2026
Certificate of Coverage

July 1, 2026-June 30, 2027

For the faculty and staff of the
University of Pittsburgh
who are enrolled in the
Self-Insured Advantage HMO
or Enhanced Access HMO

HMOA04

UPMC HEALTH PLAN

Welcome and General Information for Members

This document is your Certificate of Coverage. Your Certificate of Coverage establishes the terms of coverage for your group health benefit plan. 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 you receive will be covered under your benefit plan. It also describes how you can add a dependent to your plan, submit a claim, file an appeal, and it provides other information you may need to know in order to access your health care benefits.

The Certificate of Coverage can be referenced in addition to your Summary Plan Description for your employer's self-insured group health benefit plan. It sets forth your obligations as an employee/member and the University of Pittsburgh's, our obligations as the administrator of your group health benefit plan, and your employer or group health benefit plan sponsor's obligations. It is important to use this Certificate of Coverage along with your Schedule of Benefits. Your Schedule of Benefits is the document that outlines your coverage amount and Benefit Limits. This plan does not impose any pre-existing condition exclusions.

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 on non-premium expenses. Your Deductible is the amount you must pay for Covered Services before the 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 Certificate of Coverage or the Schedule of Benefits.

This Certificate of Coverage includes coverage for 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 be reasonably attended to by a Participating Provider, the 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 its license that is not a contracted provider with the Health Plan and, if applicable, is not a provider within the Health Plan's Extended Network. For more information about the Extended Network, see **Section X. General Provisions.**

Certain in-network care and all out-of-network non-emergent care and services are not covered under this plan, unless UPMC Health Plan has Prior Authorized the services. UPMC Health Plan encourages the coordination of health care services through a Primary Care Provider, however a referral is not required to access benefits from Participating Providers.

Your newborn children, whether natural born, adopted, or placed for adoption, are entitled to the health care benefits set forth in the terms and conditions of this Certificate of Coverage from the moment of birth to a maximum of thirty-one days from the date of birth. In order to continue coverage for your newborn after the 31st day, you **must** add the child to your coverage by contacting your employer or plan sponsor. For more information, see **Section II. Eligibility for Coverage.**

The coverage described in this Certificate of Coverage 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 the Consolidated Appropriations Act, 2021. If at any time any part or provision of this Certificate of Coverage is in conflict with any applicable law, regulation, or other controlling authority, the requirement of that authority prevails.

This Health Maintenance Organization benefit plan may not cover all of your health care expenses. Read this contract and all other plan documents carefully to determine which health care services are covered.

If you have any questions about this Certificate of Coverage or want more information about your benefits contact your HR representative or UPMC Health Plan[1] Member Services Department at 1-888-499-6885, or write to:

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

[1] UPMC 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.

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Section I.

Terms and Definitions to Help You Understand Your Coverage

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

Actuarial Value (AV) — The average share of overall costs that a health plan is expected to pay for Covered Benefits. For example, a health plan that was designed to pay for 70 percent of a Member's covered health care costs would have an Actuarial Value of 70 percent. The covered Member would pay the other 30 percent of Member costs.

- Qualified Health Plans will be identified in four categories based on their Actuarial Value. The metallic categories must fall within 2% of the following levels:
    - Bronze (60%)
    - Silver (70%)
    - Gold (80%)
    - Platinum (90%)

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) ~~or~~ 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 Denial).
- 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 your group health plan will pay for a Covered Service. The Benefit Limit may be expressed in many ways, such as a dollar amount, the number of days, or the number of services. Some Benefit Limits are discussed in this Certificate of Coverage, but generally they are described in your Schedule of Benefits.

Benefit Period — The period (for which you are eligible for coverage during your employer group/plan sponsor's contract year) during which charges for Covered Services must be incurred in order to be eligible for payment by your group health plan. A charge is considered incurred on the date you receive the service or supply.

Childhood Stuttering — A speech disorder characterized by repetition of sounds, syllables or words, prolongation of sounds and interruptions in speech developed between two and six years of age.

Coinsurance — The percentage of expenses for Covered Benefits that you are responsible to pay, after meeting your Deductible, if you have one. The amount of your Coinsurance depends upon the plan the University of Pittsburgh offers. 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 a managed care plan. Instructions for filing a Complaint are in **Section VIII. Resolving Disputes with the 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 Service — 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.

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

Emergency Services — Any health care service provided after sudden onset of a medical or behavioral 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 member, the health of the pregnant parent or the 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.

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 be marketed 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 as 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 of 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 of the UPMC Health Plan Service Area.

Explanation of Benefits (EOB) — 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.

Health Maintenance Organization or HMO — An organized system for health care that provides or arranges for comprehensive health care services through a network of health care providers. In an HMO, the Member's care is coordinated by a Primary Care Provider for such services as office visits, diagnostic tests, hospital care, surgical care, emergency care, and preventive services. Services provided outside of the HMO's provider network are not covered except

for Emergency Services or services that were approved by the HMO prior to obtaining those services.

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 the Member's 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 an individual's condition or level of functioning, and 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. Authorizations for coverage based upon Medical Necessity shall be made by UPMC Health Plan, at its discretion, with input from the treating provider. Note that 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 for purposes of coverage.

Member — A person who meets eligibility requirements specified in the Eligibility for Coverage section of this Certificate of Coverage and who is entitled to receive Covered Benefits under this Certificate of Coverage by virtue of having enrolled in this plan. References throughout this Certificate of Coverage 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. Copayments, Coinsurance, and Deductibles apply towards your Out-of-Pocket Maximum. 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 UPMC Health Plan Members and, 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 at **www.upmchealthplan.com** 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.

Primary Care Provider or PCP — A provider whom you choose who will supervise, coordinate, prescribe, and otherwise provide initial and basic health care services, initiate referrals for specialist care, and maintain continuity of your health care. Your PCP must participate in the UPMC Health Plan provider network. For more information on choosing a PCP, go to **Section III. A Guide to Obtaining Covered Benefits** in this Certificate of Coverage.

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 Certificate of Coverage. A Rider may expand or restrict the benefits set forth in your Certificate of Coverage. 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 or the University of Pittsburgh.

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.

Specialist — 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 or your employer. 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 an employee of the covered employer/plan sponsor, reside in the United States and you meet the eligibility criteria established by your employer and/or UPMC Health Plan. Other than yourself, you may enroll the following individuals that reside in the United States as dependents:

- Your spouse under a legally valid existing marriage.
- A Domestic Partner who meets the criteria set forth in the University of Pittsburgh's Domestic Partner policy located at **https://hr.pitt.edu/current-employees/benefits/health-wellness/medical-plans/documentation-requirements-dependents/benefits**
- Children under 26 years of age, including newborn children, stepchildren, children legally placed for adoption, and children for whom coverage is mandated by a qualified medical child support order or court order, or children for whom you have custody or guardianship as set forth in a court order or other legally binding document, are eligible for coverage under the terms of the Certificate of Coverage, except as provided in an Eligibility Rider. See **Section VII. Benefit Coverage and Reimbursement** for information regarding coordination of benefits. Coverage of a dependent child automatically terminates at the end of the month in which the child reaches the age of 26 or otherwise becomes ineligible under the terms of an Eligibility Rider.
- Disabled dependents who meet the criteria set forth in the subsection titled "Disabled Dependents," which is located in the "How do you enroll a dependent?" section.
- The home address on file with the employer must be within the UPMC Service Area to be eligible for coverage under this Plan.

