professional 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 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.

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. Transplantation services must be Prior Authorized by UPMC Health Plan. 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 medical diagnoses such as 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 corrective 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 the additional cost of the corrective intraocular lens. You will be responsible for any and all upgrades.

Health management services

UPMC Health Plan provides services aimed at improving your overall health and wellness. Health management services are as follows:

MyHealth OnLine: This portal offers engaging health and wellness tools including self-directed programs and trackers to help guide behavioral lifestyle changes.

Lifestyle health coaching: Through virtual (AnywhereCare) telephonic, and digital (RxWell mobile app) modalities, consultation, health coaches may address lifestyle health needs. Please visit our website at upmchealthplan.com/members/ or call 1-800-807-0751 for additional information.

Condition management coaching: A medical-behavioral approach to help manage chronic conditions and improve your health. Coaches identify problems and develop treatment plans based on specific medical needs while in collaboration

with your physicians. The condition management program staff consists of licensed nurses, exercise physiologists, certified diabetes educators, and other professionals. Members are identified for condition management through a variety of means, including self-referrals, identification through stratification of claims and other data, internal coaching referrals, screenings, and on-site events.

Case management: Case management coaches are licensed nurses, social workers, and other clinical professionals who help you manage your health by coordinating with your providers and providing access to resources. You may engage case management coaches by calling Member Services. UPMC Health Plan may also contact you about the availability of coaching opportunities that may be beneficial to you.

Supportive Counseling: Up to six coaching and counseling sessions per issue you experience. Sessions can be in-person, telephonic, or virtual. For more information or for assistance in accessing these sessions, please call 1-800-647—3327 or download the UPMC AnywhereCare app and select Virtual Counseling.

Member discounts

As a UPMC Health Plan Member, you have access to various retailer discounts, discounts on vision services for adults 19 and older, health and wellness related resources and incentives, and more. Availability of all Member discounts and incentives are subject to change. For a full listing, login to the Member portal at *MyHealth OnLine* or call Member Services at the number on your ID card.

Section V.

Exclusions

Not all health care services are Covered Services. Unless otherwise set forth in a Rider, the following is a list of services that are not covered under your benefit plan. If you are not sure if a service is covered, you can call UPMC Health Plan Member Services to ask if that service is covered under your benefit plan.

- 1. Administrative Purposes:** Physical examinations, immunizations, diagnostic testing, completion of forms, preparation of specialized reports, or any other service performed for a non-therapeutic or administrative purpose, including, but not limited to: for insurance; licensing; employment; premarital examinations; submission of applications for government or private benefits; foreign travel; participation in school, camp, sports or other similar activities; except as set forth in the Preventive care subsection of Section IV. (Covered Services) or as required by law.
- 2. Alternative Medicine:** Including, but not limited to, acupuncture, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation, or yoga.
- 3. Assisted Fertilization:** Assisted fertilization services, including, but not limited to, GIFT, ZIFT, embryo transplants, and in vitro fertilization.
- 4. Bariatric Surgery:** Bariatric Surgery is not covered under any circumstances.
- 5. Blood:** Non-purchased blood or blood products, including autologous donations.
- 6. Corrective Appliances:** Corrective appliances primarily intended for athletic purposes or related to a sports medicine treatment plan, and other appliances or devices, or any related services. These services include, but are not limited to, when sports-related, children's corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, shoe inserts or orthopedics shoes. For covered corrective appliances, please see **Section IV. Covered Services**, subsection **Corrective appliances (orthotics and prosthetics)**.
- 7. Cosmetic Surgery:** Surgical or other services for cosmetic purposes, except as such surgery or services are required to be covered by law. A service is cosmetic if it is performed to reshape a body structure for the improvement of the person's appearance, and if it is not an accepted treatment for an underlying health condition. Excluded services include, but are not limited to, removal of 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.
- 8. Court Ordered:** Any services that are court-ordered, unless such services are otherwise Covered Services and Medically Necessary.
- 9. Custodial Care:** Custodial care, domiciliary care, or protective and supportive care, including, but not limited to, assisted living, personal care homes, halfway house or three-quarters house, respite care, custodial educational services (including therapeutic boarding school), convalescent care, dietary services, homemaker services, maintenance therapy, and food or home-delivered meals.
- 10. 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 Certificate of Insurance or Schedule of Benefits, or as mandated by law.
- 11. 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.

