

2016 Student Policy
Fully Insured Health Benefit Plan for Student Groups Utilizing the UPMC Health Options Inc. PPO
Benefit Design (PPO)

Welcome and General Information for Members

This document is a Student Accident and Insurance Policy (hereinafter referred to as the “Policy”). This Policy establishes the terms of coverage for your health benefits. It sets forth what services are covered and what services are not covered. It explains the procedures that you must follow to ensure that the health care services that you receive will be covered under this Policy. It also describes how you can add a dependent to your plan, submit a claim, file an appeal, and other information that you may need to know to access your health benefits. The Policy sets forth your obligations as a member and the obligations of UPMC Health Plan¹ as the administrator of this Policy. It is important to use this Policy along with your Schedule of Benefits. Your Schedule of Benefits is the document that outlines your coverage amounts and Benefit Limits.

This benefit plan has cost sharing, including Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limits. An Out-of-Pocket Limit puts a cap on the amount of money you can spend 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 will pay Copayments and/or Coinsurance each time you go to the doctor or pick up a prescription from the pharmacy and at other times.

This Policy includes coverage for Emergency Services at the highest benefit level. This is true even if you use health care providers who are not in our network. We know that it’s not always possible to go to a Participating Provider in an emergency. If you require Emergency Services and cannot 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 is not a provider within one of the Health Plan’s contracted Out-of-Area Networks.

In addition, all out-of-network non-emergency care and services that have been Pre-Certified by the Health Plan will also be covered at the Participating Provider level. A referral is not required to access benefits from providers. That means that if you need to go to a specialist, you can go.

Your newborn children, whether natural born, adopted, or placed for adoption, are entitled to the health care benefits set forth in the terms and conditions of this Policy from the moment of birth to a maximum of thirty-one (31) days from the date of birth.

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

This Preferred Provider Organization benefit plan may not cover all of your health care expenses. Read this Policy carefully to determine which health care services are covered.

¹For purposes of this Student Accident and Insurance Policy and all applicable Riders, UPMC Health Plan means UPMC Health Options, Inc., UPMC Health Plan, Inc., UPMC Health Coverage, Inc., and UPMC Health Network, Inc.

For purposes of any and all coverage provided under this Policy, "Policy Year" is defined as the one-year period set by the school for the purpose of providing student accident and insurance coverage. Coverage of benefits is provided during one or more periods throughout the Policy Year in accordance with an eligible member's payment of applicable premiums.

If you have any questions about this Policy or want more information about your benefits or UPMC Health Plan, contact the Member Services Department at the phone number on the back of your member identification card, or write to:

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

Table of Contents

Section I. Terms and Definitions to Help You Understand Your Coverage	4
Section II. Eligibility for Coverage	7
Section III. A Guide to Obtaining Covered Benefits	10
Section IV. Covered Services	14
Routine and preventive services.....	14
Colorectal cancer screening.....	14
Women’s care	15
Hospital services	15
Maternity services	15
Emergency services	16
Ambulance services	16
Physician/surgical services.....	16
Inpatient medical services.....	17
Convenience care.....	17
eVisits.....	18
Urgent care	18
Outpatient medical care.....	18
Allergy services.....	18
Diagnostic services.....	18
Rehabilitative and habilitative therapy services.....	18
Medical therapy services.....	19
Pain management and rehabilitation outpatient program	19
Behavioral health services	19
Substance abuse services.....	19
Acupuncture.....	19
Corrective appliances.....	20
Durable medical equipment.....	20
Emergency dental services related to accidental injury.....	20
Fertility testing.....	20
Home health care.....	21
Hospice care	21
Nutritional counseling and medical nutrition therapy.....	21
Nutritional products	21
Podiatry services.....	22
Skilled nursing facility services	22
Therapeutic manipulation	22
Diabetic equipment, supplies, and education.....	23
Clinical trials and research studies	23
Lifestyle modification program for reversing heart disease.....	23
Pediatric dental services.....	24
Pediatric vision services	24
Transplantation services.....	24
Vision services for a medical condition	24
Section V. Exclusions	26
Section VI. Care When You Are Away from Home	32
Section VII. Benefit Coverage and Reimbursement	33
Section VIII. Resolving Disputes with UPMC Health Plan	37
Section IX. Termination of Coverage	41
Section X. General Provisions	42

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

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

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

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

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

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

Copayment — The specified dollar amount that you pay at the time of service for certain Covered Benefits. Copayments do not apply toward your Coinsurance or Deductible. You are expected to pay your Copayment at the time of service. Refer to your 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 UPMC Health Plan begins to pay for Covered Benefits. See your Schedule of Benefits to determine which services, if any, apply to the Deductible and the Deductible amounts. Under some plans, if you have several covered dependents, you may have a family Deductible.

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

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

Transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service if the condition is as described.

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.

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

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

This term does not include a Complaint. Instructions regarding how to file a Grievance are set forth in **Section VIII. Resolving Disputes with UPMC Health Plan.**

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 your condition or level of functioning;
- In conformity, at the time of treatment, with medical management criteria/guidelines adopted by UPMC Health Plan or its designee;
- Provided not only as a convenience or comfort measure or to improve physical appearance; AND
- 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. The fact that a provider orders, prescribes, recommends, or approves a health care service does not mean that the service is Medically Necessary or a Covered Benefit.