To obtain coverage for a spouse, partner or dependent, you may be required by your employer, plan sponsor, and/or UPMC Health Plan to provide the University of Pittsburgh with proof that the individual meets criteria for one of the above eligibility categories.

How do you enroll a dependent?
There are three ways you can enroll an eligible dependent. First, you may enroll a dependent within 31 days upon being hired. Second, you may enroll an eligible dependent within 60 days[2] of the date on which the dependent becomes eligible for coverage due to a qualified status change. Finally, you may enroll an eligible dependent during your open enrollment period. You must complete and submit an enrollment form or a status change form if not an initial enrollment or during open enrollment to the University of Pittsburgh within the applicable time frame.

The following are rules for special circumstances relating to coverage of dependents:

Newborn and adopted children: Newborn children are covered automatically from the moment of birth for 31 days in the state of Pennsylvania regardless of the length of your covered period. To obtain coverage for that child beyond the initial 31-day period, you must contact the University of Pittsburgh to enroll the child as a dependent within 60 days of the birth. If you do not contact your employer or plan sponsor, coverage for that child will end after the 31-day automatic coverage period and they would not be eligible to be added until the next Open Enrollment period. In order to add a newborn child through adoption, you must contact your employer or plan sponsor to enroll the child as a dependent within 60 days of the placement date. If you do not contact your employer or plan sponsor, the child will not be eligible for coverage. However, the child can be added during the next Open Enrollment period.

Court order: The University of Pittsburgh may determine whether a court order is applicable for coverage. For more information regarding court orders, contact the University of Pittsburgh.

(1) **Qualified Medical Child Support Orders (QMCSO):** A medical child support order is a judgment, decree, or order made

[2] Days in the Certificate of Coverage refer to calendar days unless stated as business days.

by a court of competent jurisdiction or an authorized state administrative agency that is made under state domestic relations law or state laws relating to medical child support. The order provides for medical support or health benefit coverage for a child of a Member under a group health plan. A QMCSO is a medical child support order that contains at least the following information The name and last known mailing address of the Member and each child to be covered under the QMCSO[3];

(2) A reasonable description of the type of health coverage to be provided to each child or the manner in which such coverage is to be determined; and

(3) The period of time to which the QMCSO applies. The University of Pittsburgh may determine whether a medical support order is a QMCSO. For more information regarding QMCSOs, contact the University of Pittsburgh.

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 the Member is legally obligated to provide principal support through a QMCSO.

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, college, or university has been called to active duty (other than active duty for training) for a period of 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 a dependent who is called to active duty may not terminate by reason of age when Member enrollment was interrupted because of the 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 15 credit hours or its equivalent and 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 the dependent 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 the student has re-enrolled as a full-time student, as set forth above, for the first term or semester starting 60 or more days after Member release from active duty.

When you are on a leave of absence or are laid off, University of Pittsburgh may choose to continue your coverage. If so, your coverage will continue as long as UPMC Health Plan receives the required premium from University of Pittsburgh. Also, if University of Pittsburgh does not continue coverage during a period of leave of absence or layoff, University of Pittsburgh may allow you to resume coverage upon returning to work. Contact University of Pittsburgh for more information.

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 60 days of the loss of such coverage if:

- When you declined the coverage, you stated in writing that you did so because you or your dependent had other health coverage; or
- When you declined the coverage, you or your dependent had COBRA coverage and that coverage has since

[3] The order may substitute the name and mailing address of a state or local official for a child's mailing address

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.
    - Notwithstanding the 60 day enrollment period set forth in the subsection above, 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, you or your dependent(s) will have 60 days to enroll in coverage under this plan.

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 the University of Pittsburgh's contribution toward the premium for the coverage. To be eligible for this special enrollment period, prior coverage must not have been terminated because of your or your dependent's failure to make timely premium payments or for cause (for example, making a fraudulent claim).

Medically Necessary leave of absence
If your coverage under this Certificate of Coverage 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
As a new hire, you may apply for initial enrollment for yourself or a dependent within 31 days. You may also apply for enrollment due to a qualified status change for yourself or a dependent within 60 days. Changes to enrollment status are also allowed during open enrollment during the designated time period set by the University. To apply for initial or open enrollment, complete and submit an Enrollment Form to the University of Pittsburgh. Qualified status changes require an Enrollment Form along with a Status Change Form. Remember that, for the University of Pittsburgh and UPMC Health Plan to properly manage your benefits and coverage, you must keep the University of Pittsburgh up to date regarding any changes in your personal information (Social Security number, address, telephone number, etc.) and changes in your family status (marriages, deaths, births, etc.) related to you or your enrolled dependents.

When will your coverage begin?
Your coverage will begin on the effective date communicated to you by the University of Pittsburgh. Note that the University of Pittsburgh may set minimum waiting periods before your coverage will be effective.

What happens to your coverage when you are on leave or are laid off?
Refer to the University of Pittsburgh policies on leaves of absence and COBRA.

Section III.

A Guide to Obtaining Covered Benefits

You have chosen the UPMC Health Plan Health Maintenance Organization (HMO), which is a health benefit plan that uses an exclusive network of providers. What does this mean for you? First, it means that you must use Participating Providers. Your group health plan generally allows the designation of a Primary Care Provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. For information on how to select a PCP and for a list of the participating PCP, contact UPMC Health Plan's Member Services Department at the phone number listed on your member identification card. Second, you may self-direct your care as long as you use Participating Providers. This means you do not need referrals to obtain care from a Specialist. 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.

Pursuant to your group health benefit plan design, you need to choose a Primary Care Physician. You should receive preventive care through your PCP. Also, you generally will receive the highest level of benefit coverage if your specialist care is coordinated through your PCP; however, you also can obtain health care services from specialists on a self-directed basis, without a referral from your PCP. While you can self-direct your specialist care, UPMC Health Plan encourages you to coordinate your care through your PCP. Refer to your Schedule of Benefits for applicable Copayment amounts. Female Members have direct access to an obstetrician or gynecologist for health care services, and may select an obstetrician-gynecologist as a PCP. Finally, you must use Participating Providers, also called in-network providers. Except for Emergency Services, UPMC Health Plan will not cover services obtained from Non-Participating, also called Out-of-Network Providers, unless you get Prior Authorization from UPMC Health Plan to see that Non-Participating Provider.

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 was in-network in accordance with the Consolidated Appropriations Act, 2021.

Your Primary Care Provider

Why do you need a PCP?
Your PCP is responsible for providing you with basic health services and for coordinating your health care when you need to see a specialist or any other health care provider or when you need to be admitted to a hospital or other facility. Having a PCP means that you have access to a health care provider who knows you and your medical history. Your PCP can help you determine the most appropriate specialist to see if you need specialist care. The name and telephone number of your PCP practice will appear on the front of your member identification card, so you can call at any time to address your health care needs.

How do you choose a PCP?
PCPs are listed in your provider directory. You can access the provider directory online at **www.upmchealthplan.com** or you can request a paper copy by calling UPMC Health Plan Member Services. Once you pick your PCP, you need to let UPMC Health Plan know whom you have chosen. You can let UPMC Health Plan know in two ways. First, you can call UPMC Health Plan Member Services. Second, you can go to **www.upmchealthplan.com** and choose a PCP by using the UPMC Health Plan member site.

