

**2009-2010
Point Park University
Student Accident and
Insurance Policy**

UPMC HEALTH PLAN

UPMC Health Plan

Preferred Provider Organization

**2009-2010 Point Park University
Student Accident and Insurance Policy**

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Welcome and General Information for Members

This document is the Point Park University 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, and file an appeal, and it provides 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.

This student blanket policy benefit plan may not cover all of your health care expenses. Read this Policy carefully to determine which health care services are covered.

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 1-888-876-2756 or write to:

Member Services Department
UPMC Health Plan, Inc.
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

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

Terms and Definitions to Help You Understand Your Coverage

Health insurance can often seem complicated and confusing. The following are some important and frequently used terms and definitions that UPMC Health Plan uses in this Policy and 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, number of days, or number of services. Some Benefit Limits are discussed in this Policy, but generally are set forth in your Schedule of Benefits.

Benefit Period — For students who enroll for full-year coverage, the Benefit Period is the later of August 1, 2009, or the date which UPMC Health Network, Inc. (UPMCHN) receives a completed Enrollment Form and premium payment from an Eligible Student and/or Eligible Dependent through July 31, 2010. For students who enroll in the spring semester, the Benefit Period is the later of January 1, 2010, or the date which UPMCHN receives a completed Enrollment Form and premium payment from an Eligible Student and/or Eligible Dependent through July 31, 2010.

Coinsurance — The percentage of expenses for Covered Benefits that you are responsible to pay, after you have met your Deductible, if any. Refer to your Schedule of Benefits to determine Coinsurance amounts.

Complaint — A dispute or objection regarding a Participating Provider or the coverage, operations, or management policies of a managed care plan, which has not been resolved by UPMC Health Plan and has been filed with the plan. A Complaint does not include a Grievance. Instructions regarding how to file a Complaint are set forth on page 26 of this Policy.

Copayment — The specified dollar amount that you pay at the time of service for certain Covered Benefits. Copayments do not apply toward your Coinsurance, Deductible, or Out-of-Pocket Limit. 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 that meets the requirements set forth in this Policy, including, but not limited to, Medical Necessity and Precertification, if applicable.

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 Deductible amounts. Under some plans, if you have several covered dependents, you may have a family Deductible. This means that, to meet your Deductible, you can count the expenses incurred by you and your dependents. However, the amount contributed toward the Deductible for any one covered individual cannot be more than the amount of the individual Deductible. If one family member meets the individual Deductible, UPMC Health Plan would begin to cover that person's health care benefits even if the family Deductible has not been met.

Emergency Services — Any health care service provided after 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:

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

Emergency transportation and related emergency services provided by a licensed ambulance service shall constitute an Emergency Service.

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

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 review 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 of Experimental/Investigational set forth above.

Grievance — A request by a member or a health care provider, with the written consent of the member, 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. A Grievance may be filed regarding the decision that:

- Disapproves full or partial payment for a requested health care service;
- Approves the provision of a requested health care service for a lesser scope or duration than requested; 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 on page 27 of this Policy.

Medical Necessity or Medically Necessary — Those 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; and
- 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; and
- Reasonably expected to improve an individual's condition or level of functioning; and
- In conformity, at the time of treatment, with medical management criteria/guidelines adopted by UPMC Health Plan or its designee; and
- 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. Note that the fact that a provider orders, prescribes, recommends, or approves a health care service does not mean that the service is Medically Necessary or a Covered Benefit for purposes of coverage.

Out-of-Pocket Limit — The maximum dollar amount for which you are responsible during a Benefit Period before UPMC Health Plan will pay for your Covered Benefits. Copayments do not count toward your Out-of-Pocket Limit. See your Schedule of Benefits for Out-of-Pocket Limit amounts.

Precertification or Prior Authorization — The process through which UPMC Health Plan determines whether certain health care services are a Covered Benefit and/or if certain services are Medically Necessary.

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

Eligibility for Coverage

Who is eligible for coverage?

A Full-Time University Student as determined by the University is one who timely enrolls and submits the required Enrollment Form and premium payment to UPMCHN. Full-Time students (and their dependents) shall have a period of no more than thirty-one (31) days after the start of the school year to submit enrollment forms and payment to UPMCHN (if seeking full-year coverage) and no more than thirty-one (31) days after the start of the semester to enroll and submit payment to UPMCHN (if seeking coverage for the semester). If timely enrollment and payment is made within the applicable 31-day period, coverage will be effective on the date the enrollment application and payment is received by UPMCHP.