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

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

Out-of-Pocket Limit — The maximum dollar amount you are responsible for paying during a Benefit Period before UPMC Health Plan will pay for your Covered Benefits. See your 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 or is a provider with one of UPMC Health Plan’s contracted networks. All Health Plan Participating Providers are listed in our most current provider directory available online at www.upmchealthplan.com or you can call UPMC Health Plan Member Services at the phone number on the back of your ID card to have a provider directory sent to you.

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

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

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

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

Section II. Eligibility for Coverage

Who is eligible for coverage?

A registered full-time student as determined by the school. The number of credits an individual must carry to be considered a full-time student is determined by the school in its sole discretion.

An eligible student also may enroll the following individuals as dependents:

- Your spouse under a legally valid existing marriage. A spouse who is eligible for Medicare coverage may not be eligible for this coverage.
- Children under the age of 26 including newborn children, stepchildren, children legally placed for adoption, and children for whom coverage is mandated by a qualified medical child support order.
- Disabled Dependents who meet the criteria set forth in the subsection titled “Disabled Dependents,” located in the “How do you enroll a dependent?” section.

To obtain coverage for a dependent, you may be required by UPMC Health Plan or the school to provide proof that the individual meets one of the above criteria.

How do you enroll a dependent?

There are two ways you can enroll an eligible dependent. First, you may enroll an eligible dependent during your open enrollment period. Second, you may enroll an eligible dependent within 60 days of the date on which the dependent becomes eligible for coverage. You must complete and submit an enrollment application to UPMC Health Plan, accompanied by any applicable premium amount, within the 60-day period.

The following are rules for special circumstances regarding coverage of dependents.

Newborn and adopted children: Newborn children, whether natural born, adopted, or placed for adoption, are covered automatically from the moment of birth or from the date of legal placement for 31 days regardless of the length of your coverage period. To obtain coverage for that child beyond the initial 31-day period, you must contact UPMC Health Plan to enroll the child as a dependent before the end of the initial 31-day coverage period. If you do not contact UPMC Health Plan, coverage for that child will end after the 31-day automatic coverage period.

Court order: Coverage for dependents who are required to be covered under a court order will be effective no later than thirty (30) days from the Health Plan’s receipt of the court order provided that such dependent has submitted a completed Application and Medical Disclosure Questionnaire that has been accepted by the Health Plan and the Insured makes appropriate premium payment when due.

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

- Be unmarried and remain unmarried while enrolled in UPMC Health Plan;
- Be chiefly dependent (more than 50%) upon the member for support and maintenance; and
- Be the child of the member (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 Court Order

Military leave: If an eligible dependent child who is a member of the Pennsylvania National Guard or any reserve component of the United States Armed Forces and a full-time student at a school, college, or university has been called to active duty (other than active duty for training) for a period of 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 such a dependent who is called to active duty may not terminate by reason of age when his or her enrollment was interrupted because of such 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 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 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 his or her release from active duty.

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

- When you declined the coverage, you stated in writing that you did so because 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 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 30-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 an employer or plan sponsor’s contribution toward the premium for the coverage. To be eligible for this special enrollment period, prior coverage must not have been terminated because of your or your dependent’s failure to make timely premium payments or for cause (for example, making a fraudulent claim).

Enrolling or changing enrollment status

You may apply for enrollment or change the enrollment status for yourself or a dependent during open enrollment or within 31 days of a dependent becoming eligible for coverage. Enrollment and changes to enrollment status can be submitted electronically to UPMC Health Plan. Remember that, for UPMC Health Plan to properly manage your benefits and coverage, you must keep UPMC Health Plan up to date regarding any changes in your contact information (address, telephone number, etc.) and changes in your family status (marriages, deaths, births, etc.).

When will your coverage begin?

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

What happens to your coverage if you lose eligibility?

Once enrolled, each covered person must continue to meet the applicable eligibility criteria identified in this Policy to continue to be covered under this plan. In the event that a dependent becomes ineligible for coverage under this plan due to divorce or legal separation or reaching the maximum age (for children), coverage under the

plan shall terminate; however, the dependent may apply within sixty (60) days of loss of eligibility for conversion coverage or an individual policy as a separate policyholder, without evidence of insurability.

Section III. A Guide to Obtaining Covered Benefits

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

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

The UPMC Health Plan provider network

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

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

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

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

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

Contracted providers are also called Participating Providers.

Contracted providers include:

- Audiologists
- Behavioral Health – Doctoral (PhDs) and/or master's level psychologists, master's level social workers, master's level clinical nurse specialist or psychiatric nurse practitioners, and other Behavioral Specialists
- Chiropractors (DC)
- Clinical laboratories
- Dentists (DDS or DMD) for our Dental Network
- Occupational therapists
- Physical therapists
- Physician Extenders – Certified Nurse Midwives (CNM), Certified Registered Nurse Practitioners (CRNP), and Certified Nurse Anesthetists (CRNA) Podiatrists (DPM)
- Primary Care Physicians (PCP) includes both Medical Doctor (MD) and Doctor of Osteopathy (DO) physicians

- Respiratory therapists
- Specialists Physicians – includes both MDs and DOs
- Speech pathologists

Facility Providers

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

Transitioning care from non-participating providers to participating providers

If you are a new member, you may be receiving care from a Non-Participating Provider. You may want to select a Participating Provider to obtain covered services at the higher level of benefit coverage.