You can change your PCP at any time by contacting the Member Services Department or by visiting **www.upmchealthplan.com.** If you change your PCP by calling Member Services, the change will be effective immediately. If you change your PCP by using UPMC Health Plan member site, there may be a slight processing delay. Each time you change your PCP, you will receive a new identification card reflecting the change.

Can you choose a doctor who is not listed as a PCP as your PCP?
If you have a life-threatening, degenerative, or disabling disease or condition, you may contact Member Services to request that a specialist act as your PCP. Another option is to request a standing referral to a specialist. If UPMC Health Plan determines that you meet the established standards, you will be permitted to have a specialist designated to provide and coordinate both your primary and specialty care or to have a standing referral to a specialist. The specialist may have to submit a treatment plan for your care to UPMC Health Plan. UPMC Health Plan will review the treatment plan in consultation with you and the physician. You will receive a decision within 45 days of your request.

If, for any reason, UPMC Health Plan terminates your PCP's Participating Provider contract, UPMC Health Plan will notify you and Member Services will assist you in selecting a new PCP.

Obstetrician-gynecologists (ob-gyn)
Your ob-gyn is responsible for providing and coordinating care, including: (a) performing screening gynecological examinations and Pap test/HPV tests; (b) referring you to other professional providers for mammograms and other diagnostic tests; (c) providing antepartum and postpartum care; and (d) providing and/or referring you to other professional providers for related surgical services. Although you are encouraged to consult with your ob-gyn to coordinate your care, you may self-direct to other professional providers for specialist care.

If, for any reason, UPMC Health Plan terminates your ob-gyn's Participating Provider contract, UPMC Health Plan will notify you and Member Services will assist you in selecting a new ob-gyn.

The UPMC Health Plan provider network
Because you have chosen an HMO plan, you must obtain all Covered Services from participating or in-network providers. UPMC Health Plan's network includes physicians, other professional providers, and hospitals. All 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 your 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.

Remember that, except in an emergency, you must use Participating Providers to obtain Covered Services. If you do not use a Participating Provider, UPMC Health Plan will not cover those services.

Below is a list of types of providers from whom you may seek care. Note that using or not using an adjective such as Participating, Preferred, Non-Participating, or Non-Preferred to modify 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. If so, you must select a Participating Provider. Also, if you are receiving preventive care from a Participating Provider who is not considered to be a PCP by UPMC Health Plan, you must select a participating PCP.

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. This period gives your current provider time to communicate with your new provider to coordinate your care.

When you enroll, if you are currently in active ongoing treatment with a Non-Participating Provider, you may be able to continue this treatment 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 (TOC) 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. This TOC is necessary to obtain Prior Authorization from UPMC Health Plan to receive coverage at the in-network rate for continued treatment with a Non-Participating Provider during the transition period. If you are pregnant and undergoing a course of treatment for the pregnancy on the effective date of your enrollment, the transition of care period extends through postpartum care related to the delivery of your child.

You must obtain Prior Authorization from UPMC Health Plan thereafter, to continue treatment with a Non-Participating Provider.

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 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. You must obtain Prior Authorization from UPMC Health Plan to continue care with a provider whose contract is terminated.

Managing your health care

In order to receive coverage for services, those services must be Medically Necessary. UPMC Health Plan's 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 attending 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 the services. Some, but not all, Prior Authorization requirements are listed in this section and in the **Covered Services** section of this Certificate of Coverage. If you are unsure whether a service requires Prior Authorization, a list of services that must be Prior Authorized is available 24/7 on our website at **www.upmchealthplan.com** or you can contact UPMC Health Plan Member Services 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 may include, but is not limited to, medical records. If you or your provider does not provide UPMC Health Plan with 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 an inpatient at a hospital. This 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 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 Medical Management, Quality Audit, and Fraud, Waste and Abuse departments will review services that were provided without 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 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 during discharge planning 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.

Section IV.

Covered Services

Your group health benefit plan provides coverage for the following health care services in accordance with the UPMC Health Plan Policies and Procedures when those services are Medically Necessary. Refer to your Schedule of Benefits for Copayment, Deductible, and Coinsurance amounts, as well as any Benefit Limits related to Covered Services. You must obtain care from Participating Providers to obtain coverage for these health care services, except in a true emergency or when Prior Authorized by UPMC Health Plan. 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 this 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 services are covered:

- 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 have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.
- Evidence-based preventive care and screenings as recommended by the American Academy of Pediatrics (AAP) Bright Futures for infants, children, adolescents, and preventive care and screenings for adults provided in the comprehensive guidelines as supported by the Health Resources and Services Administration.
- Routine gynecological examination, 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) may include MRI/Ultrasound imaging for dense breasts or other forms of imaging as required by federal and state law, are covered for all 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 who 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 one (1) to three (3) years or
        - Computed tomography (CT) colonography every five (5) years or
        - Test consistent with approved medical standards and practices as determined by UPMC Health Plan to detect colon cancer or
        - Colonoscopy screening once every ten (10) 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 a high or increased risk for colorectal cancer and are age 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 and may therefore not be covered at no cost sharing until plan years beginning on or after that date.

Hospital services
Your benefit plan covers the following services that you receive in a hospital or ambulatory surgical 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 your admission to the hospital
  - Drugs and medicines provided to you while 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 surgery, including removal of sutures, anesthesia and anesthesia supplies, and services furnished by an employee of the hospital or ambulatory surgical 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 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. Reassessments 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 may be 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 inpatient 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 Caesarean section.

You and your baby also are covered for a home health care visit, both at no cost-share, within forty-eight (48) hours of an early discharge from the hospital if you are discharged prior to receiving 48 hours of inpatient care after a vaginal delivery, or ninety-six (96) hours after a Caesarean section. Home health care visits 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 provider 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 PCP who knows you and your medical history. Remember that non-Emergency Services provided in an emergency room will not be covered, unless those services were authorized by your PCP or UPMC Health Plan.

As an HMO Member, you are expected to utilize Participating Providers to obtain Emergency Services while you are in the UPMC Health Plan Service Area; however, if you are unable to do so, Emergency Services received from a Non-Participating Provider will be covered. All Emergency Services at Non-Participating Providers will be covered at the Participating Provider level. If you require emergency health care services and cannot reasonably be attended to by a Participating Provider, the group health plan shall pay the Emergency Services so that you are not liable for a greater Out-of-Pocket expense than if you were attended to by a Participating Provider.

You should contact your PCP within 24 hours of receiving Emergency Services to facilitate 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. Remember that, in the event that you are admitted to a non-participating facility after receiving Emergency Services, you may be required to transfer to a participating facility when it is medically safe and appropriate to do so, as determined by your treating provider and UPMC Health Plan.

Emergency transportation
Your benefit plan covers ambulance services by a specially designed and equipped vehicle when you are sick or injured. Emergency transportation include transportation from your home or the scene of an accident or medical emergency to the nearest 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 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 (e.g. wheel chair accessible van, ambulance, or other methods of transport given medical needs) following discharge from an acute setting may be a Covered Benefit, when such transportation is Medically Necessary. Services will 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 include, 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 affected 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 those who are 7 years or younger; 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 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-emergent surgery, or surgery that can be delayed.