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

- Your spouse under a legally valid existing marriage between persons of the opposite sex. A spouse does not include an individual who is eligible for Medicare coverage because of his or her age and who has elected that coverage instead of coverage offered under this Policy.
- Unmarried children under the age of 19, including newborn children, stepchildren, children legally placed for adoption, and children for whom coverage is mandated by a qualified medical child support order.
- Unmarried children between the ages of 19 and 25 who are enrolled in and regularly attend an accredited school, college, or university on a full-time basis, and who are solely dependent upon you for support.

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

How do you enroll a dependent?

There are two ways you can enroll an eligible dependent. First, you may enroll an eligible dependent during your open enrollment period. Second, you may enroll an eligible dependent within 31 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 31-day period. The following are rules for special circumstances regarding coverage of dependents.

Newborn Children: Newborn children are covered automatically from the moment of birth for 31 days. 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.

Adopted Children: Adopted children are covered automatically from the date of legal placement for 31 days. 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 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.

Qualified Medical Child Support Orders: A medical child support order is a judgment, decree, or order made by a court of competent jurisdiction or an authorized state administrative agency that is made under state domestic relations law or state laws relating to medical child support. The order provides for medical support or health benefit coverage for a child of a member under a group health plan. A Qualified Medical Child Support Order (QMSCO) is a medical child support order that contains at least the following information: (1) the name and last known mailing address of the member and each child to be covered under the QMSCO,² (2) a reasonable description of the type of health coverage to be provided to each child, or the manner in which such coverage is to be determined, and (3) the period of time to which the QMSCO applies. Point Park University may determine whether a medical support order is a QMSCO. For more information regarding QMSCOs, contact UPMC Health Plan.

²The order may substitute the name and mailing address of a state or local official for a child's mailing address.

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 an individual becoming eligible for coverage. To apply for enrollment or change enrollment status, complete and submit an Enrollment Form 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?

For students who enroll for full-year coverage, the Benefit Period is the later of August 1, 2009, or the date which UPMCHN receives a completed Enrollment Form and premium payment from an Eligible Student and/or Eligible Dependent through July 31, 2010. For students who enroll in the spring semester, the Benefit Period is the later of January 1, 2010, or the date which UPMCHN receives a completed Enrollment Form and premium payment from an Eligible Student and/or Eligible Dependent through July 31, 2010.

A Guide to Obtaining Covered Benefits

This Policy is a Student Blanket 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, or out-of network providers, for most Covered Services. If you obtain services from Participating Providers, you will receive the highest level of benefits. 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, though, if you use Non-Participating Providers, you may receive a lower level of benefit coverage and you may be balance billed by those providers. This means that, because UPMC Health Plan does not have a contract with Non-Participating Providers, they can bill you for any amount of their charges that UPMC Health Plan does not cover.

The UPMC Health Plan provider network

Because this is a PPO plan, you may obtain all Covered Services from participating or in-network providers. UPMC Health Plan's network includes thousands of physicians and other professional providers and over 80 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, visit www.upmchealthplan.com, or call Member Services for assistance.

You may also obtain most Covered Services from Non-Participating Providers. Remember that if you obtain care from a Participating Provider, you will receive a higher level of benefit coverage. If you choose to utilize Non-Participating Providers, 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.

The following is a list of types of providers from whom you may seek care if they are Participating Providers:

Facility Providers

Hospitals
Psychiatric hospitals
Rehabilitation hospitals
Alcohol abuse treatment facilities
Ambulance services
Ambulatory surgical centers
Birthing facilities
Drug abuse treatment facilities
Freestanding dialysis clinics
Freestanding nuclear magnetic resonance imaging facility
Home health care agency
Home infusion therapy provider
Hospice
Outpatient alcohol and/or drug abuse treatment facility
Outpatient physical rehabilitation facility
Outpatient psychiatric facility
Skilled nursing facility
Convenience Care Clinics
Urgent Care Centers

Professional Providers

Audiologist
Certified registered nurse (if not employed by a health care facility or anesthesiology group)
Clinical laboratory
Dentist
Nurse-midwife
Occupational therapist
Physical therapist
Physician
Psychologist
Respiratory therapist
Speech pathologist

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. The Medical Management Department monitors your care at many levels described below.

Prior Authorization and Precertification: Certain Covered Services require Prior Authorization, or Precertification, from UPMC Health Plan's Medical Management Department. This means that you or your attending provider must obtain approval for coverage of these services from UPMC Health Plan before you receive the services. All UPMC Health Plan Participating Providers are educated about Prior Authorization. Some Prior Authorization requirements are listed in this section and in the Covered Services section of this Policy. If you are unsure as to whether a service requires Prior Authorization, call Member Services and a representative will assist you.