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 application within thirty (30) calendar days of your effective date, available from UPMC Health Plan's Member Services Department by calling the phone number on the back of your ID card, and obtain Prior Authorization from UPMC Health Plan to continue treatment with a Non-Participating Provider during the transition period. If you are in the second or third trimester of pregnancy on the effective date of your enrollment, the transition of care period extends through postpartum care related to the delivery of your child.

Provider terminations

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

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

Managing your health care

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

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

UPMC Health Plan's large 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 from a provider who is not in the network. You must obtain Pre-Certification for Covered Services performed by a Non-Participating Provider in order for those services to be covered at the in-network rate. When UPMC Health Plan reviews your request, the Medical Management Department will see if a Participating Provider can perform the Covered Services you need.

When you or your provider requests Prior Authorization, the Medical Management Department may ask you or your provider for additional information necessary to make the coverage decision. Such additional information may include, but is not limited to, medical records. In the event that you or your provider does not provide the requested information, UPMC Health Plan may deny the request for Prior Authorization.

Concurrent Reviews: Sometimes the Medical Management Department will review services that you are currently receiving. These reviews might happen while you are actually a patient in the hospital. That is what "concurrent" means. UPMC Health Plan does this to determine the Medical Necessity of the length of stay in a facility and/or the level of care being provided to you. The Medical Management staff reviews your treatment plan and ongoing progress with the hospital or facility staff or other professional provider. Based upon this information, the Medical Management staff 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 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.

Nurse Advice Line

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

Health coach

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

Relationship with providers

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

Section IV. Covered Services

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

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

Routine and preventive services

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

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

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

Colorectal cancer screening

- Benefits if you do not have symptoms and are age fifty (50) and over:
 - An annual fecal occult blood test (or fecal immunochemical test) or
 - A sigmoidoscopy, a screening barium enema, or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five years or
 - A colonoscopy at least once every ten years.
- Benefits if you have symptoms:
 - A colonoscopy, sigmoidoscopy, or any combination of colorectal cancer screening tests at a frequency determined by a treating physician.
- Benefits if you do not have symptoms but are at an increased risk for colorectal cancer and are under 50 years of age:
 - A colonoscopy or any combination of colorectal cancer screening tests in accordance with current appropriate medical guidelines.

Lung cancer screening (Low-dose Computed Tomography (CT) for Lung Cancer Screening)

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

Women's care

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

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

Hospital services

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

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

Maternity services

- Your benefit plan covers services necessary to provide comprehensive care for both mothers and babies. If you believe that you are pregnant, contact your treating provider or an obstetrician or nurse-midwife. If your provider determines that you are pregnant, you are eligible for prenatal care coverage, including Medically Necessary sonograms, delivery, postpartum care, and care for your newborn while you are in the hospital.
- You will receive coverage for hospital services associated with delivery of your baby for at least forty-eight (48) hours following a vaginal delivery and for at least ninety-six (96) hours following a Cesarean

section.

- You and your newborn are also covered, with no cost-sharing, for one home health care visit within forty-eight (48) hours of inpatient care after a vaginal delivery or ninety-six (96) hours after a Cesarean section. Home health care visits shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. At the mother's sole discretion, any visits may occur at the facility of the provider.

Emergency services

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

Use Emergency Services only when it is appropriate to do so. For situations such as a sore throat or earache, it may be better for you to contact your treating provider who knows you and your medical history. Remember that routine or non-Emergency Services provided in an emergency department will not be covered, unless your treating provider or the Health Plan authorized those services.

You should contact your treating provider within 24 hours of receiving Emergency Services or obtaining follow-up care. In the event of an emergency admission to a hospital or other facility, the hospital or other facility must contact the Health Plan within 48 hours or on the next business day following the admission.

Ambulance services

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

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

Physician/surgical services

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

- Surgery performed by a professional provider, including pre- and post-operative office visits. Surgery includes the following procedures:
 - Oral surgery is covered only for the following procedures in an outpatient setting or in an inpatient setting when such setting is determined to be Medically Necessary.
 - Extraction of impacted third molars that are partially or totally covered by bone;
 - Excision of malignant lesions/tumors of the mandible, mouth, lip, or tongue;
 - Incision of accessory sinuses, mouth, salivary glands, or ducts;
 - Manipulation of dislocations of the jaw;
 - Reconstruction to repair a non-dental physiological condition that has resulted in a severe functional impairment;
 - Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct bony deficits associated with extremely wide clefts that affected the alveolus;
 - Surgery for temporomandibular joint disease.
 - In order for surgery to be covered, documentation in the medical record must support that treatment of TMJ disorder when conventional non-surgical therapy has not resulted in adequate improvement.