Provider Medical Services

Inpatient medical services
Your benefit plan covers the following services that you may 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:

- 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

Outpatient medical care
Outpatient medical care consists of visits to a licensed 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 would 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
A virtual visit is a visit with a provider that is conducted either through a video on a mobile device or computer or through secure messaging. UPMC Health Plan offers these visits as a covered benefit for Members. Services include:

- **Virtual Urgent Care** — A visit with a provider conducted through secure, live video.
- **Scheduled (Primary Care)** — A non-emergent visit with a Primary Care Provider conducted through secure, live video or secure messaging.
- **Scheduled (Specialist)** — A non-emergent visit with a Specialist Provider conducted through secure, live video or secure messaging.
- **Virtual Visit-Behavioral Health:** A live video, telephone, or asynchronous visit with a behavioral health provider.

UPMC *My*Health 24/7 Nurse Line
If you have a health concern and need quick assistance, UPMC *My*Health 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 *My*Health 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 therapy services when 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. Your 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 when 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 and 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 (FDA) 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 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. In order to ensure compliance with the Mental Health Parity and Addiction Equity Act, some Covered Services not listed below may have reduced cost-sharing when provided in relation to a behavioral health condition.

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, or other trained staff
    - Individual, group and family psychotherapy or counseling
    - Psychological and neuropsychological testing
    - Urgent care visits for the treatment of a behavioral health condition
- 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 the treatment of a behavioral health condition, including for the treatment of Childhood Stuttering
- Laboratory testing related to treatment of a behavioral health

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 behavior analysis
- Rehabilitative/habilitative care and therapeutic care

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 or 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 (e.g., leg braces).

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 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; 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.

Other special limitations:

- Your benefit plan only covers orthopedic shoes and shoe inserts if you have diabetes or peripheral vascular disease to prevent foot injury and/or disease.
- Wigs are covered if you are suffering hair loss due to chemotherapy. You are allowed one wig per chemotherapy regimen. You must pay for the wig and then submit a Wig Reimbursement Form along with a receipt to UPMC Health Plan for reimbursement, which will be at the in-network level up to a limit of $750.

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 licensed, 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.

Emergency dental services related to accidental injury

Your benefit plan only covers emergency dental services necessary to treat an accidental injury to sound, natural teeth when the services are obtained within the first 72 hours following the accidental injury. This coverage applies only to the emergency dental services made necessary by the 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, post-orthodontics, prosthodontics, and restorative procedures. Injury as a result of chewing or biting is not considered an accidental injury.

All other dental services are excluded, except as provided by a Dental Rider. If you or your eligible dependent(s) are under the age of 19, you may be eligible for Essential Health Benefits (EHB). Please refer to your Pediatric Dental EHB Rider for additional coverage description. All other benefits that are not listed herein or in a Dental Rider or Pediatric Dental EHB Rider are excluded from coverage.

Hearing aids

For information regarding your hearing aid benefits that include hearing aid devices, examinations for the prescription of hearing aids, fitting of hearing aids, and batteries for hearing aids, contact Amplifon (www.amplifonusa.com/pitt) at 1-866-978-9379.

Home health care

Your benefit plan covers the following services that 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 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 aide 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 supporting care to terminally ill patients and their families. You are covered for hospice care when you have a life expectancy of 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 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 including, but not limited to, IUI (Intrauterine Insemination), GIFT (GAMET intrafallopian transfer), ZIFT (Zygote intrafallopian transfer), embryo transplants, and in-vitro fertilization.

To be eligible for coverage for infertility testing and diagnostic procedures, the member(s) must meet the following criteria:
- Documentation of the documented inability of the female to conceive a child within a twelve (12) month period of unprotected sexual intercourse, or after at least six (6) episodes of artificial insemination, AND
- Evidence that the female is premenopausal and reasonably expects fertility as a natural state or, if the female is menopausal, such menopause is experienced at an early age.

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

To be eligible for coverage for the assisted fertilization procedures set forth above, the member must be diagnosed as infertile.

For purposes of coverage of Assisted Fertilization Procedures under this rider, members generally must utilize UPMC Health Plan participating providers who are credentialed reproductive endocrinologists. In the event that a member does not have reasonable access to a UPMC Health Plan participating provider who is credentialed in reproductive endocrinology, as determined by UPMC Health Plan, the member may submit a request to UPMC Health Plan to utilize another provider. UPMC Health Plan will only review such requests where the non-participating provider is Board Certified in Reproductive Endocrinology and practices in the county the member resides or an adjacent county. If such a provider is unavailable, UPMC Health Plan will review a request for services where the provider is a Board Certified Obstetrician/Gynecologist with the appropriate credentials and hospital privileges, as determined by UPMC Health Plan in its sole discretion, to provide services under this rider, practicing within the county the member resides or in an adjacent county.

The Lifetime Maximum is the total dollar amount of coverage available to a Member covered by the University of Pittsburgh. Any amount that a Member accrues toward the Lifetime Maximum set forth above for Assisted Fertilization Procedures or Infertility Prescription Drugs shall apply regardless of whether a Member changes benefit plans. The amount accrued toward the applicable Lifetime Maximum shall carry over to the new benefit plan(s). Benefit limits do not apply to artificial insemination.

Medical nutrition therapy
Medical nutrition therapy helps individuals with certain diseases or conditions to 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 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 and/or nutrition therapies to treat a chronic illness or condition. 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 UPMC Health Plan's discretion, warrants specialized podiatric care.

Private duty nursing services
Your benefit plan covers services provided by an actively practicing registered nurse or practical nurse when Medically Necessary and approved by UPMC Health Plan. The ordering physician must obtain Prior Authorization from UPMC Health Plan for such services.

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; and
- The admission is arranged or ordered by your attending physician; and
- Your medical condition is such that you require skilled care 24 hours per day; and
- The skilled care 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; and
- 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 restorative potential in a reasonable and generally predictable period of time and you 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 adjacent 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. 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 seven (7) years old, the provider must obtain Prior Authorization from UPMC Health Plan for therapeutic manipulation services.

Diabetic equipment, supplies, and education

Except to the extent already covered under another policy, including prescription drug coverage, your benefit plan covers the following services when required for the treatment of diabetes. Services must be Medically Necessary and prescribed by a provider who is authorized to prescribe such services under the law.

- Equipment and supplies:
  - Blood glucose monitors
  - Continuous glucose monitors
  - Monitor supplies
  - Insulin
  - Injection aids
  - Syringes
  - Insulin delivery devices
  - 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 the 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.

Additional Services

Bariatric and metabolic surgery
Surgery on the stomach and/or intestines to help a person with severe or extreme obesity lose weight. Bariatric surgery services must be Prior Authorized by UPMC Health Plan and meet all Medical Necessity criteria.

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 Certificate of Coverage.
- When only the recipient is a Member, both the donor and the recipient are entitled to the benefits of this Certificate of Coverage 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; and
  - Benefits provided to the donor will be charged against the recipient's coverage under this Certificate of Coverage.
- When only the donor is a Member, the donor is entitled to the benefits of this Certificate of Coverage, 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 Certificate of Coverage, and
  - No benefits will be provided to the non-Member transplant recipient.
- 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 Member recipient'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 you have one of these qualifying conditions, 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 any and all upgrades. You will be responsible for the additional cost of the corrective intraocular lens.
If you or your eligible dependent(s) are under the 19 years old, you may be eligible for Essential Health Benefits (EHB).