- 12. 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.
- 13. Experimental/Investigational:** Services that are Experimental/Investigational in nature, or otherwise are not evidence-based, as determined by UPMC Health Plan.
- 14. Food Supplements/Vitamins:** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except as otherwise set forth herein.
- 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 law.
- 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:** 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 medical equipment and supplies that are (a) expendable in nature (i.e., disposable items such as incontinence pads, diapers, adult briefs, ace bandages, elastic stockings, and dressings) or (b) primarily used for non-medical purposes (i.e., shower chairs, grab bars, scales), regardless of whether recommended by a professional provider.
- 21. Immunizations and Drugs:** Physical examinations, prophylactic medications and immunizations required by foreign travel, school or university, or employment, except when such 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. Military Service:**
 - a. 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.
 - b. Services that are provided to members of the armed forces and the National Health Service or to individuals in Department of Veterans Affairs facilities for military service-related illness or injury, unless you have a legal obligation to pay.

- 26. Miscellaneous:** Any services, supplies, or treatments not specifically listed in the Policy as Covered Benefits, services, supplies, or treatments including, but not limited to:
- A. Services and supplies that are not 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 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.
 - E. Services for which you otherwise would have no legal obligation to pay.
 - F. Charges for telephone consultations, unless otherwise allowed in accordance with UPMC Health Plan policy.
 - G. Charges for failure to keep a scheduled appointment.
 - H. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
 - I. Charges for completion of any insurance form or copying of medical records.
 - J. Services rendered by a professional provider who is a member of your immediate family. Immediate family is defined as your spouse or legal partner, domiciliary partner, child, stepchild, parent, sibling, or persons who ordinarily reside in the household of the insured. This includes services that may be covered by any Schedule of Benefit attached to this Policy, such as a Prescription Medication benefit.
 - K. Services that are submitted by two different professional providers for the same services performed on the same date for the same individual.
 - L. Services for, or related to, any illness or injury suffered after the Effective Date of your coverage that is the result of any act of war.
- 27. 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.”
- 28. Non-Medical Items:** Health club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, non-hospital beds, stair glides, home or automobile modifications, car seats, whirlpools or similar items, even if recommended by a professional provider.
- 29. Non-Medical Services:** Services or therapies that are not primarily medical in nature, regardless of diagnosis, including, but not limited to: barber or beauty service; disciplinary services, including truancy-related services; services that are primarily educational in nature – including, but not limited to, vocational rehabilitation, recreational therapy, educational therapy, or experiential education; guest service; intensive health coaching; testing for learning disabilities; resource coordination activity; sensitivity training; sexual surrogate programs; summer camp programs; therapeutic boarding school or transitional programs; and twelve-step model programs.
- 30. Nutritional Products:** All food, food products, specialty foods, medical foods or modified solid food supplements and nutritional formulas, powders, shakes, pudding or supplements, whether or not prescribed for the treatment or management of any condition; except nutritional formulas considered Medically Necessary in the treatment of inborn errors of metabolism and inherited metabolic disorders, as specified in **Section IV. Covered Services**, subsection **Nutritional formulas**.
- 31. Oral Surgery:** Services, including or related to oral surgery, except as set forth in **Section IV. Covered Services**, subsections **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:** Vitamins, medications not requiring a prescription (analgesics, antihistamines, cold medicines, digestive relief medicines, etc.), other nutritional and over-the-counter electrolyte supplements, except as set forth in **Section IV. Covered Services**, subsection **Nutritional formulas** or when coverage is required by the Affordable Care Act.
- 33. Private Duty Nursing:** Private Duty Nursing is not covered under any circumstances.
- 34. Rehabilitative Therapy:** Physical, occupational, speech, cardiac, and pulmonary rehabilitation therapy services provided in excess of the maximum number of visits per Benefit Period, as indicated in the Schedule of Benefits; 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.
- 35. Reversal of Voluntary Sterilization Procedures:** Services to reverse sterilization.
- 36. Smoking Programs:** Nicotine cessation programs and/or classes and prescription and non-prescription medications not otherwise included in the Preventive Services Reference Guide. For more information about the Preventive Services Reference Guide, see **Section IV. Covered Services** subsection **Preventive care**.
- 37. 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.
- 38. Transportation:** Non-emergent transportation, by any means, including via ambulance provider except as set forth in **Section IV. Covered Services** subsection **Emergency transportation**.
- 39. Treatment Outside the United States:** Treatment for non-emergent or non-urgent services received outside of the United States.
- 40. 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
- 41. 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 unless you have coverage for anti-obesity medications in your Prescription Medication Schedule of Benefits. For more information about the Preventive Services Reference Guide, see **Section IV. Covered Services** subsection **Preventive care**.
- 42. Wigs (cranial prosthesis):** Manufactured coverings for the head made of natural or synthetic hair, including but not limited to, hairpieces and similar manufactured coverings that are used to replace or supplement hair.

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 at the in-network benefit level when you are traveling outside the UPMC Health Plan Service Area.

Because you are enrolled in a PPO plan, you may self-direct your care to Non-Participating, or out-of-network, Providers outside the UPMC Service Area. However, services that are not urgent care or Emergency Services will receive a lower level of benefit coverage, and the Non-Participating Provider may bill you for the amount of the charges that UPMC Health Plan does not cover.