- Anesthesia for dental procedures may be covered after medical necessity review and Prior Authorization for services. Eligible dental patients include children who are seven (7) years old or younger, patients of any age who are developmentally disabled and for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia, or patients of any age with documented medical conditions, including but not limited to, severe local oral infection or certain physical or mental health conditions.
- All other oral surgery and related services are excluded from coverage
- Mastectomy and Breast Cancer Reconstruction: Your benefit plan covers a mastectomy performed on an inpatient or outpatient basis, as well as any surgery needed to re-establish symmetry or alleviate functional impairment. This includes:
 - All stages of reconstruction of the breast on which the mastectomy was performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - External Breast Prostheses. Initial and replacement breast prosthesis are covered as per your benefit plan and the Health Plan policy in accordance with the federal Women’s Health and Cancer Rights Act of 1998;
 - Treatment of physical complications at all stages of the mastectomy, including lymphedema; and
 - If requested by your physician, one home health care visit may be obtained within 48 hours following a hospital discharge if that discharge from the hospital occurs within 48 hours of admission for the mastectomy.
- Surgical assistant services, meaning the services of a physician who actively assists the operating surgeon who is performing covered surgery, only in the event that an intern, resident, or house staff member is not available.
- A second surgical opinion from a professional provider and related diagnostic services to confirm the need for elective covered surgery. The second opinion must be from a physician other than the physician who initially recommended the elective surgery. Elective surgery is non-emergency surgery, or surgery that can be delayed.

Provider Medical Services

Inpatient medical services

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

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

Convenience care

When you cannot see your family doctor right away, but you require medical attention, you may want to use convenience care. At a convenience care clinic (such as one found in a drug store), you may be seen by a certified nurse practitioner or physician assistant. You 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 motion sickness prevention, allergy symptoms, earaches, sore throats, sprains/strains, and similar problems.

Urgent care

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

eVisits

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

Outpatient medical care

Outpatient medical care consists of visits to a professional provider's office, whether a treating provider or specialist, for an illness or injury not related to surgery, pregnancy, or behavioral health condition. Your benefit plan covers the evaluation, examination, services, and supplies necessary to diagnose and treat basic medical illnesses, diseases, and injuries, if such services are Medically Necessary.

Allergy services

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

Diagnostic services

Your benefit plan covers the following diagnostic services when Medically Necessary and ordered by a professional provider:

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

Rehabilitative and habilitative therapy services

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

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

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

Medical therapy services

Radiation therapy 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: Cancer chemotherapy and cancer hormone treatments, which have been approved by the United States Food and Drug Administration for general use in the treatment of cancer, whether performed in a physician's office, in an outpatient department of a hospital, in a hospital as a hospital inpatient, or in any other Medically Necessary treatment setting, are covered.

Pain management programs

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

Behavioral health services

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

- Inpatient facility services as outlined in your Schedule of Benefits. These services include a semiprivate room and board; individual, group, and family psychotherapy or counseling; medications and electroconvulsive therapy; medical supplies and services; and diagnostic and other therapeutic services.
- Outpatient facility services as outlined in your Schedule of Benefits.
- Psychological and neuropsychological testing is covered except as set forth in the Exclusion section, and as outlined in your Schedule of Benefits.

Substance abuse services

Your benefit plan covers the following services when Medically Necessary and obtained from a participating hospital or other facility provider.

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

Other Medical Services

Acupuncture

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

Corrective appliances

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

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

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

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

Durable medical equipment (DME)

Your benefit plan covers the rental or, at the Health Plan's discretion, the purchase of durable medical equipment for therapeutic use when prescribed by a professional provider if such services are Medically Necessary.

Examples of DME are hospital beds, wheelchairs, ventilators, oxygen tanks or concentrators, crutches, walkers, canes, commodes, and suction machines.

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

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

Emergency dental services related to accidental injury

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

Fertility testing

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

Home health care

Your benefit plan covers the following services, which you may receive from a home health care agency or hospital program for home health care when Medically Necessary. Prior Authorization may be required.

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

Hospice care

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

Nutritional counseling and medical nutrition therapy

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

Nutritional products

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

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

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

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

Podiatry care

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

Skilled nursing facility services

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

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

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

Therapeutic manipulation/Chiropractic care

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

Your benefit plan will cover the following services directly related to therapeutic manipulation when Medically Necessary: evaluation, vertebral adjustment or manipulation, therapeutic exercise, and adjunctive procedures.

Services must be obtained from a provider who is licensed to provide such services. Consult your Schedule of Benefits for Benefit Limits regarding therapeutic manipulation.

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

Diabetic equipment, supplies, and education

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

- Equipment and supplies:
 - Blood Glucose Monitors
 - Monitor Supplies
 - Insulin
 - Injection Aids
 - Syringes
 - Insulin Infusion Devices
 - Pharmacological Agents for Controlling Blood Sugar
 - Orthotics

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

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

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

Additional Services

Clinical trials and research studies

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

Lifestyle Modification Program for Reversing Heart Disease

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

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

complete the program.

- This program is only offered at selected participating sites; class size may be limited.

Transplantation services

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

- When both the donor and the recipient are members, each is entitled to the benefits of this Policy.
- When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this Policy subject to the following additional limitations:
 - The donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, or any government program; and
 - Benefits provided to the donor will be charged against the recipient's coverage under this Policy.
- When only the donor is a member, the donor is entitled to the benefits of this Policy, subject to the following additional limitations:
 - The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Policy, and
 - No benefits will be provided to the transplant recipient who is not a Health Plan member.

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

Vision services for a medical condition

Prescription eyewear and the fitting and adjustment of contact lenses are covered only if you have cataracts, keratoconus, or aphakia. If one of these qualifying conditions is present, prescription lenses and contact lenses are limited to one pair of standard contact lenses OR one pair of standard eyeglasses per Benefit Period. When Special lenses for Presbyopia and Astigmatism are used instead of Traditional intraocular lenses following Cataract surgery, only the cost of the traditional intraocular lens is covered. You will be responsible for any and all upgrades.