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

UPMC Health Plan member site: This personalized portal offers you access to review your plan benefits online. You can also use this portal to request visits such as virtual care, talk therapy, psychiatry, and pharmacy support. You can research health conditions, access a treatment cost tool and more.

LifeStyle health coaching: Through virtual, and digital modalities, health coaches may address lifestyle health needs. Please visit our website at www.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 or attending on-site events (if offered by your Employer). UPMC Health Plan may also contact you about the availability of coaching opportunities that may be beneficial to you.

Member discounts

As a UPMC Health Plan Member, you have access to discounts on various services. This includes discounts at local retailers, gyms, dental and vision services for adults 19 and older, and more. For a full list of discounts, login to the member portal at UPMC Health Plan member site 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, acupressure, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation, or yoga.

3. **Blood:** Non-purchased blood or blood products, including autologous donations.

4. **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 orthopedic shoes. For covered corrective appliances, please see **Section IV. Covered Services**, subsection **Corrective appliances (orthotics and prosthetics)**.

5. **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.

6. **Court Ordered:** Any services that are court-ordered, unless such services are otherwise Covered Services and Medically Necessary.

7. **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.

8. **Dental Care:** Except as otherwise set forth herein, services directly related to the care, treatment, removal, or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth, including, but not limited to, treatment of dental abscesses or granuloma, treatment of gingival tissues (other than for tumors), and dental examinations, unless you have a Dental Rider. All other Dental services are excluded except as provided by a Pediatric Dental EHB Rider.

9. **Employment Related or Employer Sponsored Services:**
   A. 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.

B. 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 except those University of Pittsburgh dentists who participate with UPMC Health Plan.

10. **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.

11. **Experimental/Investigational:** Services that are Experimental/Investigational in nature, or otherwise are not evidence-based, as determined by UPMC Health Plan.

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

13. **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.

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

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

16. **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.

17. **Immunizations and Drugs:** Physical examinations, prophylactic medications and immunizations required by foreign travel, school, or employment, except when such coverage is required by the Affordable Care Act or by the University of Pittsburgh as a condition of employment.

18. **Medical Services Not Provided in this Certificate of Coverage:** Any other medical service or treatment, except as provided in this Certificate of Coverage or as mandated by law.

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

20. **Medicare:** Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary; however, this exclusion does not apply when your employer or group plan sponsor is required to offer you all of the benefits set forth in this Certificate of Coverage by law and you elect this coverage as your primary coverage.

21. **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.

22. **Miscellaneous:** Any services, supplies, or treatments not specifically listed in the Certificate of Coverage 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 Certificate of Coverage.
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 the Member's 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.

23. **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 Certificate of Coverage relating to "Coordination of benefits."

24. **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 physician.

25. **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.

26. **Nutritional Formulas:** 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 certain inborn errors of metabolism and inherited metabolic disorders, as specified in **Section IV. Covered Services,** subsection **Nutritional formulas.**

27. **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.

28. **Over-the-Counter Drugs:** Vitamins, medications not requiring a prescription (analgesics, antihistamines, cold medicines, digestive relief medicines, etc.) and 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.

29. **Prescription Drugs:**
    A. Prescription drugs unless you have a Prescription Medication Rider, except when such coverage is required by law.
    B. Products, including combinations or derivatives of drug products, lacking FDA approval (e.g., medical marijuana)
    C. Products not dispensed by a licensed pharmacy
    D. Products not required to bear the legend "Caution – Federal Law prohibits dispensing without a prescription" except to the extent such coverage is required by law
    E. Products ordered by anyone other than a licensed provider who is:
        - Authorized to prescribe: AND
        - Acting and prescribing within the provider's scope of practice.

30. **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.

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

32. **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 a Member acting as a surrogate mother.

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

34. **Treatment Outside the United States:** Treatment for non-emergent or non-urgent services received outside the United States.

35. **Vision:**
    A. Eyeglasses, contact lenses and vision examinations, including those for prescribing or fitting eyeglasses or contact lenses, unless you have a Vision Rider (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.

36. **Weight Reduction:** Weight reduction programs 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, glucagon-like peptide (GLP-1) receptor agonists and lipase inhibitors. For more information about the Preventive Services Reference Guide, see **Section IV. Covered Services** subsection **Preventive care.**

37. **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 your benefit plan covers urgent care and Emergency Services when you are traveling outside the UPMC Health Plan Service Area. Remember, services that are not urgent care or Emergency Services are not covered when obtained from Non-Participating Providers in or outside of the UPMC Health Plan Service Area.

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 X. 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 or a family member should contact UPMC Health Plan within 24 hours of the admission or as soon as reasonably possible. If you do not notify UPMC Health Plan of the admission, you may be financially responsible for all or some of the non-emergent health care services provided to you after your admission to the out-of-network facility. 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 our policies and procedures regarding Medical Necessity or billing Members. Therefore, you may receive services that are not Medically Necessary and will not be covered under your benefit plan. You will be financially responsible for any non-Covered Services. If you receive out-of-network Emergency Services that are Medically Necessary and covered under the benefit plan, such services and treatments 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 the 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 Plan's Extended Network; however, UPMC Health Plan encourages your dependents to schedule appointments for health care services within the UPMC Service Area if possible. Dependents attending college 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 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
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 Certificate of Coverage** 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 private duty nursing, the shifts worked, charge per day, nurse's license number, and signature of the ordering provider
- 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 University of Pittsburgh or our Member Services Department (call the phone number on your member ID card). Or you can 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 the 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 Charge as outlined in **Section I. Terms and Definitions to Help You Understand Your Coverage.** The Health Plan applies all your Deductible, Copayment, and Coinsurance amounts to the Reasonable & Customary Charge to determine the benefit amount payable by UPMC Health Plan. 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 Certificate of Coverage. 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 the Certificate of Coverage.

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 (EOB) that describes the services that you received and how much your group health benefit plan paid for those services on your behalf. Your EOB also lists the amount that you may owe for Copayments, Deductibles, or Coinsurance for that service.

UPMC Health Plan will not honor a request to retract 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, Deductible, 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 whether or not additional benefit payments can be made under this plan.
- When you are covered as an employee under one plan and as a dependent under another, the employee coverage pays first.
- When the 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 employee under this plan and as an individual under a state funded Medicaid policy, the Medicaid policy is the payor of last resort.
- When none of the above circumstances apply, 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.

When you are covered as an employee under this plan and as an individual under a state funded Medicaid policy, the Medicaid policy is the payor of last resort.

If you are enrolled in Medicare, UPMC Health Plan will follow the Medicare Secondary Payer regulations and coordinate the benefits payable for Covered Services under this Certificate of Coverage with benefits payable by Medicare or your Medicare plan as applicable.

If you are eligible for but do not enroll and maintain Medicare Part B coverage, UPMC Health Plan will follow the Medicare Secondary Payer Regulations and coordinate the benefits payable for Covered Services under this

Certificate of Coverage as if you were enrolled in Medicare Part B. This means we will calculate payment by taking into account the benefits that would have been paid under Medicare Part B had you enrolled.