Some services require Prior Authorization regardless of whether they are obtained from participating or non-participating providers. Generally, however, you do not need to obtain Prior Authorization for Covered Services performed by a Non-Participating (out-of-network) Provider. However, if the Non-Participating Provider does not obtain Prior Authorization, you may receive a lower level of benefit coverage. If your Non-Participating Provider does obtain Prior Authorization, you may receive a higher level of benefit coverage.

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 includes, 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 receiving throughout a course of treatment. This may occur while you are an inpatient at a hospital. This method of review is used to assess 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 necessary to extend your care or suggest an alternate level of care.

Retrospective or Post-Service Reviews: In limited circumstances, the Medical Management, Quality Audit, and Fraud and Abuse departments will use a retrospective review when a service has been rendered without the required authorization or in cases where further clarification regarding Medical Necessity or appropriate reimbursement is needed.

Discharge Planning: Discharge Planning is a review of your case prior to discharge from a hospital or other facility. The purpose of the review is to assess your needs during and after discharge to make sure that you will have the care that you need when you leave the hospital or other facility. Discharge planning occurs throughout your stay at a hospital or other facility and is coordinated with input from your attending provider and other facility staff responsible for your care. Information considered 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 case management.

Health Coach: If you experience a serious illness or injury or if you have chronic or multiple conditions, you may be enrolled in the Health Coaching program. UPMC Health Plan Health Coaches work with you, your family or other individuals in your support system, and your health care providers to coordinate and implement a plan of care that meets your needs. Health Coaches also work with you to identify community-based services that may help you with your ongoing health care needs and to help you find alternative resources for coverage of health care services if it is determined that you may exhaust your benefits.

Covered Services

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

Hospital services

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

- Room and Board:
 - A semiprivate room and board;
 - A private room and board when determined to be Medically Necessary;
 - A bed in a special or intensive care unit when your condition requires constant attendance and treatment for a prolonged period of time;
 - General nursing care;
 - Ancillary services and supplies related to the inpatient stay.
- Pre-Admission Testing, including tests and studies that are required before your admission to the hospital.
- Drugs and medicines provided to you while you are an inpatient.
- Use of operating and delivery rooms 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.

Emergency services

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

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

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

Medical/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. All other oral surgery and related services are excluded from coverage.
 - 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; and
 - 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.

- 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;
 - Prostheses;
 - Treatment of physical complications at all stages of the mastectomy, including lymphedema;
 - One home health care visit, if requested by your physician, following a hospital discharge that 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.

Inpatient medical services

Your benefit plan covers the following services that you may receive from a professional provider while you are an inpatient in a hospital or other facility for a condition not related to surgery, 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 infant while the mother is an inpatient.

Routine and preventive care

Routine physical examinations are covered for adults 19 years of age and older when performed by a Participating Provider who is credentialed by UPMC Health Plan as a primary care provider. Coverage for routine physical examinations includes physical examination, regardless of Medical Necessity, including a complete medical history, height and weight measurement, and diagnostic testing necessary, based upon your sex, age, and medical history, when determined to be Medically Necessary.

Routine and preventive pediatric care and immunizations are covered when performed by a Participating Provider who is credentialed by UPMC Health Plan as a primary care provider. Coverage includes:

- Well-child and routine physical examinations and diagnostic services regardless of Medical Necessity, including complete medical history, height and weight measurement, and counseling when appropriate.
- Pediatric immunizations, when performed and billed by a hospital, facility, physician, or other professional provider, which, as determined by the Pennsylvania Department of Health, conform with the standards established by the Centers for Disease Control and the United States Department of Health and Human Services.
- Benefits for pediatric immunizations are exempt from Deductibles and Benefit Limits maximums and are limited to members who are under the age of 21.

Outpatient medical care

Outpatient medical care consists of visits to a professional provider's office for an illness or injury not related to surgery, pregnancy, or a 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.

Routine 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.

Mammograms: Beginning at age 40, all women are covered for one annual routine mammogram. Mammograms are covered for all female members at any age if ordered by a physician.

Diagnostic services

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

- Diagnostic x-ray, including, radiology, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine;
- Diagnostic pathology consisting of laboratory and pathology tests;
- Diagnostic medical procedures consisting of electrocardiogram, electroencephalogram, and other electronic diagnostic medical procedures and physiological medical testing approved by UPMC Health Plan; and
- Allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Therapy services

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

Physical Therapy (PT) and Occupational Therapy (OT): Your ordering provider must provide a diagnostic evaluation prior to ordering these therapy services to establish whether or not these services are Medically Necessary. The ordering 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.

Radiation Therapy, Chemotherapy, Dialysis Treatment, and Infusion Therapy: These services are covered when provided at the appropriate level of care.