Pediatric dental services

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

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

Pediatric vision services

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

Prescription Drugs

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

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

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. **Alternative Medicine:** Acupressure, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation, or yoga.
2. **Assisted Fertilization:** Assisted fertilization services, including, but not limited to, GIFT, ZIFT, embryo transplants, in vitro fertilization.
3. **Bariatric Surgery:** Bariatric Surgery is not covered under any circumstances.
4. **Behavioral Health Services:** The following behavioral health services (unless provided elsewhere in this Policy):
 - A. Any psychotherapy, psychiatric care, or treatment services for mental health or substance use which are court-ordered, unless such services are Medically Necessary.
 - B. Inpatient or outpatient treatment related to intellectual disability or pervasive developmental disorder. Inpatient or outpatient treatment for autism, which extends beyond traditional medical management, unless covered by an Autism Spectrum Disorders Coverage Rider attached to this Policy.
 - C. Eligibility for and maintenance of Social Security disability benefits does not determine whether UPMC Health Plan will cover specific behavioral health or substance abuse treatment services. Medical necessity criteria will be used to determine whether specific treatment services are covered.
 - D. Any treatment/services related to personal or professional growth/development, educational or professional training or certification, or treatment services required for investigative purposes related to employment.
 - E. Any services necessary to obtain or maintain employment or insurance or for judicial or administrative proceedings, including, but not limited to, adjudication of marital, child support, or custody cases.
 - F. Methadone maintenance for the treatment of chemical dependency.
 - G. Marriage or family counseling, unless such services are Medically Necessary.
 - H. Chronic maintenance therapy, unless such services are Medically Necessary. Medical Necessity criteria will be used to determine whether specific treatment services are covered.
 - I. Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies, such as art or psychodrama, and hyperbaric or other therapy.
 - J. Sex therapy without a diagnosis as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
 - K. Sedative action electrostimulation therapy.
 - L. Sensitivity training.
 - M. Twelve step model programs as sole therapy for conditions, including, but not limited to addictive gambling.
 - N. Treatment or consultation provided by the members' parents, siblings, children, current or former spouse or domiciliary partner.
 - O. Truancy or disciplinary problems not associated with a treatable mental disorder.
 - P. Psychoanalysis or other therapies that are not short-term or crisis-oriented, unless such services are Medically Necessary. Medical Necessity criteria will be used to determine whether specific treatment services are covered.

- Q. Psychological and neuropsychological testing for learning disabilities or problems, other school-related issues, to obtain or maintain employment, to submit a disability application for a mental or emotional condition, and any other testing that does not require administration by a behavioral health professional, including self-test reports.
 - R. Intensive health coaching services, resource coordination activity, behavioral health rehabilitation services for children and adolescents, and summer camp programs are not covered services.
 - S. Respite services.
5. **Blood:** Non-purchased blood or blood products, including autologous donations.
 6. **Corrective Appliances:** Corrective Appliances primarily intended for athletic purposes or related to a sports medicine treatment plan, and other appliances/devices, and any related services, including but not limited to: children's corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, and shoe inserts and orthopedics shoes except as provided in **Section IV. Covered Services**, subsection **Corrective appliances**.
 7. **Cosmetic Surgery:** Surgical or other services for cosmetic purposes performed to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected, except as such surgery or services are required to be covered by law. Excluded services include, but are not limited to, port wine stains, augmentation procedures, reduction procedures, and scar revisions. Exceptions to this exclusion are: (a) surgery to correct a congenital birth defect; (b) cosmetic surgery necessitated by a covered sickness or injury; and (c) expenses otherwise covered that are necessary for repair of an accidental bodily injury.
 8. **Court Ordered:** Court-ordered services when your physician or other professional provider determines that those services are not Medically Necessary.
 9. **Custodial Care:** Custodial care, domiciliary care, residential care, or protective and supportive care, including, but not limited to, respite care, rest cures, educational services, convalescent care, dietary services, homemaker services, maintenance therapy, and food or home-delivered meals.
 10. **Dental Care:** Except as otherwise set forth herein, covered under the Pediatric Dental EHB Rider or other Dental Rider, or as required by law, services directly related to 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.
 11. **Dental Services Not Provided in this Policy:** Any other dental service or treatment, except as provided in **Section IV. Covered Services** of this Policy, any applicable Dental COI or Schedule of Benefits, or as mandated by law.
 12. **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.