If you or your provider received more than you should have received when your benefits are coordinated, you or your provider will be expected to repay the overpayment.

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 regards 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 Certificate of Coverage. Any amounts paid shall be considered to be benefits paid in full under this Certificate of Coverage.

In the event that UPMC Health Plan makes payment for Covered Services in excess of the amount of payment pursuant to this Certificate of Coverage, irrespective of to whom those amounts were paid, UPMC Health Plan shall have 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 such documents as may be required 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 Certificate of Coverage, 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 conditions of this Certificate of Coverage.

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 shall only be responsible for coordination of benefits to the extent that information regarding your other insurance is provided to UPMC Health Plan by you, the University of Pittsburgh, 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. Your group health benefit plan and/or UPMC Health Plan have the right to seek repayment from the other person or organization, their insurance company, or other responsible party for the cost of any benefits that have paid or provided related to or arising out of injuries or accident.

Your group health benefit plan's and/or 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 Certificate of Coverage. UPMC Health Plan will pursue 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. Your group health benefit plan's and/or 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. To the extent permissible by law, if you have received payment from any party that may be liable, a third party's insurance policy, your own insurance policies, a workers' compensation program or policy, or other source of recovery, you

must reimburse your group health benefit plan and/or UPMC Health Plan out of that payment.

UPMC Health Plan may use any and all legal remedies available in order to assert its or the group health benefit plan's right(s) of recovery. UPMC Health Plan will attempt to recover all amounts paid to treat your injury. Your group health benefit plan's and/or 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, your group health benefit plan's and/or 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 Certificate of Coverage. Subject to any other limitations set forth in this Certificate of Coverage, 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 your group health benefit plan, UPMC Health Plan, or other designated agent(s) to produce documents or take other actions in subrogation efforts. Your group health benefit plan and/or UPMC Health Plan may, at their 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 your group health benefit plan, UPMC Health Plan or other designated agent(s) in seeking a subrogation recovery or otherwise impair your group health benefit plan and/or UPMC Health Plan's subrogation right. UPMC Health Plan is not responsible for any attorney's fees or other expenses you may incur toin obtaining payment for your injuries from another party. In the event that you do not cooperate with your group health benefit plan, UPMC Health Plan, or other designated agent(s) in exercising its respective subrogation interest, those entities may use any available legal remedies to obtain full and complete reimbursement.

All Covered Services provided under this Certificate of Coverage are subject to this section to prevent duplicative benefit payments.

Medicare eligibility

If you are eligible for Medicare, the benefits provided under this Certificate of Coverage do not constitute duplicate benefits otherwise covered under the Medicare program, including Medicare Part B, except as provided by applicable federal law.

Under federal law, employers are required to identify those employees and their dependents enrolled in a group health plan who are eligible for Medicare. It is your responsibility to notify University of Pittsburgh if you or any of your dependents have or are eligible for Medicare coverage. You must tell the University of Pittsburgh of your Medicare status, including your Health Insurance Claim (HIC) number, the reason for Medicare eligibility (age, end-stage renal disease, or disability), effective dates of Medicare Part A and Part B eligibility, and any other information required by the University of Pittsburgh for the correct coordination of benefits.

Notice of claim/Proofs of loss/Claim forms

Notice of claim: UPMC Health Plan will not be liable under this Certificate of Coverage 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 Certificate of Coverage 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 date the Covered Service was rendered.

Time of payment of claims
All claims payable under this Certificate of Coverage 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 Certificate of Coverage 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 your coverage or with the health care services you have received. A dispute about the coverage, operations, or management policies of UPMC Health Plan or about a UPMC Health Plan Participant Provider 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 UPMC Health Plan member site. 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 calendar 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 the 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 of the First Level Complaint Review 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. We 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.

UPMC Health Plan will provide you with the opportunity to participate in the review by telephone, videoconference 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 free of charge. 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. If you have given written consent to your Provider to file an Appeal, please read the section below (Provider-Initiated Appeals) for more information.

You or your representative may file an Appeal with UPMC 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 UPMC Health Plan member site. To submit an Appeal in writing, please mail your Appeal to P.O. 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.

You are entitled to receive, upon request, reasonable access to either copies of all documents relevant to your Appeal free of charge, 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.

Provider-Initiated Appeals
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, 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 services that are the subject of the Appeal until the External Review process has been completed or you rescind your consent.

First Level Appeal
UPMC Health Plan's Adverse Benefit Determination appeal process offers two Levels of review. You must submit your First Level Appeal within 180 days of the date on which the denial occurred. For example, if your Appeal is regarding denial of pre-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 Member Services 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.

A First Level Adverse Benefit Determination Review Committee will investigate the allegations set forth in the Appeal. If the Adverse Benefit Determination at issue involves 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), 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 evidence 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 reasonable opportunity to respond before issuing a decision.

The Committee will notify you and your representative of its decision within 30 days of receipt of your Appeal (or 15 days for a pre-service coverage denial). The notification letter will explain the Committee's decision and describe the process to request a Second Level review of that decision. A copy of the decision letter will be sent to you and/or your representative and/or your provider, as applicable.

Second Level Appeal
If the Committee denies your First Level Appeal, you, your representative, or your provider has 60 days from the date on the First Level Adverse Benefit Determination Review to request another review. If you choose not to request a Second Level Appeal review within that time frame, the decision of the First Level Adverse Benefit Determination Review Committee will be final.

If you submit a Second Level Appeal, UPMC Health Plan will send you a letter to let you know we received your Appeal. We will also let you know the date and time for your Second Level Adverse Benefit Determination Review Committee meeting. UPMC Health Plan will give you at least 15 calendar days' notice of the post-service review meeting and 7 calendar days' notice for the pre-service review meeting. We will also explain what happens at review meetings and how you can participate in the meeting. You, your representative, or your provider has the right, but is not required, to attend the Second Level Adverse Benefit Determination Review Committee meeting. The meeting will be held at the offices of UPMC Health Plan. If you, your representative, and/or your provider cannot appear in person at the Second Level review, UPMC Health Plan will provide you, your representative, and your provider the opportunity to communicate with the review committee by telephone or other appropriate and available means. We will be as flexible as is reasonably possible in facilitating your participation. If the Committee relies on or considers new or additional evidence 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 reasonable opportunity to respond before issuing a decision.

The Second Level Adverse Benefit Determination Review Committee will issue a written decision to you, your representative, or your provider, as applicable, within fifteen (15) calendar days of the request for a pre-service or thirty (30) calendar days for a post-service second level appeal. The decision letter will explain the decision and any further rights you may have available to you.

Appeals from a Cigna Healthcare Medical Necessity Decision
If you sought or received services from the Cigna Healthcare extended network and have a dispute or objection regarding an Adverse Benefit Determination made by Cigna, you may ask Cigna Healthcare for an appeal of that Adverse Benefit Determination. You or your representative may file an appeal with Cigna Healthcare 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 Healthcare 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). You, your representative, or your provider may file a request for an external review with UPMC Health Plan within four (4) months of the date on the Committee's decision letter. If your provider is filing the request for an external review, your provider must submit a copy of your written consent. The request must contain any materials, supporting information, or necessary justification for the external review.

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. A rescission of your coverage (cancellation of coverage based on a claim that you gave false or incomplete information when you applied for coverage); and

4. 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.