Pain Management and Rehabilitation Outpatient Programs: These services are covered if you are diagnosed with refractory chronic pain of at least 6 months duration. Your ordering provider must demonstrate that he or she anticipates these services to result in substantial improvement to your medical condition.

Maternity services

Your benefit plan covers services necessary to provide excellent and comprehensive care for both mothers and babies. If you believe that you may be pregnant, contact your treating provider, an obstetrician, or a nurse-midwife. If your provider determines that you are pregnant, you are eligible for coverage of prenatal care, 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 48 hours following a vaginal delivery and for at least 96 hours following a cesarean section.

You also are covered for one maternity home health care visit within 48 hours of a discharge from the hospital that occurs prior to 48 hours of inpatient care after a vaginal delivery or 96 hours after a cesarean section.

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 hospital or other facility:

- Inpatient facility services are covered subject to the Benefit Limits set forth in your Schedule of Benefits. These services include a semiprivate room and board; individual, group, and family psychotherapy or counseling; medications and electroconvulsive therapy; medical supplies and services; and diagnostic and other therapeutic services.
- Outpatient facility services are covered subject to the Benefit Limits set forth in your Schedule of Benefits. Outpatient group counseling visits and 15-minute medication visits equal ½ of a visit.
- Psychological and neuropsychological testing is covered only if your provider obtains Prior Authorization from UPMC Health Plan for such testing.
- Serious Mental Illness Care Services:
 - A serious mental illness means any of the following mental disorders as defined by the American Psychiatric Association: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder.
 - You are covered for the treatment of serious mental illness for up to 30 inpatient days per benefit period. A maximum of 30 of these inpatient days may be exchanged on a one-for-two basis to secure up to 60 additional outpatient days per benefit period. You are covered for outpatient services for serious mental illness for up to 60 outpatient days per benefit period. Each outpatient visit constitutes an outpatient day.
 - Remember that if you use an inpatient day for a serious mental illness, that day counts toward your Benefit Limit for inpatient days for non-serious mental illnesses. Additionally, if you use an inpatient day for a non-serious mental illness, that day counts toward your Benefit Limit for inpatient days for serious mental illnesses.

Substance abuse services

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

- Inpatient and non-hospital detoxification services are covered for a maximum of 7 days per admission. You have a Lifetime Maximum of 4 admissions.
- Inpatient and non-hospital residential rehabilitation therapy is covered for 30 days per benefit period. You have a Lifetime Maximum of 90 days. Covered inpatient services include room and board; physician, psychologist, nurse, and certified addictions counselor services; diagnostic x-ray; psychiatric, psychological, and medical laboratory testing; medications; equipment use; and supplies.
- Outpatient rehabilitation services are covered for a maximum of 60 full-session visits or the equivalent partial visits per calendar year. You have a Lifetime Maximum of 120 days. You can exchange a

maximum of 30 of your outpatient rehabilitation visits on a two-for-one basis to secure up to 15 additional inpatient non-hospital residential and rehabilitation therapy days beyond the 30-day limit referred to above. The additional exchange days will count toward your Lifetime Maximum. Outpatient services include individual and group counseling and psychotherapy, psychiatric and psychological testing, and family counseling for the treatment of alcohol and drug abuse.

Ambulance services

Your benefit plan covers ambulance services by a specially designed and equipped vehicle 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. Prior Authorization must be obtained for all non-emergent ambulance transports.

Home health care

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

- 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 aide 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 you have a life expectancy of 180 days or less, as determined by your attending physician. 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. Hospice care must be ordered, directed, and approved by your attending physician and coordinated by an interdisciplinary team.

Emergency dental services related to accidental injury

Your benefit plan only covers dental services necessary to treat an accidental injury to sound, natural teeth when the services are obtained within the first seventy-two (72) hours following the accidental injury. This coverage applies only to the emergency therapy rendered for and made necessary by the injury. These services include services obtained in an emergency room. Injury as a result of chewing or biting is not considered an accidental injury. Your benefit plan does not provide coverage for any follow-up care related to the accidental injury, including, but not limited to, orthodontia, post-orthodontics, and restorative procedures. All other dental services are excluded, unless you have a Dental Rider.

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

Acupuncture

Your benefit plan covers acupuncture treatment only for the following conditions when Medically Necessary:

- Nausea and vomiting of pregnancy (hyperemesis gravidarum)
- Post-operative nausea and vomiting
- Post-chemotherapy nausea and vomiting

Acupuncture services must be prior authorized by UPMC Health Plan.