There are certain services that, if received from a Non-Participating Provider, require Prior Authorization by UPMC Health Plan in order to be eligible for reimbursement under your plan. This means that if you fail to obtain Prior Authorization, you may be responsible for the entire amount of charges billed by your provider. To determine whether a service received by a Non-Participating Provider requires Prior Authorization, visit our website at www.upmchealthplan.com or contact Member Services by calling the phone number on your ID card.

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.

For unplanned, non-emergent care when traveling outside of the Service Area, UPMC Health Plan has entered into agreements with two provider networks (collectively referred to as the “Extended Network”) in order to better serve you when you need medical care. The Extended Network is intended for use when you are traveling outside of the UPMC Health Plan Service Area. For more information refer to **Section XI. General Provisions** subsection **Provider networks**.

Emergency Services

If you are traveling and suffer from an illness or injury that is an emergency, you should go to the nearest emergency department. If the illness or injury is an emergency, the health care services that are received from the emergency department will be paid at the Participating Provider cost-share. 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 financially 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. UPMC Health Plan will consider both the presenting symptoms and the services provided in processing a claim for reimbursement of Emergency Services.

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 the Service Area

Your dependents can obtain the care they need while living outside the Service Area by visiting providers within the Health Plans Extended Network; however, UPMC Health Plan encourages your dependents to schedule appointments for health care services within the UPMC 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. Dependents attending school or university may receive in-network care from an on-campus student health center. Non-emergent services obtained while your dependent is outside of UPMC Health Plan's Service Area may require Prior Authorization. In an emergency, your dependent should go to the nearest emergency department. 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 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 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 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.

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

As a UPMC Health Plan Member, you authorize us to make payments directly to providers from whom you 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 Reasonable & Customary Charge. 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. For the avoidance of doubt, the foregoing does not apply to services that are protected by the No Surprises Act. For more information, please refer to the No Surprises Act section of this Policy.

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.

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

When you or your covered dependents are 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 as the subscriber under one plan and as a dependent under another, the subscriber insured 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. The Member must provide a copy of the court order to UPMC Health Plan.
- 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 of 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 is provided to UPMC Health Plan by you, the school or university which provided this Policy, another insurance company, or any other entity or person authorized to provide such information.

When you or your family member has more than one insurance provider, UPMC Health Plan follows Coordination of Benefits (COB) standards to determine if UPMC Health Plan is the primary or secondary payer. These are standards set by the National Association of Insurance Commissioners (NAIC) and the Medicare Secondary Payer regulations. UPMC Health Plan coordinates benefits payable for Covered Services with benefits payable by other plans, consistent with state law. Claims submitted to UPMC Health Plan for secondary payment must include the primary carrier's Explanation of Benefits (EOB). If UPMC Health Plan is your secondary plan and your primary plan has a limited network, UPMC Health Plan shall cover benefits in accordance with your primary plan's network, except for emergency services or services that have been prior authorized by your primary plan.

Subrogation

If you incur covered health care expenses for injuries or an accident caused by another person or organization, the person or organization causing the injuries or accident may be responsible for paying these expenses, whether directly or through another insurer. UPMC Health Plan has the right to seek repayment from the other person or organization, his/her/its insurance company, or other responsible party for the cost of any benefits that UPMC Health Plan has paid or provided related to or arising out of those injuries or accident.

UPMC Health Plan's right to pursue subrogation recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under this Policy. UPMC Health Plan will pursue its recovery of the amounts paid for such benefits to the greatest extent permitted by law, including by seeking recovery directly from you in the case that you are paid directly by another party's insurance company. To the extent permissible by law, UPMC Health Plan's right of reimbursement extends to any payment received from any party that may be liable, a third party's insurance policies, your own insurance policies, a workers' compensation program or policy, or otherwise.

UPMC Health Plan may use any and all legal remedies available in order to assert its right(s) of recovery. UPMC Health Plan will attempt to recover all amounts paid to treat your injury. UPMC Health Plan's right to reimbursement out of the benefit payments received by you or your representatives, heirs, administrators, successors, or assignees shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. To the extent permissible by law and as set forth herein, UPMC Health Plan's right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount

of damages claimed. UPMC Health Plan will not deduct or offset the value of any applicable subrogation claim(s) against your future benefits under this Policy. Subject to any other limitations set forth in this Policy, UPMC Health Plan will also cover the cost of treatment that exceeds the amount of the payment you received.