13. **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.
14. **Experimental/Investigational:** Services that are Experimental/Investigational in nature as determined by UPMC Health Plan.
15. **Food Supplements/Vitamins:** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth herein.
16. **Genetic Counseling and Testing:** Genetic counseling and testing not Medically Necessary for treatment of a defined medical condition, except when such coverage is required by the Patient Protection and Affordable Care Act.
17. **Growth Hormones:** Growth hormone therapy unless prescribed for Classic Growth Hormone Deficiency, Turner's Syndrome, or certain other diagnoses as determined by UPMC Health Plan and authorized in accordance with applicable policy and procedure.
18. **Hearing Aids:** Hearing aids, examinations for the prescription or fitting of hearing aids, and batteries for hearing aids.
19. **Hearing Examinations:** Hearing examinations and related services, except when such coverage is required by the Patient Protection and Affordable Care Act.
20. **Home Care:** Home care for chronic conditions such as permanent, irreversible disease, injuries, or congenital conditions requiring long periods of care or observation.
21. **Home Medical Equipment:** Comfort or convenience items, for your comfort or convenience or the comfort or convenience of your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, elevators, stair glides, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a professional provider. Medical equipment and supplies that are: (a) expendable in nature (i.e., disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and (b) primarily used for non-medical purposes, regardless of whether recommended by a professional provider.
22. **Immunizations and Drugs:** Physical examinations and immunizations required by foreign travel, school, or employment, except when such coverage is required by the Patient Protection and Affordable Care Act.
23. **Intellectual Disability:** Inpatient or outpatient treatment related to intellectual disability or pervasive developmental disorder that extends beyond traditional medical management.
24. **Medical Services Not Provided in this Policy:** Any other medical or dental service or treatment, except as provided in this Policy or as mandated by law.
25. **Medically Unnecessary Services:** Services that are not Medically Necessary as determined by UPMC Health Plan.
26. **Medicare:** Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary.

27. **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 Veterans Administration facilities for military service-related illness or injury, unless you have a legal obligation to pay.
28. **Miscellaneous:** Any services, supplies, or treatments not specifically listed in the Policy as Covered Benefits, services, supplies, or treatments, unless they are preventive care services.
- A. Services and supplies which are not provided or arranged by a UPMC Health Plan physician and authorized for payment in accordance with UPMC Health Plan's medical management policies and process.
 - B. Any services related to or necessitated by an excluded item or non-Covered Service.
 - C. Services provided by a non-licensed practitioner.
 - D. Services that are primarily educational in nature, including, but not limited to, vocational rehabilitation or recreational or educational therapy.
 - E. Services rendered prior to the effective date of your coverage or incurred after the date of termination of your coverage, except as provided elsewhere in this Policy.
 - F. Services for which you otherwise would have no legal obligation to pay.
 - G. Charges for telephone consultations unless otherwise allowed in accordance with UPMC Policy.
 - H. Charges for failure to keep a scheduled appointment.
 - I. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
 - J. Charges for completion of any insurance form or copying of medical records.
 - K. Services rendered by a professional provider who is a member of your immediate family. Immediate family is defined as the member's spouse, child, stepchild, parent, sibling, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law, brother-in-law, or grandparent.
 - L. Services that are submitted by two different professional providers for the same services performed on the same date for the same individual.
 - M. 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.
29. **Motor Vehicle Accident/Workers' Compensation:** Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a motor vehicle insurance policy, or any injury sustained in the course and scope of performing work for which coverage is afforded under a workers' compensation policy, including, but not limited to, a qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payment in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act or equivalent law of another state. For information on coverage for injuries in excess of that paid or payable under a motor vehicle insurance policy or a workers' compensation policy, see the section of this Policy relating to "Coordination of benefits."
30. **Non-Medical Items:** Health club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a physician.
31. **Nutritional Supplements:** Blenderized food, baby food, or regular shelf food when used with an enteral system; milk- or soy-based infant formula with intact proteins; any formula, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance; oral semisynthetic intact

protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; food additives, including, but not limited to, thickeners, vitamins, fiber supplements, calorie or protein supplements and lactose digestion products, and normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

32. **Oral Surgery:** Services, including or related to oral surgery, except as set forth in **Section IV. Covered Services**, subsections Physician/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.
33. **Over-the-Counter Drugs:** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except as set forth in **Section IV. Covered Services**, subsection Nutritional products, or when coverage is required by the Affordable Care Act.
34. **Physical Examinations:** Routine or periodic physical examinations, immunizations, or behavioral health services obtained for the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive or Medically Necessary purposes, including, but not limited to, premarital examinations, physicals for employment, school, camp, and participation in sports or travel, except when such coverage is required by the Patient Protection and Affordable Care Act.
35. **Private Duty Nursing Services:** Private Duty Nursing is not covered under any circumstances.
36. **Rehabilitative Therapy:** Rehabilitative therapy services, including, but not limited to, physical therapy, occupational therapy, and speech therapy provided to correct or alleviate developmental delay, school-related problems, apraxic disorders (not caused by accident or episodic illness), stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders. Physical, occupational, and speech rehabilitation therapy services provided in excess of the maximum number of visits per Benefit Period, 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.
37. **Reversal of Voluntary Sterilization Procedures:** Services to reverse sterilization.
38. **Gender Reassignment Surgery and Procedures, and Medications:** All Services, Procedures and Medications related to gender reassignment surgery, except for sickness or injury resulting from such treatment or surgery.
39. **Smoking Programs:** Nicotine cessation programs and/or classes and prescription and non-prescription medications not otherwise included in the Preventive Services Reference Guide.
40. **Surrogate Motherhood:** Services and supplies associated with surrogate motherhood, including, but not limited to, all services and supplies relating to conception, prenatal care, delivery, and postnatal care of a member acting as a surrogate mother.
41. **Transportation:** Non-emergent transportation, by any means, including via ambulance provider, except as set forth in Section IV **Covered Services** subsection **Ambulance services**.
42. **Treatment Outside the United States:** Treatment for non-emergent or non-urgent services received outside the United States.