Nutritional supplements and therapy

Nutritional supplements are a liquid source of nutrition administered under the direction of a physician, which may contain some or all the nutrients necessary to meet minimum daily nutritional requirements, and are 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.

Your benefit plan covers nutritional supplements when Medically Necessary and when under the direction of a physician on an outpatient basis, either orally or through a tube, for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia, and homocystinuria. Coverage is exempt from Copayments, Deductibles, and Coinsurance.

Your benefit plan may cover nutritional supplements administered on an outpatient basis for treatment of or related to conditions other than those set forth above when such supplements are determined by UPMC Health Plan to be Medically Necessary for a medical condition:

- When provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
- When provided through a catheter inserted into the superior vena cava when your gastrointestinal tract does not function sufficiently to permit normal oral or enteral feedings; or
- When provided orally, and identified as formulae with hydrolyzed (pre-digested) protein or amino acids; specialized content for special metabolic needs; modular components; or standard nutrients.

If UPMC Health Plan determines that coverage is Medically Necessary, by Prior Authorization, these benefits may be subject to applicable Copayments, Deductibles, and Coinsurance.

Diabetes treatment

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 policies and procedures established by UPMC Health Plan.

Orthopedic shoes and shoe inserts

Your benefit plan only covers orthopedic shoes and shoe inserts if you have diabetes or peripheral vascular disease to prevent foot injury and/or disease.

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, call UPMC Health Plan Member Services to inquire if that service is covered under your benefit plan.

- **Adult Immunizations:** Adult immunizations, including, but not limited to, the HPV vaccine.
- **Allergy Treatment:** Services for the purpose of diagnosis or treatment of allergies.
- **Alternative Medicine:** Acupuncture, except as set forth in this Policy. Acupressure, aromatherapy, Ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation, or yoga.
- **Assisted Fertilization:** Assisted fertilization services, unless you have an Infertility Rider, including, but not limited to, GIFT, ZIFT, embryo transplants, in vitro fertilization, reversal of voluntary sterilization procedures, and sex transformation services and procedures.
- **Behavioral Health Services:**
 - A. Any psychotherapy, psychiatric care, or treatment services for mental health or substance use which are court-ordered, unless such services meet medical necessity criteria.
 - B. Inpatient or outpatient treatment related to mental retardation, pervasive developmental disorder, or autism, which extends beyond traditional medical management,
 - C. Treatment for personality disorders where that is the primary diagnosis.
 - D. 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.
 - E. 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.
 - F. Any services necessary to obtain or maintain employment or insurance or for judicial or administrative proceedings, including, but not limited to, adjudication of material, child support, or custody cases.
 - G. Methadone maintenance for the treatment of chemical dependency.
 - H. Treatment for chronic behavioral conditions, once you have been restored to the pre-crisis level of function.
 - I. Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder.
 - J. Chronic maintenance therapy, except in the case of serious mental illness.
 - K. 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.
 - L. Sex therapy without a diagnosis as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
 - M. Sedative action electrostimulation therapy.
 - N. Sensitivity training.
 - O. Twelve step model programs as sole therapy for conditions, including, but not limited to, eating disorders or addictive gambling.
 - P. Treatment or consultation provided by the members' parents, siblings, children, current or former spouse or domiciliary partner.
 - Q. Truancy or disciplinary problems not associated with a treatable mental disorder.

- R. Psychoanalysis or other therapies that are not short-term or crisis-oriented.
- S. 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 licensed behavioral health professional, including self-test reports.
- T. Long-term residential treatment services for behavioral health disorders, including, but not limited to, substance use and eating disorders.
- U. Intensive case management services, resource coordination activity, behavioral health rehabilitation services for children and adolescents, and summer camp programs are not covered services,
- V. Skilled nursing facility care provided for treatment of a mental illness or treatment of substance abuse or dependency.
- W. Respite services

- **Blood:** Non-purchased blood or blood products, including autologous donations.
- **Cardiac and Pulmonary Rehabilitation Services**
- **Chiropractic Services**
- **Corrective Appliances:** Corrective appliances primarily intended for athletic purposes or related to a sports medicine treatment plan and other appliances or devices, or any related services, including, but not limited to, children's corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, shoe inserts, or orthopedic shoes, unless otherwise set forth herein.
- **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.
- **Court Ordered:** Court-ordered services when your physician or other professional provider determines that those services are not medically appropriate.
- **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.
- **Dental Care:** Except as otherwise set forth herein, 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, unless you have a Dental Rider.
- **Durable Medical Equipment:** Durable Medical Equipment.
- **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.