You may be asked to assist UPMC Health Plan or its Agent(s) to produce documents or take other actions as part of UPMC Health Plan's subrogation recovery efforts. UPMC Health Plan may, at its option and to the extent permissible by law, choose to exercise its right of subrogation and pursue a recovery from any liable party as successor to your rights. You and/or your dependents must not take any action that would prejudice or impede UPMC Health Plan or its Agent(s) in seeking a subrogation recovery or otherwise impair UPMC Health Plan's subrogation rights. UPMC Health Plan is not responsible for any attorney's fees or other expenses you may incur in obtaining payment for your injuries from another party. All Covered Services provided under this Policy are subject to this section ("Subrogation").

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 your ID card. The notice must include the data necessary for UPMC Health Plan to identify the insured and determine benefits. Notification provided as stated in this paragraph shall be deemed notice to the insurer. 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 above. The proof of loss may be submitted to UPMC Health Plan at the address that appears on your ID card. The claim form to be used under this clause is the Health Care Financing Administration Form-1500. The provision for Health Care Financing Administration Form-1500 shall not apply to medical payments made by the Federal Government.

Proofs of Loss: Written proof of loss must be furnished to UPMC Health Plan at the address that appears on your ID card 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. A dispute about the coverage, operations, or management policies of UPMC Health Plan is called a “Complaint.” A dispute regarding UPMC Health Plan’s denial, reduction, or termination of a benefit, or failure to make payment for a benefit – also known as an “Adverse Benefit Determination” – is called an “Appeal.”

The Complaint process

If you have a dispute or objection regarding the coverage, operations, or management policies of UPMC Health Plan, or about a UPMC Health Plan Participating Provider, 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, or coordination of benefits. The Complaint process offers two levels of review.

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 and include a signed Personal Representative Designation (PRD) form signed by you and your designee. To obtain a PRD form, visit www.upmchealthplan.com or call the Member Services number on your Member identification card.

You or your representative may file a Complaint with UPMC Health Plan in writing or over the phone. You can also file a complaint online by completing the online “Complaint or Appeal Submission Form” which can be found on MyHealth Online. To submit a Complaint in writing, please mail your Complaint to P.O. Box 2939, Pittsburgh, PA 15230- 2939. You are encouraged to send any other written information you have to support your Complaint. Include in the Complaint the remedy, resolution, or corrective action you want from UPMC Health Plan.

To submit a Complaint over the phone, you or your representative may call the Member Services phone number on your Member identification card. A Health Plan employee will assist you or your representative, at no charge, to prepare your Complaint, but will not be able to resolve your Complaint. This employee will not have previously participated in any of UPMC Health Plan’s decisions regarding your Complaint.

First Level Complaint

You must submit your First Level Complaint within 180 days of the date on which the incident occurred. UPMC Health Plan will send you a letter to let you know we received the Complaint.

A First Level Complaint Review Committee will investigate the allegations in your Complaint within 30 days of receipt of your Complaint. The Committee will notify you of its decision in writing within five (5) business days of receipt of your Complaint decision. The notification letter will explain the Committee’s decision and describe the process by which you may request a Second Level review of the decision.

Second Level Complaint

If you are not satisfied with the results of your First Level Complaint, you can request another review. You have 60 days from the date on the Committee’s decision letter to request another review. If you choose not to request a Second Level review within that time frame, the decision of the First Level Complaint Review Committee will be final.

If you submit a Second Level Complaint, UPMC Health Plan will send you a letter to let you know that we received your Complaint. We will also tell you the date and time for your Second Level Complaint Review Committee meeting. UPMC Health Plan will give you at least 15 days’ notice of the meeting. UPMC Health Plan will also explain what happens at review meetings and how you can participate in the meeting. You and/or your representative have the right, but are not required, to attend the Second Level Complaint Review Committee meeting. The meeting will be held at the offices of UPMC Health Plan.

If you or your representative cannot appear in person at the Second Level Complaint Review Committee meeting, UPMC Health Plan will provide you with the opportunity to participate in the review by telephone or other appropriate and available means. We will be as flexible as is reasonably possible in facilitating your participation.

The Second Level Complaint review will be completed within 45 days of receiving your request for such review. The Second Level Complaint Review Committee will issue a decision in writing to you and your representative no more than five (5) business days after the date of the meeting.

You are entitled to receive, upon request, reasonable access to and copies of all documents relevant to your Complaint. To request this documentation, please call the phone number on your member identification card.

The Adverse Benefit Determination Appeal process

You have the right to appeal any Adverse Benefit Determination made by UPMC Health Plan. An Adverse Benefit Determination includes the following:

1. A decision that a service is not covered because it is not Medically Necessary (including decisions about the appropriateness of service, health care setting, level of care, or effectiveness of a service);
2. A decision that a service is Experimental/Investigational;
3. An “Administrative Denial.” An administrative denial is a decision to deny authorization, coverage, or payment for a service because (a) you are not eligible for coverage; (b) you or your provider failed to submit sufficient information with which to make a coverage decision; or (c) or your provider has failed to comply with an administrative policy of UPMC Health Plan.
4. A rescission of your coverage (cancellation of coverage based on a claim that you gave false or incomplete information when you applied for coverage).