43. **Vision:**
- A. Eyeglasses and 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 aphakic).
 - 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.
 - E. All other Vision services are excluded except as provided by a Pediatric Vision EHB Rider.
44. **Weight Reduction:** Weight reduction programs and products not included in the Preventive Services Reference Guide. Weight reduction programs, including all related diagnostic testing and other services, except when such coverage is required by the Patient Protection and Affordable Care Act. Anti-obesity medication, including, but not limited to, appetite suppressants and lipase inhibitors.

Section VI. Care When You Are Away from Home

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

Urgent care

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

Emergency services

If you are traveling and suffer from an illness or injury that is an emergency, you should go to the nearest emergency department. If the illness or injury is an emergency, the health care services that you receive from the emergency room will be paid at the highest level. If you are admitted to a facility outside of 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 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.

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 100 miles away from your home, you have access to UPMC Health Plan's travel assistance program. The travel assistance program can help you obtain Emergency Services or urgent care when you are traveling far from home. Services include making appointments for you with nearby physicians, providing translation services, making arrangements for medical evacuations, and the return of mortal remains. Contact UPMC Health Plan Member Services for more information regarding the travel assistance program or refer to www.upmchealthplan.com.

Coverage for students or dependents up to age 26 while living outside of the service area

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

Section VII. Benefit Coverage and Reimbursement

How to submit a claim

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

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

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

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

Make sure that you 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 the Member Services Department. 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 set forth below within **90 days** of the date of service. UPMC Health Plan will not accept any member claims for reimbursement more than one year after the end of the Benefit Period in which the benefits were payable.

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

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

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

Payment to providers

As a UPMC Health Plan member, you authorize us to make payments directly to providers from whom you receive Covered Services. The portion of the Covered Services for which UPMC Health Plan is responsible is the percentage of the Reasonable and Customary Charge **as outlined in Section I. Terms and Definitions to Help You Understand Your Coverage**. UPMC Health Plan applies all your Deductible, Copayment, and Coinsurance

amounts to the Reasonable and Customary Charge to determine the benefit amount payable by UPMC Health Plan. In addition to all Deductibles, Coinsurance, and Copayments, you will also be responsible for any difference between the Non-Participating Provider's billed charge and the UPMC Health Plan payment. However, UPMC Health Plan reserves the right to make the payments directly to you, if necessary. You cannot assign or transfer your right to receive payment for Covered Services under this Policy.

UPMC Health Plan reserves the right to establish threshold amounts at which UPMC Health Plan will pay a Non-Participating Provider's billed charges. UPMC Health Plan further reserves the right to negotiate a one-time rate with the Non-Participating Provider for a particular Covered Service. In the event of a one-time rate negotiation, you will incur no liability beyond applicable Deductibles, Coinsurance, and Copayments for that Covered Service.

If UPMC Health Plan pays a provider directly, you will receive an Explanation of Benefits (EOB) that describes the services that you received and how much UPMC Health 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, Deductibles, or Coinsurance to that provider.

Coordination of benefits

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

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by that coverage will be taken into account when we determine if additional benefit payments can be made under this plan.
- When you are covered as the subscriber under one plan and as a dependent under another, the subscriber insured coverage pays first.
- When the dependent child is covered under 2 plans, the plan covering the parent whose birthday occurs earlier in the calendar year pays first. If both parents have the same birthday, then the plan under which one parent was covered longest pays first.
- If the dependent child's parents are separated or divorced and:
 - The parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
 - The parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent's coverage, if any, pays before the coverage of the parent without custody.
 - There is a court order that specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first. The member must provide a copy of the court order to UPMC Health Plan.
- When you are covered as an individual under this plan and also covered under a state funded Medicaid policy, the Medicaid policy is the payor of last resort.
- When none of the above circumstances applies, the coverage that you have had the longest generally applies first.

If you or your provider receive more than you should have 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 made under another benefit plan, UPMC Health Plan has the right to pay to the benefit plan that has made such payment any amount that UPMC Health Plan determines to be appropriate under the terms of this Policy. Any amounts paid shall be considered to be benefits paid in full under this Policy.

In the event that UPMC Health Plan makes payment for Covered Services in excess of the amount of payment pursuant to this Policy, 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 Policy, UPMC Health Plan will make payment for Covered Services that you incur in excess of the maximum allowable coverage under the motor vehicle insurance policy or workers' compensation policy, subject to the terms and limitations set forth herein.

UPMC Health Plan is not required to determine whether you have other health care benefits or insurance or the amount of benefits payable under any other health care benefits or insurance. UPMC Health Plan 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 school, college or university which provided this Policy, another insurance company, or any other entity or person authorized to provide such information.

Subrogation

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

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

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

Medicare eligibility

If you are eligible for Medicare, the benefits provided under this Policy do not constitute duplicate benefits otherwise covered under the Medicare program, including Medicare Part B, except as provided by applicable

federal law. When Medicare is the appropriate payer, all amounts paid by the Medicare Program for benefits provided to you under this Policy are payable to and retained by UPMC Health Plan.