- **Experimental/Investigational:** Services that are Experimental/Investigational in nature as determined by UPMC Health Plan.
- **Food Supplements/Vitamins:** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth herein.
- **Genetic Counseling Studies:** Genetic counseling and studies not Medically Necessary for treatment of a defined medical condition.
- **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.
- **Hearing Aids:** Hearing aids, examinations for the prescription or fitting of hearing aids, and batteries for hearing aids.
- **Hearing Examinations:** Routine hearing examinations and related services.
- **Home Care:** Home care for chronic conditions such as permanent, irreversible disease, injuries, or congenital conditions requiring long periods of care or observation.
- **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, 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.
- **Immunizations and Drugs:** Physical examinations and immunizations required by foreign travel, school, or employment.
- **Medical/Dental Services Not Identified as “Covered” in this Policy:** Any other medical or dental service or treatment, except as provided in this Policy or as mandated by law.
- **Medically Unnecessary Services:** Services that are not Medically Necessary as determined by UPMC Health Plan.
- **Medicare:** Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary; however, this exclusion does not apply when your employer or group plan sponsor is required to offer you all of the benefits set forth in this Policy by law and you elect this coverage as your primary coverage.
- **Medicare Eligibility:** Any amounts that you are required to pay under the Deductible and/or Coinsurance provisions of Medicare or Medicare supplement coverage.
- **Mental Retardation:** Any amounts that you are required to pay under the Deductible and/or Coinsurance provisions of Medicare or Medicare supplement coverage. Inpatient or outpatient treatment related to mental retardation, pervasive developmental disorder, or autism, which extends beyond traditional medical management.

- **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.
- **Miscellaneous:** Any services, supplies, or treatments not specifically listed in the Policy as Covered Benefits, services, supplies, or treatments, unless they are a basic health service.
 - 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 or practitioner not recognized by UPMC Health Plan.
 - D. Services that are primarily educational in nature, including, but not limited to, vocational rehabilitation or recreational or educational therapy.
 - E. Services incurred after the date of termination of your coverage, except as provided elsewhere in this Agreement. Services rendered prior to the effective date of your coverage.
 - F. Services for which you otherwise would have no legal obligation to pay.
 - G. Charges for telephone consultations.
 - 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.
- **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, 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.
- **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.
- **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.

- **Oral Surgery:** Services, including or related to oral surgery, except as otherwise set forth herein. 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) treatment of temporomandibular joint syndrome or temporomandibular joint disorders, except as set forth in this Policy under the Covered Benefits section the Medical/Surgical Services subsection; (e) removal of asymptomatic, non-impacted third molars; and (f) orthodontia and related services.
- **Orthotic and Prosthetic Devices:** Orthotic and prosthetic devices, except as otherwise set forth in this Policy.
- **Over-the-Counter Drugs:** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth herein.
- **Physical Examinations:** Routine or periodic physical examinations or behavioral health services obtained for the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, including, but not limited to, premarital examinations, physicals for employment, school, camp, and participation in sports or travel, which are not Medically Necessary, except as otherwise set forth herein or as required by law. Physical examinations and immunizations required by foreign travel or employment.
- **Podiatry Services:** Palliative or cosmetic foot care, including, but not limited to: (1) treatment of weak, strained, flat, unstable, or unbalanced feet; (2) metatarsalgia or bunions (except open cutting procedures); and (3) treatment of corns, calluses, or toenails (except removal of nail roots) if determined to be Medically Necessary by UPMC Health Plan. Supportive orthotic devices for the foot are excluded unless you have diabetes or peripheral vascular disease.
- **Prescription Drugs:** Prescription drugs unless you have a Prescription Drug Rider.
- **Private Duty Nursing Services**
- **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; cardiac rehabilitation services provided in excess of twelve (12) weeks; pulmonary rehabilitation services provided in excess of twenty-four (24) visits per Benefit Period; 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.
- **Reversal of Voluntary Sterilization Procedures:** Services to reverse sterilization.
- **Sex Transformation Services and Procedures:** Treatment leading or related to transsexual surgery, except for sickness or injury resulting from such treatment or surgery.
- **Skilled Nursing Facility Services**
- **Smoking Programs:** Nicotine cessation programs and/or classes and prescription and non-prescription medication prescribed for cessation of smoking unless you have a smoking cessation benefit rider that provides such benefits.

- **Speech Therapy Services**
- **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.
- **Temporomandibular Joint Syndrome:** Treatment of temporomandibular joint syndrome or temporomandibular joint disorders, regardless of the nature of the problem, except as set forth in this Policy.
- **Transportation:** Routine or non-emergent transportation, by any means, including via ambulance provider, unless such transportation is prior authorized by UPMC Health Plan.
- **Treatment Outside the United States:** Treatment for non-emergent or non-urgent services received outside the United States.
- **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.
- **Weight Reduction:** Weight reduction programs, including all related diagnostic testing and other services. Anti-obesity medication, including, but not limited to, appetite suppressants and lipase inhibitors.