You, your designated representative, or your provider who has your written consent may file an Appeal of an Adverse Benefit Determination. We will refer to a provider who has your written consent to file an Appeal as your provider. If you have given written consent to file an Appeal, please read the section below for more information.

You or your representative may file an Appeal with the Health Plan in writing or over the phone. You can also file an Appeal online by completing the online “Complaint or Appeal Submission Form” which can be found on MyHealth Online. To submit an Appeal in writing, please mail your Appeal to PO Box 2939, Pittsburgh, PA 15230-2939. You are encouraged to send any other written information to support your Appeal. You may include in the Appeal the remedy, resolution, or corrective action you want from UPMC Health Plan.

To submit an Appeal over the phone, you or your representative may call the Member Services phone number on your member identification card. A Health Plan employee will assist you or your representative, at no charge, to prepare your Appeal, but will not be able to resolve your Appeal. This employee will not have previously participated in any of UPMC Health Plan’s decisions regarding your Appeal.

Provider-Initiated Appeal

You may give your provider consent to file an Appeal on your behalf. Please note that if you do so, you cannot file your own Appeal for the same denied treatment or service.

Here are some important rights regarding giving your provider consent to file an Appeal on your behalf:

- If you give your provider consent to file an Appeal on your behalf, that consent must be in writing, it must contain certain language required by law, and it can be rescinded at any time.
- Your provider may not require you to give the provider permission to file an Appeal on your behalf as a condition of providing a treatment or service.
- Your provider must notify you if the provider decides not to file the Appeal.

- Your provider has 10 days to file an Appeal from the date of the denial of the treatment or services, and their ability to file an Appeal on your behalf is automatically rescinded if they fail to do so.
- If your provider files the Appeal on your behalf, your provider may not bill you for the services that are the subject of the Appeal until the External Review process has been completed or you rescind your consent.

Internal Appeals

UPMC Health Plan's Adverse Benefit Determination appeal process offers one level of review. You must submit your Appeal within 180 days of the date on which the denial occurred. For example, if your Appeal is regarding denial of prior authorization for a service, you must file the Appeal within 180 days of the date on the letter you received informing you of that denial. While it is preferable that you file an Appeal in writing, you may call UPMC Health Plan to request assistance and file an Appeal verbally. UPMC Health Plan will send you a letter to let you know your Appeal was received. UPMC Health Plan may also contact you to ask for additional information, if necessary to process your Appeal.

An Adverse Benefit Determination Review Committee will investigate the allegations set forth in the Appeal. The Committee will seek input from a licensed health care provider with experience in the same or similar specialty that typically manages or consults regarding the disputed health care service. If the Committee relies on or considers new or additional information in reviewing your Appeal 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 and your representative of its decision within thirty (30) days of receipt of your Appeal. The notification letter will explain the Committee's decision and any additional appeal rights. A copy of the decision letter will be sent to you and/or your representation and/or your provider, as applicable.

You are entitled to receive, upon request, reasonable access to either copies of all documents relevant to your Appeal or instructions on how to obtain the documents. Documentation may include the benefit provision, guideline, protocol, diagnosis codes, or treatment codes on which the decision was based. To request this documentation, please call the phone number on your member identification card.

Appeals from a Cigna Medical Necessity Decision

If you sought or received services from the Cigna extended network and have a dispute or objection regarding an Adverse Benefit Determination made by Cigna, you may ask Cigna for an appeal of the Adverse Benefit Determination. You or your representative may file an appeal with Cigna in writing or over the phone. To submit an appeal over the phone, please call 866-494-4872. To submit an appeal in writing, please mail your appeal to Cigna National Appeals Unit, P.O. Box 188011, Chattanooga, TN 37422. You are encouraged to send any other written information to support your appeal.

The External Review process

If you and/or your provider are still dissatisfied with UPMC Health Plan's final decision regarding your Complaint or Adverse Benefit Determination, you may have the right to file a request for an external review by an Independent Review Organization (IRO).

An External Review may be requested for the following issues:

1. A decision that a service is not covered because it is not Medically Necessary (including decisions about the appropriateness of service, health care setting, level of care, or effectiveness of a service);
2. A decision that a service is Experimental/Investigational;
3. Disputes regarding UPMC Health Plan's compliance with the surprise-billing and cost-sharing protections of the No Surprises Act.

Note that Administrative Denials are not eligible for external review by an IRO.

You, your representative, or your provider may file a request for an external review with the Pennsylvania Insurance Department within four (4) months of the date on the Committee's decision letter. For more information on the independent external review process, you can visit the Pennsylvania Insurance Department's website at: www.insurance.pa.gov/externalreview.