When the request for an external review is received, UPMC Health Plan will complete a preliminary review of the request within five (5) business days. The purpose of the preliminary review is to determine whether (1) you area 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 in writing as to whether or not your request 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 (4) month filing period or within the 48-hour period following your receipt of notification, whichever is later. If your request is eligible for external review, we will notify you of the IRO name, address, and phone number.

Within five (5) business days of determining that your request is eligible for external review, UPMC Health Plan will forward a copy of all written documentation regarding the Adverse Benefit Determination to an IRO. Documentation will include the correspondence concerning the decision, all reasonable supporting documentation, and a summary of any applicable clinical rationale. At the same time, UPMC Health Plan will provide you, your representative, or your provider with the name and contact information of the assigned IRO, as well as a 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 five (5) business days after your receipt of this notice. The IRO will forward any additional information it receives to UPMC Health Plan to supplement our records.

The IRO will review all information UPMC Health Plan and you, your representative, or your provider provided. If applicable, the IRO will determine whether the service in question is/was Medically Necessary under the terms established by UPMC Health Plan. The IRO will issue a decision within 45 days of receipt of the external review. 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 review from UPMC Health Plan 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. 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.

To request an expedited external review, you should contact UPMC Health Plan and explain the need for an expedited external review. You must obtain written certification from your treating provider that your life, health, or ability to regain maximum function would be placed in jeopardy by the delay inherent in the regular time frames of the external review process. The certification must include a clinical rationale and facts to support your provider's position. You must provide any additional information for consideration in an expedited manner so we can comply with the requirements for an expedited review. Within 24 hours, UPMC Health Plan will submit your appeal to an IRO, which will provide you with notice of its decision as quickly as possible, but not later than 72 hours after our receipt of your request for the expedited external review.

ERISA appeal rights
You also may have appeal rights under section 502 (a) of the Employee Retirement Income Security Act (ERISA) if your benefit plan is an ERISA plan. You should contact your employer or plan sponsor to determine if your benefit plan is an ERISA plan and to ask what your appeal rights are under that plan. Remember that you must exhaust your administrative remedies prior to exercising your right to file a claim in a court of competent jurisdiction under ERISA. For questions about your rights or this notice or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Section IX.

Termination of Coverage

There are a few reasons why your coverage with UPMC Health Plan may terminate. Some of those reasons are:

- You are deceased.
- You are no longer an employee.
- You fail to make any required premium contribution for your coverage and, as a result, your employer or plan sponsor notifies UPMC Health Plan that you are no longer eligible for coverage.
- The University of Pittsburgh no longer contracts for coverage or fails to remit payment to UPMC Health Plan. If the University of Pittsburgh decides to terminate its contract with UPMC Health Plan, it is the University of Pittsburgh's responsibility to tell you that your coverage will terminate.
- UPMC Health Plan determines that you have 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 Certificate of Coverage. This includes improper use of your member identification card, such as allowing another person to use your card to obtain health care services.

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 member identification card. Please note that your coverage under this Certificate of Coverage will not be terminated or rescinded because of your health status or requirements for health services.

You do have options for coverage if your group coverage is terminated. Federal and state laws provide COBRA and Conversion plans to help you maintain health benefits in that situation.

COBRA coverage
The Consolidated Omnibus Budget Reconciliation Act, known as COBRA, requires certain employers who have 20 or more employees to offer employees the opportunity for a temporary extension of health coverage in certain instances in which coverage would otherwise terminate (for example voluntary or involuntary termination of employment for reasons other than gross misconduct; reduction in the number hours of employment resulting in loss of benefits). Eligible dependents may also qualify for continuation coverage if they lose eligibility as a dependent child or separate from or divorce the employee/subscriber, or if the employee/subscriber dies or becomes eligible for Medicare benefits. If you or your dependents are eligible for and choose COBRA coverage, your coverage will be identical to your current benefits; however, you will be required to pay the premium plus a minimal administrative fee. Please check with your employer and/or plan sponsor to determine if you are eligible for COBRA coverage.

Termination of COBRA
In the event of legal separation, divorce, or loss of eligibility of a dependent child, you must notify the University of Pittsburgh within 60 days of the date of the event. Your notification must include appropriate documentation of the change in eligibility status. For a legal separation, documentation must include a valid court order.

When you notify the University of Pittsburgh of the occurrence any of the events listed above, the University of Pittsburgh will notify you about how to continue coverage. If you do not complete a status change form and submit appropriate documentation of the change in accordance with established time frames, COBRA notification for continuation of coverage will not be sent to the individual losing coverage. If you decide to choose COBRA coverage, you must do so within 60 days from the date of termination of coverage under this Certificate of Coverage or the notification from the University of Pittsburgh, whichever is later.

Your COBRA coverage may be terminated by UPMC Health Plan for any of the following reasons:

- You fail to pay your premiums in a timely manner.
- University of Pittsburgh no longer offers any group health plans.
- You become eligible for coverage under another group health plan (as long as that plan does not impose an exclusion or limitation affecting a pre-existing condition on you or your eligible dependents).

- You become eligible for Medicare benefits.
- You engaged in fraud or made an intentional misrepresentation in information submitted to UPMC Health Plan when obtaining or using benefits under your extended coverage.
- You fail to provide requested and required documentation.

For more information regarding COBRA coverage, please visit the University of Pittsburgh website at **https://www.hr.pitt.edu/current-employees/benefits/cobra-coverage**

Conversion coverage
In some cases, the University of Pittsburgh may not offer COBRA coverage or your COBRA coverage has been exhausted. If so, you may be eligible for UPMC Health Plan's conversion coverage or coverage offered by other carriers. You also may be eligible for conversion coverage if you chose an extension of coverage under COBRA and that coverage expired.

You are not eligible for conversion coverage if:
- Your previous coverage was terminated for cause, including failure to pay your required premium contribution.
- You are eligible for another group health care benefit plan.
- You are eligible for Medicare.
- You reside outside of the UPMC Health Plan Service Area.

The terms of the conversion coverage may be different from the terms of your current coverage. You must apply and make your first premium payment for conversion coverage within 31 days after the termination of your previous coverage. If requested by UPMC Health Plan, you must certify or provide evidence that you are not eligible for other group coverage.

UPMC Health Plan is not responsible to notify you of the opportunity to purchase conversion coverage. Application and payment for conversion coverage is your responsibility. If you do not apply and pay for coverage within the required time period, you will not be eligible for conversion coverage. Contact Member Services for an application or for more information regarding conversion coverage.

What are my benefits after termination?
If you are totally disabled on the date of termination of coverage, you will continue to receive benefits but will be required to make Medicare primary, after 24 months, until the long term disability is closed.

Totally disabled means that you have a condition resulting from an illness or injury for a continuous period of 24 months that causes you to be unable to perform all of the substantial and material functions of any job for which you are reasonably suited, based upon your education, training, or experience. To be considered totally disabled to qualify for continued coverage after termination, you must obtain certification of total disability from your physician and approved by the University's third-party disability administrator. To remain eligible for this continued coverage, you must (1) remain totally disabled through the entire continuation period, (2) not be engaged in any activity whatsoever for wage or profit, and (3) be under the regular care of a physician.