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, routine services and services that are not urgent care or Emergency Services are not covered when obtained from non-participating providers in or outside of the UPMC Health Plan service area.

Urgent care

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. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering or severe pain, such as a high fever. If you are traveling outside of the UPMC Health Plan service area and you need urgent care, you should seek that care. You should contact your treating provider or other treating provider within 24 hours or a reasonable time of receiving urgent care to arrange or obtain necessary follow-up care.

Emergency services

If you are traveling and suffer from an illness or injury that is a true emergency, you should go to the nearest emergency room. If the illness or injury is a true 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 don't 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 hospital. If you are admitted to an out-of-network facility after receiving Emergency Services, you may be required to transfer to a participating facility when it is medically safe to do so.

Remember, out-of-network providers are not obligated to contact UPMC Health Plan and do not have to comply with our policies and procedures regarding Medical Necessity or billing members. Therefore, you may receive services that are not Medically Necessary and not covered under your benefit plan and for which you will be financially responsible.

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 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.

Coverage for dependent students while away at school

Dependent students can obtain routine and preventive health care services from Participating Providers and Non-Participating Providers. You should try to schedule appointments for such health care services when the student is at home for holidays or breaks. All other Covered Services will be paid at the appropriate benefit level according to the type of provider from whom the dependent student chooses to obtain care.

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.
- For private duty nursing, the shifts worked, charge per day, nurse's license number, and signature of the ordering provider.
- For durable medical equipment, the certification of the ordering provider.
- If you have already made payment, proof of payment or a receipt.

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. 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 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. However, UPMC Health Plan reserves the right to make the payments directly to you, if necessary. You cannot assign or transfer your right to receive payment for Covered Services under this Policy.

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

UPMC Health Plan will not honor a request to 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 an employee under one plan and as a dependent under another, the member coverage pays first.
- When the dependent child is covered under two plans, the plan covering the parent whose birthday occurs earlier in the calendar year pays first. If both parents have the same birthday, then the plan under which one parent was covered longest pays first.
- If the dependent child’s parents are separated or divorced and:
 - The parent with custody of the child has not remarried; the coverage of the parent with custody pays first.
 - The parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent’s coverage, if any, pays before the coverage of the parent without custody.
 - There is a court order that specifies the parent who is financially responsible for the child’s health care expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage that you have had the longest 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.

UPMC Health Plan is not required to determine whether or not 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, Point Park University, 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 legal remedies available to it to obtain full and complete reimbursement.

Subrogation applies to all insurance policies and all other sources of recovery to the extent permitted 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.

Resolving Disputes with UPMC Health Plan

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

The complaint process

If you have a dispute or objection regarding a provider, the coverage, operations, or management policies of UPMC Health Plan, you may submit a Complaint to UPMC Health Plan. You may submit a Complaint about issues, including, but not limited to, quality of care or service, benefits exclusions, claim denials, or coordination of benefits.

You may either file a Complaint verbally over the phone with the Member Services Department or by sending a written Complaint to P.O. Box 2939, Pittsburgh, PA 15230-2939. You may also send any other written information that you have to support your Complaint. You may indicate in the Complaint the remedy, resolution, or corrective action that you seek 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 the Health Plan's decisions regarding your Complaint.

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

A First Level Complaint Review Committee will investigate the allegations in your Complaint. 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 and explain the process by which you may request a second level review of the decision.

You have 60 days from the date of a First Level Complaint Review Committee decision letter, to request a second level review. If you choose not to request a second level review within that time frame, the decision of the First Level Review Complaint Committee will be final.

If you submit a second level Complaint, we will send you a letter to let you know that we received your Complaint and to let you know the date and time for your Second Level Complaint Review Committee meeting. UPMC Health Plan will give you at least 15 days notice of the meeting. UPMC Health Plan will also explain the meeting procedure and your rights at the meeting. You and/or your representative have the right, but are not required, to attend the Second Level Complaint Review Committee meeting. The meeting will be held at the offices of UPMC Health Plan. If you or your representative cannot appear in person at the second level complaint review, we will provide you with the opportunity to participate in the review by telephone or other appropriate and available means and will be as flexible as is reasonably possible in facilitating your participation.

The Second Level Complaint Review Committee will issue a decision in writing to you and your representative no more than 5 business days after the date of the meeting. The decision letter will explain the decision.

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. A Grievance may be filed by you, your designated representative, or a provider who has your written consent. We will refer to a provider who has your written consent to file a Grievance as “your provider.”