To submit a request for either standard or expedited independent external review (expedited reviews are discussed in more detail below), you must submit a copy of your Adverse Benefit Determination or Final Adverse Benefit Determination notice and a completed independent external review request form to:

Mail: Pennsylvania Insurance Department
Attn: Bureau of Managed Care
1311 Strawberry Square
Harrisburg, PA 17120

Fax: 717-231-7960
Email: RA-IN-ExternalReview@pa.gov
Phone: Consumer Services, 1-877-881-6388

For an external review of a determination that a service is Experimental/Investigational, your provider must certify that standard healthcare services have not been effective in improving your condition, standard Covered Services are not medically appropriate, or that the requested service is likely to be more beneficial than any standard Covered Services, based on the provider's professional opinion or based on scientifically valid studies.

Once PID receives your request, the Insurance Department will confirm your eligibility for independent external review with UPMC Health Plan. UPMC Health Plan will complete a preliminary review within five (5) business days to determine whether (1) you are a covered Member; (2) the service requested is a Covered Service under your plan (or would be a Covered Service if not Experimental/Investigational); (3) you exhausted internal appeals; and (4) you provided all information and forms necessary to process the external review.

Within one (1) business day after completion of the preliminary review, UPMC Health Plan will issue a notification to you and PID in writing as to whether or not your Adverse Benefit Determination 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 Adverse Benefit Determination or Final Adverse Benefit Determination is eligible for independent external review, the Pennsylvania Insurance Department will assign an Independent Review Organization (IRO) and provide you with notice of the assignment and information on how you may submit information to support your position.

Within five (5) business 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 the 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 review.

You, your representative, or your provider may supply additional information to the IRO to consider in the external review within 15 business days of notification that your Adverse Benefit Determination is eligible for external review (5 business days in the case of an external review of an Experimental/Investigational decision). The IRO will forward any additional information it receives to UPMC Health Plan to supplement our records.

The IRO will review all information provided by UPMC Health Plan and you, your representative, or your provider. The Independent Review Organization will issue a decision to uphold, partially uphold, or overturn UPMC Health Plan's decision based on the information provided by you and UPMC Health Plan. The IRO will issue a decision within forty-five (45) days of receipt of the external review (20 days in the case of a review of an Experimental/Investigational decision). 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 Complaint or Appeal. 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 your member identification card.

Expedited review process

If you believe your life, health, or ability to regain maximum function may be jeopardized due to the standard time frames for standard internal Complaint or Adverse Benefit Determination review, you may request an expedited internal review from UPMC Health Plan and/or an expedited external review request from the Pennsylvania Insurance Department at any stage of the Plan's review process.

Expedited internal review process

You may request an expedited internal review if your life, health, or ability to regain maximum function may be jeopardized due to the standard time frames for a standard internal review.

To request an expedited review, you should contact Member Services and explain the need for an expedited 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 Complaint or Adverse Benefit Determination process. The certification must include a clinical rationale and facts to support your provider's position. In the case of a review of a decision that a treatment is Experimental/Investigational, your treating provider must certify that the services that are the subject of the request would be significantly less effective if not promptly initiated. UPMC Health Plan will inform you of the decision verbally and in writing.

The expedited review process follows all the requirements of a standard second level review, with the following exceptions:

- If UPMC Health Plan cannot accommodate you or the committee members as to time and distance to be present at the review, the review may be held by telephone or other appropriate and available means. UPMC Health Plan will ensure that all appropriate information is read into the record.
- You must provide any additional information for consideration in an expedited manner so UPMC Health Plan can comply with the requirements for an expedited review.
- The internal committee will issue a decision within 72 hours of receipt of the request for review and the provider certification described above.

Expedited external review process

You may request an expedited external review if your life, health, or ability to regain maximum function may be jeopardized due to the standard time frames for a standard internal review. You may also request an expedited external review following exhaustion of the internal Adverse Benefit Determination review process if the Adverse Benefit Determination at issue concerns an admission, availability of care, continued stay, or health care service for which you received emergency services but have not been discharged from the facility.

To request an expedited external review, you should contact the Pennsylvania Insurance Department. For more information on the independent external review process, you can visit the Pennsylvania Insurance Department's website at: www.insurance.pa.gov/externalreview.

To submit a request for either standard or expedited independent external review, you must submit a copy of your Adverse Benefit Determination or Final Adverse Benefit Determination notice and a completed independent external review request form to:

Mail: Pennsylvania Insurance Department
Attn: Bureau of Managed Care
1311 Strawberry Square
Harrisburg, PA 17120

Fax: 717-231-7960
Email: RA-IN-ExternalReview@pa.gov
Phone: Consumer Services, 1-877-881-6388

The request must include 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 Complaint or Adverse Benefit Determination process. In the case of a review of a decision that a treatment is Experimental/Investigational, your treating provider must certify that the services that are the subject of the request would be significantly less effective if not promptly initiated.