Section VIII. Resolving Disputes With the Health Plan

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

The Complaint process

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

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

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

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

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

The Grievance process

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

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

- Your provider may request written consent to pursue a Grievance at the time of treatment — but not as a condition of providing that treatment.
- You and your provider cannot file separate Grievances regarding the same treatment or service.
- Once you give written consent to a provider to file a Grievance, the provider has 10 days from the receipt of denial notification to file the Grievance. Your provider does not need to inform you if and when he/she files the Grievance; however, your provider must inform you if he/she decided NOT to file the Grievance.
- Your consent is automatically rescinded if your provider fails to file a Grievance within the appropriate

time frames.

- If you wish to file a Grievance, but already gave written consent to your provider, you must rescind your consent in order to proceed with your Grievance.

You may either file a Grievance over the phone with the Member Services Department by calling the phone number on the back of your member identification card or by sending a written grievance to UPMC Health Plan at UPMC Health Plan, P.O. Box 2939, Pittsburgh, PA 15230-2939. You may also send any other written information to support your Grievance. You may include in the Grievance the remedy, resolution, or corrective action that you seek from UPMC Health Plan.

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

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

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

The external Grievance review process

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

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

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

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

You, your representative, or your provider may supply additional information to the IRO to consider in the external appeal within five business days of notification that your grievance is eligible for external review. The IRO will then provide this information to UPMC Health Plan within one day so that UPMC Health Plan has an opportunity to consider the additional information as well.

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

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

Expedited Grievance Review Process

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

Expedited External Grievance Review Process

You may request an expedited external Grievance review at the same time you request an expedited internal Grievance review, or you may request an expedited external Grievance review within two business days from receipt of the expedited internal Grievance review decision.

To request an expedited external grievance review, you should contact UPMC Health Plan and explain the need for an expedited external review. You must obtain written certification from your treating provider that your life, health, or ability to regain maximum function would be placed in jeopardy by the delay inherent in the regular time frames of the external review process. The certification must include a clinical rationale and facts to support

your provider's position. You must provide any additional information for consideration in an expedited manner so we can comply with the requirements for an expedited review. The Health Plan will submit your appeal to an IRO, which will provide you with notice of its decision as quickly as possible, but not later than 72 hours after our receipt of your request for the expedited external grievance review. If notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision.

Expedited Pharmacy Review Process

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

Additional appeal to government agency

If you are dissatisfied with the Health Plan's decision and/or your adverse benefit decision does not meet the criteria for an external review by an IRO, the Pennsylvania Insurance Department or the Pennsylvania Department of Health may be able to help to resolve the dispute. Generally, the Department of Health reviews appeals that concern quality of care or quality of service issues, whereas the Insurance Department reviews appeals that concern problems relating to contract exclusions, coverage disputes, and other insurance-related issues, such as subrogation.

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

**Pennsylvania Department of Health, Bureau of Managed Care, P.O. Box 90, Harrisburg, PA
17108-0090 (1-888-466-2787)**

**Pennsylvania Insurance Department, Bureau of Consumer Services, 1321 Strawberry
Square, Harrisburg, PA 17120 (1-877-881-6388)**

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

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

Section IX. Termination of Coverage

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

- The Benefit Period ends.
- You fail to pay your required premium contribution to UPMC Health Plan. In this case, your coverage will terminate at the end of the last month for which a premium payment was made.
- The school no longer contracts for coverage with UPMC Health Plan. If the school decides to terminate its contract with UPMC Health Plan, it is the school's responsibility to tell you that your coverage will terminate.
- UPMC Health Plan determines that you committed fraud or made an intentional misrepresentation of material fact in information submitted to UPMC Health Plan or in obtaining or using services under this Policy. This includes improper use of your member identification card, such as allowing another person to use your card to obtain health care services.

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, you should contact UPMC Health Plan's Member Services Department at the phone number on the back of your member identification card.

What are my benefits after termination?

If you are totally disabled on the date of termination of coverage, you will continue to receive benefits directly related to the condition causing the total disability, but for no other condition, illness, disease, or injury. Such benefits will be provided for the following time periods:

- For a maximum of 12 consecutive months; OR
- Until the maximum amount of benefits have been paid; OR
- Until the total disability ends; OR
- Until you become covered without limitation as to the disabling condition under any group coverage, whichever occurs first.

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 approval from a UPMC Health Plan Medical Director. 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 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
- Until the maximum amount of benefits for an inpatient stay has been paid under this Policy; OR
- Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under a group benefit plan, whichever occurs first.

Section X. General Provisions

Your contract with UPMC Health Plan

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

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

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

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

Fraud 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 or abuse, call or email our Special Investigations Unit at 1-866-FRAUD01 (372-8301) or specialinvestigationunit@upmc.edu.

UPMC Health Plan's relationship with providers

The relationship between UPMC Health Plan and participating providers is that of independent contractors and neither UPMC Health Plan nor any participating provider shall be considered an agent or representative of the other for any purpose.

UPMC Health Plan makes no express or implied warranties or representations concerning the qualifications or continued participation of any participating provider. The choice to use a particular provider is solely your own. Participating providers may be terminated 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. Participating providers are solely responsible for any health services rendered to you and their other patients. UPMC Health Plan is not liable for any act or omission of

any provider who renders health care services to you. UPMC Health Plan has no responsibility for provider's failure or refusal to render health care services to you.

Governing law

This Policy is entered into and is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions hereof 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 provision of this Policy shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.