If you are an inpatient in a hospital or skilled nursing facility on the day of termination of coverage, you will continue to be covered for health care services that you receive as an inpatient:
- Until you are discharged from the hospital or skilled nursing facility; OR
- Until the maximum amount of benefits for an inpatient stay has been paid under this Certificate of Coverage; OR
- Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group benefit plan, whichever occurs first.

Section X.

General Provisions

Your relationship with UPMC Health Plan

UPMC Health Plan is the third party administrator acting on behalf of the group health benefit plan established by the University of Pittsburgh. UPMC Health Plan's liability is limited to that set forth in its contract with the University of Pittsburgh.

You have no entitlements or privileges under this Certificate of Coverage except as specifically set forth herein. Except with regard to Medically Necessary covered transplantation services, as described herein, no person other than you or your eligible enrolled dependents are entitled to receive benefits under this Certificate of Coverage. Your right to benefits and coverage under this Certificate of Coverage is not transferable or assignable.

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 Certificate of Coverage may provide that information, including copies of medical records, to UPMC Health Plan, upon request.

As a UPMC Health Plan Member, you and your eligible enrolled dependents understand and agree that information related to your health/claims may be shared among the various UPMC Insurance Services Division entities for all lawful purposes, including administration of workers' compensation and short-term disability, medical management, and implementation of health/wellness initiatives. UPMC Health Plan may amend, modify, or terminate this Certificate of Coverage as agreed by UPMC Health Plan and University of Pittsburgh without your consent. UPMC Health Plan has the right to amend this Certificate of Coverage 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 statute:

Any person who knowingly and with intent to defraud any insurance company or other person 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 e-mail our Special Investigations Unit at 1-866-FRAUD01 (372-8301) or **specialinvestigationsunit@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 in 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 provider's failure or refusal to render health care services to you.

Notice of privacy practices
UPMC Health Plan and the University of Pittsburgh respect and safeguard the confidential information that we maintain regarding you and your dependents. UPMC Health Plan and the University of Pittsburgh each maintain a Notice of Privacy Practices that outlines each entity's policy regarding the privacy of your protected health information. UPMC Health Plan will send you a copy of its Privacy Practices upon request. Additionally, you may obtain a copy of the UPMC Health Plan Privacy Practices by contacting the Member Services Department or by visiting **www.upmchealthplan.com.** You may access the University of Pittsburgh's Notice of Privacy Practices and related privacy policies on **http://www.pitt.edu/hipaa** or by contacting the University of Pittsburgh's Privacy Officer at the following address:

University of Pittsburgh
809 Cathedral of Learning
Pittsburgh, PA 15260
Attention: Privacy Officer

Entire contract; changes
Subject to the contract between your employer and UPMC Health Plan, this Certificate of Coverage, including the schedules, riders, and other documents attached hereto and issued in accordance herewith, represents the entire contract of insurance between you and UPMC Health Plan. No agent or representative of UPMC Health Plan other than a Health Plan officer may otherwise change this Certificate of Coverage or waive any of its provisions. No change in this Certificate of Coverage shall be valid until approved by a Health Plan officer and unless such approval be endorsed hereon or attached hereto.

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 Certificate of Coverage. All statements you made will, in the absence of fraud, be deemed representations, and not warranties, and no such statement will be in defense to a claim under this Certificate of Coverage, 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.

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.

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 Certificate of Coverage. 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.

Governing law
Unless preempted by federal law, this Certificate of Coverage is entered into and is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect 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 Certificate of Coverage 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 Health Coverage Access, Administration, and Appeals 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)

Provider networks

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 in out-of-area plans (as communicated by your employer), dependents under age 26, and any Members traveling outside of the UPMC Health Plan Service Area, 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.
- For care outside of the UPMC Service Area and Ohio, the Cigna Healthcare PPO Network[4] is available to you. Cigna Healthcare is an independent company and not affiliated with UPMC Health Plan. Access to the Cigna Healthcare PPO Network is available through the contractual relationship between Cigna Healthcare and 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 Healthcare because Cigna Healthcare 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.

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

Discrimination is Against the Law

UPMC Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. **UPMC Health Plan** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

UPMC Health Plan:

- Provides people with disabilities reasonable modifications and free and timely appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified interpreters
  - Written information in other formats (large print, Braille, other formats).
- Provides free and timely language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.
- If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact **UPMC Health Plan Member Services at** 1-844-220-4785. Help is available Monday to Friday 8 a.m. to 6 p.m.

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

Complaints/Grievances/Appeals
Attn: Chief Risk, Compliance & Ethics Officer PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-844-220-4785
TTY: 711
Fax: 412-454-7920
Email: HealthPlanCompliance@upmc.edu

You can file a complaint/grievance in person or by mail, fax, or email. If you need help filing a complaint/ grievance, **UPMC Health Plan Member Services** is available to help you.

You can also 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/smartscreen/main.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, 800-537-7697 (TDD)

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

This notice is available at **UPMC Health Plan's** website: **https://www.upmchealthplan.com/members/**

UPMC 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.

Translation Services

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-855-869-7228 (TTY: 711)** or speak to your provider.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-869-7228 (TTY: 711) o hable con su proveedor.

Chinese; Mandarin

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-869-7228（文本电话：711）或咨询您的服务提供商。

Nepali

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्।
1-855-869-7228 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Russian

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-869-7228 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات "بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-869-7228 (711) أو تحدث إلى مقدم الخدمة

Vietnamese

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-869-7228 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Ukrainian

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-855-869-7228 (TTY: 711) або зверніться до свого постачальника».

Portuguese

ATENÇÃO: Se você fala inserir idioma, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-855-869-7228 (TTY: 711) ou fale com seu provedor.

French

ATTENTION : Si vous parlez Français, des services d’assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-869-7228 (TTY : 711) ou parlez à votre fournisseur.

Korean

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식 으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-869-7228 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Pennsylvania Dutch

ACHTUNG: Wann du Pennsylvanisch Deitsch schwetzscht, sin Hilfsdienst fer die Sprooch fer dich gratis verfügbar. Passende Hilfsmittel un Dienscht, fer Informatione in zugängliche Formate ze gebbe, sin aa gratis verfügbar. Ruf 1-855-869-7228 (TTY: 711) oder schwetz mit dein Anbieter.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-869-7228 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Igbo

NLEBARA ANYA : Ọ bụrụ na ị na-asụ asụsụ Igbo, enwere ọrụ enyemaka asụsụ n'efu maka gị. A na-enyekwa ihe enyemaka na ọrụ ndị kwesịrị ekwesị iji nye ihe ọmụma n'ụdị ndị dị mfe inweta n'efu. Kpọọ 1-855-869-7228 (TTY: 711) ma ọ bụ gwa ndị na-ahụ maka ahụike gị okwu.

Hindi

ध्यान दें: य'द आप 'हंद, बोलते हैं, तो आपके िलए िनःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ ूारूपों में जानकार, ूदान करने के िलए उपयुक् सहायक साधन और सेवाएँ भी िनःशुल्क उपलब्ध हैं। 1-855-869-7228 (TTY: 711) पर कॉल करें या अपने ूदाता से बात करें।

Italian

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l›1-855-869-7228 (TTY: TTY 711) o parla con il tuo fornitore.

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This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which services are covered.

UPMC Health Plan Member Services:
1-888-499-6885

TTY users: **711**