Within 24 hours, the Department will send a copy of the request to UPMC Health Plan, which will determine your eligibility for an expedited external review within 24 hours. Following this decision, the Department will, within 24 hours, assign an IRO to review the issue. The IRO 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 review.

Appeal of a Complaint or Administrative Adverse Benefit Determination decision to a governing agency

If you are dissatisfied with UPMC Health Plan's decision regarding your Complaint or Adverse Benefit Determination, you may have the right to file an appeal of our decision with the Pennsylvania Insurance Department. Your appeal must be filed within 15 calendar days after you receive the final decision letter regarding your Complaint or Adverse Benefit Determination Appeal.

You may also submit a complaint or appeal to the Pennsylvania Insurance Department in writing, to either of the following addresses:

- Bureau of Managed Care of the Pennsylvania Insurance Department, 1311 Strawberry Square
Harrisburg, PA 17120 (1-888- 466-2787)
- Bureau of Consumer Services of the Pennsylvania Insurance Department, 1209 Strawberry Square,
Harrisburg, PA 17120 (1-877-881-6388)

Your request should be in writing, although the Pennsylvania Insurance Department will make staff available to transcribe a verbal appeal. You should provide the following information when filing a complaint or appeal:

- Your name, address, and telephone number
- Name of the managed care plan
- UPMC Member identification number
- A brief description of the issue being appealed
- A copy of the adverse decision letter that UPMC Health Plan sent to you

Section IX.

Payment

Your first month's premium must be paid on or before the due date established by your school or university which provided 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 premium by the due date established by your school or university which provided this Policy, in order for benefits to be provided, subject to the grace period provision specified in the following subsection titled Grace period.

Grace period

Subject to meeting the eligibility requirements as determined by your school or university which provided this Policy, 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. If the required premium payment is not received by the end of the thirty (30)-day grace period, the policy will automatically terminate effective the end of the Grace Period. Any claims received and found otherwise eligible during the Grace Period will be paid and may be reduced by any then outstanding premiums.

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. Coverage will remain in effect during the applicable Grace Period.

Reinstatement

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 and you meet the eligibility requirements as determined by your school or university which provided this Policy. 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 of Coverage

There are many reasons for which your coverage with UPMC Health Plan may terminate. Some of those reasons are:

- You are deceased
- You are no longer an eligible dependent. In this case your coverage will terminate at the end of the policy year.
- The Benefit Period ends.
- You fail to pay your required premium contribution to UPMC Health Plan, subject to the grace period.
- The school or university no longer contracts for coverage with UPMC Health Plan. If the school or university decides to terminate its contract with UPMC Health Plan, it is the school's or university's responsibility to tell you that your coverage will terminate.
- UPMC Health Plan determines that you committed fraud or made an intentional misrepresentation of material fact in information submitted to UPMC Health Plan or in obtaining or using services under this Policy. This includes improper use of your member identification card, such as allowing another person to use your card to obtain health care services.
- You are enrolled in Medicare prior to enrollment.

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 your ID card. Please note that your coverage under this Policy will not be terminated or rescinded because of your health status or requirements for health services.

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 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. 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. 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.

You and your eligible enrolled dependents agree that any person or entity having information relating to an illness or injury for which benefits are claimed under this Policy may provide that information, including copies of medical records, to UPMC Health Plan, upon request.

UPMC Health Plan may amend, modify, or terminate this Policy as agreed by UPMC Health Plan and the school or university without your consent. UPMC Health Plan shall have the right to amend this Policy to increase, reduce, or eliminate any of the benefits provided for herein for the purpose of complying with the provisions of any law, regulation, or mandate of a regulatory authority.

Fraud, waste 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, waste or abuse, call or email our Special Investigations Unit at 1-866-FRAUD01 (372-8301) or specialinvestigationunit@upmc.edu. All callers may choose to remain anonymous.

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. 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, Medical Schedule of Benefits, and current ID card constitute the entire Policy between you and UPMC Health Plan. A Pediatric Dental Certificate of Insurance, and Schedule of Benefits and a Pediatric Vision Certificate of Insurance, and Schedule of Benefits are also included for Members up to 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. No change in this Policy shall be valid until approved by a Health Plan officer and unless such approval be endorsed hereon or attached hereto.

Physical examination

UPMC Health Plan at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

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 subsection **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 Medically Necessary and regularly included in the charges of the duly licensed, rendering provider when performing within the scope of applicable licensure.

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.

No Surprises Act

In accordance with the No Surprises Act, you are protected from surprise billing or balance billing when you receive emergency care out-of-network or receive services from certain out-of-network providers at in-network facilities. Specifically, you are protected from balance billing if you receive emergency services from an out-of-network provider or facility. The out-of-network provider or facility may only bill you for the cost-sharing you would be responsible for if the services had been in-network. This protection against balance billing also applies to post-stabilization services you receive following the emergency care unless you provide written consent to waive the protection.