You may either file a Grievance verbally over the phone with the Member Services Department or by sending a written Grievance to P.O. Box 2939, Pittsburgh, PA 15230-2939. You may also send any other written information to support your Grievance. You may indicate 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 UPMC Health Plan in writing that you are designating someone to represent you. Also, at any time during the Grievance process, upon your request, UPMC Health Plan can make available, at no charge, a UPMC 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.

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

A First Level 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.”

The Committee will notify you of its decision within 30 days of receipt of your Grievance. The notification letter will explain the decision and explain the process to request a second level review of that decision. A copy of the decision letter will be sent to you and/or your representative and/or your provider, as applicable.

You, your representative, or your provider has 60 days from receipt of the First Level Complaint Review Committee’s decision letter to submit a second level review. If you choose not to request a second level complaint review within that time frame, the decision of the First Level Review Committee will be final.

If you submit a second level Grievance, we will send you a letter to let you know that we received your Grievance and to let you know the date and time for your Second Level Grievance Review Committee meeting. UPMC Health Plan will give you at least 15 days notice of the meeting. UPMC Health Plan will also explain the meeting procedure and your rights at the meeting. You, your representative, or your provider has the right, but is not required, to attend the Second Level Grievance Review meeting. The meeting will be held at the offices of UPMC Health Plan. If you, your representative, and/or your provider cannot appear in person at the second level review, we will provide you, your representative, and your provider the opportunity to communicate with the review committee by telephone or other appropriate and available means and will be as flexible as is reasonably possible in facilitating your participation.

The Second Level Grievance Review Committee will issue a written decision to you, your representative, or your provider, as applicable, no more than 5 business days after the date of the meeting. The decision letter will explain the decision and also include an explanation of the procedure to request an external Grievance.

Important information regarding the grievance processes

- Your provider may request your 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 the denial notification to file the Grievance. Your provider does not need to inform you if and when he/she/it files the Grievance; however, your provider must inform you if he/she/it decides NOT to file the Grievance.
- Your consent is automatically rescinded if your provider fails to file a Grievance or fails to continue to prosecute the Grievance through the Second Level of the Grievance process 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.

The 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 Member Services 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. UPMC Health Plan then will arrange to have the Grievance reviewed within 48 hours. UPMC Health Plan will inform you of the decision orally and in writing.

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

- If we cannot accommodate you or the committee members as to time and distance to be present at the review, we may hold the review by telephone or other appropriate and available means. We will ensure that all appropriate information is read into the record.
- You must provide any additional information for consideration in an expedited manner so we can comply with the requirements for an expedited review.
- The committee will issue a decision within 48 hours of receipt of the request for review, accompanied by the provider certification described above.

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.
- Point Park University no longer contracts for coverage with UPMC Health Plan. If Point Park University decides to terminate its contract with us, it is the University's responsibility to tell you that your coverage will terminate.
- UPMC Health Plan reasonably establishes that you have committed fraud or made a material misrepresentation in information submitted to UPMC Health Plan or in obtaining or using services under this Policy. This includes improper use of your ID card, such as allowing another person to use your card to obtain health care services.

Certificates of Creditable Coverage

UPMC Health Plan will provide you with a Certificate of Creditable Coverage if you lose your health care coverage. This Certificate gives you evidence of your prior health benefit coverage. The Certificate is mailed to you automatically when your health care coverage is terminated. You can also request a certificate from UPMC Health Plan.

What are my benefits after termination?

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 another group benefit plan, whichever occurs first.

General Provisions

Your contract with UPMC Health Plan

By enrolling in UPMC Health Plan or accepting benefits hereunder, you shall be deemed to have agreed to all terms and conditions of this Policy. UPMC Health Plan's liability under this Policy is limited to the 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.

As a UPMC Health Plan member, 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 Point Park University without your consent. UPMC Health Plan shall have the right to amend this Policy to increase, reduce, or eliminate any of the benefits provided for herein for the purpose of complying with the provisions of any law, regulation, or mandate of a regulatory authority.

Fraud and abuse

UPMC Health Plan is committed to ensure 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 e-mail our Special Investigations Unit at 1-866-FRAUD01 or specialinvestigationsunit@upmc.edu.

UPMC Health Plan's relationship with providers

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

UPMC Health Plan makes no express or implied warranties or representations concerning the qualifications or continued participation of any Participating Provider. The choice to use a particular provider is solely your own. Participating Providers may be terminated 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.

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

UPMC Health Plan Member Services: 1-888-876-2756
TTY Services: 1-800-361-2629

UPMC HEALTH PLAN

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

www.upmchealthplan.com