In addition, if you go to an in-network facility but receive care from certain providers who are out-of-network, such as an anesthesiologist, radiologist, or pathologist, you are protected from balance bills and will only be responsible for the amount you would have been charged had the services been rendered by an in-network provider.

If you believe you have been wrongly billed for protected services under the No Surprises Act, you may contact:

- Bureau of Managed Care of the Pennsylvania Insurance Department, 1311 Strawberry Square, Harrisburg, PA 17120 (1-888-466-2787)
- Bureau of Consumer Services of the Pennsylvania Insurance Department, 1209 Strawberry Square, Harrisburg, PA 17120 (1-877-881-6388 or TTY/TDD 717-783-3898)
- No Surprise Help Desk (NSHD) (1-800-985-3059)

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 in certain mediums, including but not limited to hard copies of such information with an incurred date of more than twelve (12) months prior to the request, UPMC Health Plan reserves the right to charge you for the cost of retrieval of such information.

Provider Network

UPMC Health Plan manages and provides coverage through its own comprehensive network in the UPMC Service Area. This provider network includes UPMC facilities and providers as well as community providers.

All Emergency Services at Non-Participating Providers will be covered at the Participating Provider level. For more information on Emergency Services, see the **Welcome and General Information for Members** page and **Section IV. Covered Services**, subsection **Emergency Services**.

For Members travelling outside of the UPMC Health Plan Service Area, and dependents under age 26, UPMC Health Plan has entered into agreements with two national and/or regional provider networks (collectively referred to as the “Extended Network”) in order to better serve you when you need medical care. Providers in these networks accept their contracted rate as payment in full, so your care will only be subject to any applicable Copayment, Deductible, and Coinsurance amounts as specified in your plan design.

- If you need care in Ohio, the SuperMed network is available through Medical Mutual of Ohio.
- If you need care outside of the UPMC Service Area and Ohio, the Cigna PPO Network² is available to you. Cigna is an independent company and not affiliated with UPMC Health Plan. Access to the Cigna PPO Network is available through Cigna's contractual relationship with UPMC Health Plan. For more information on how to file an appeal for a service that was denied in full or in part by Cigna because Cigna determined it was not Medically Necessary, please see **Section VIII, Resolving Disputes with the Health Plan**.

To find a Participating Provider, refer to your Provider Directory. You can get a Provider Directory by visiting www.upmchealthplan.com to search our online version of the directory or you can call UPMC Health Plan Member Services at the phone number on your ID card to have a provider directory sent to you.

² The Cigna PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna PPO for Shared Administration.

**Notice of Protection Provided by
Pennsylvania Life and Health Insurance Guaranty Association**

This notice provides a **brief summary** regarding the protections provided to policyholders by the Pennsylvania Life and Health Insurance Guaranty Association (“the Association”). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

Coverage

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to \$300,000 (or \$500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life Insurance:

- Up to \$300,000 in death benefits including up to \$100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):

- Up to \$500,000 for health benefit plans, with some exceptions.
- Up to \$300,000 for disability income benefits.
- Up to \$300,000 for long-term care insurance benefits.
- Up to \$100,000 for all other types of health insurance.

Individual annuities

- Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

Limitations and Exclusions From Coverage

The Association also does not provide coverage for:

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);

- unallocated annuity contracts (which give rights to group contractholders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
- If the person is provided coverage by the guaranty association of another state
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange

Notices

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
 Guaranty Association
 290 King of Prussia Road
 Radnor Station Building 2, Suite 218
 Radnor, PA 19087
 (610) 975-0572

Pennsylvania Insurance Department
 1209 Strawberry Square
 Harrisburg, PA 17120
 1-877-881-6388
www.insurance.pa.gov

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.

Nondiscrimination Notice

UPMC Health Plan, on behalf of itself and its affiliates, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression or sexual orientation.

UPMC Health Plan provides free aids and services to people with disabilities so they can communicate effectively with us. Aids and services may include:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

UPMC Health Plan provides free language services to people whose primary language is not English. Language services may include:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact the Member Services phone number listed on your Member ID card.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression, you can file a complaint with:

Complaints and Grievances
PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-888-876-2756 (TTY: 711)
Fax: 1-412-454-7920
Email: HealthPlanCompliance@upmc.edu

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-420-9589 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-420-9589 (TTY : 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-420-9589 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-420-9589 (телетайп: 711).

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprouch. Ruf selli Nummer uff: Call 1-866-420-9589 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-420-9589 (TTY: 711)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-420-9589 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-420-9589 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-420-9589 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-420-9589 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-420-9589 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-420-9589 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-420-9589 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយភ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-866-420-9589 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-420-9589 (TTY: 711).