Comprehensive Major Medical Exclusive Provider Organization Guaranteed Renewable Policy for Individuals Utilizing the UPMC Health Options, Inc., Exclusive Provider Organization Network of Providers, Without a Referral Required
[UPMC *Advantage*]
Identified as [UPMC *Advantage*]
UPMC HEALTH OPTIONS, INC. (hereafter referred to as " UPMC Health Plan")
A Pennsylvania corporation whose address is
[U.S. Steel Tower, 600 Grant Street, Pittsburgh, Pennsylvania 15219]

INDIVIDUAL GUARANTEED RENEWABLE/[PREMIUM SUBJECT TO CHANGE]

Required Outline of Coverage for Policy Form 672

A. ***Read this Policy carefully*** – This Outline of Coverage provides a brief description of the important features of this health insurance policy. This is not the Policy and only the actual Policy provisions are applicable. The Policy itself sets forth in detail the contractual rights and obligations of both Insured and the Health Plan. **Please read this policy carefully!**

B. ***Guaranteed Renewable Comprehensive Major Medical Expense Coverage*** – This policy provides guaranteed renewable comprehensive major medical coverage for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital care, surgical services, anesthesia services, in-hospital medical services, out of hospital care, prosthetic appliances, durable medical equipment, preventive services, emergency services, and transplant services, subject to all Deductibles, Coinsurance, Copayments, and other limitations as set forth in the Policy.

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

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

The terms of this Policy will be in effect for you and your dependents after you pay the premiums for the duration of time that the premium covers. This Policy does not divide or give back any excess premiums to its members.

C. Brief overview of the Covered Services contained in the Policy (descriptions of the services and limitations are found in the Policy)

- Routine and preventive services
- Colorectal cancer screening
- Lung cancer screening
- Women's care
- Hospital services
- Maternity services
- Emergency services
- Ambulance services
- Physician/surgical services
- Inpatient medical services
- Convenience care

- Urgent care
- eVisit
- Pediatric dental services
- Pediatric vision services
- Outpatient medical care
- Allergy services
- Diagnostic services
- Rehabilitative and habilitative therapy services
- Medical therapy services
- Therapy services
- Cancer treatment
- Pain management programs
- Behavioral health services
- Substance abuse services
- Acupuncture
- Corrective appliances
- Durable medical equipment (DME)
- Emergency dental services related to accidental injury
- Fertility testing
- Home health care
- Hospice care
- Nutritional counseling and medical nutrition therapy
- Nutritional products
- Podiatry care
- Skilled nursing facility services
- Therapeutic manipulation/Chiropractic care
- Diabetic equipment, supplies, and education
- Prescription drugs
- Clinical trials and research studies
- Lifestyle Modification Program for Reversing Heart Disease
- Transplantation services
- Vision services for a medical condition

D. Benefit Durations, Limits, and Cost-Sharing for Covered Services listed in the Policy

1. **Benefit Period** – The specified period of time (for which Insured is eligible for coverage) during which charges for Covered Services must be incurred in order to be eligible for payment by UPMC Health Plan. A charge shall be considered incurred on the date an Insured receives the service or supply.

2. Reasonable and Customary Charge – For a Covered Benefit or Covered Service rendered by a Participating Provider, the Reasonable and Customary Charge is the amount agreed upon by UPMC Health Plan and the provider pursuant to a negotiated agreement. For the services authorized by UPMC Health Plan that are provided by a Non-Participating Provider, the Reasonable and Customary Charge is the amount that UPMC Health Plan determines is reasonable for Covered Services pursuant to industry standards. The percentage of the Reasonable and Customary Charge stated in the Schedule of Benefits is UPMC Health Plan's payment responsibility.

3. Payment of Benefits – After UPMC Health Plan determines the **Reasonable and Customary Charge** for Covered Services provided to the Insured by a particular type of provider, UPMC Health Plan applies all of the Insured's Deductible, Copayments, and Coinsurance amounts to the Reasonable and Customary Charge to determine the benefit amount payable by UPMC Health

Plan.

a. Participating Provider – The Reasonable and Customary Charge is the amount agreed to by the Participating Provider subject to all Insured's Deductibles, Coinsurance, and Copayments. Participating Providers accept this amount as payment in full.
b. Non-Participating Provider – Non-Participating Providers are those providers that do not have a contract with UPMC
Health Plan. Except as otherwise set forth herein, payment to these providers will be the responsibility of the Insured. No payment is made by UPMC Health Plan to Non-Participating Facility Providers.

E. SCHEDULE OF BENEFITS FOR UPMC HEALTH PLAN, INC.

UPMC HEALTH PLAN

Schedule of Benefits

Marketing Portfolio Name [ ]

Marketing Plan Name [ ]

[EPO]
Deductible: [ ]/[ ]
Coinsurance: [ ]
Total Annual Out-of-Pocket: [ ]/[ ]

Primary Care Provider: [ ]
Specialist: [ ]
Emergency Department: [ ]
Rx: [ ]

This document is your Schedule of Benefits. If you enroll in this plan, this Schedule of Benefits will be an important part of your Policy. Your Policy describes in detail the services your plan covers, while the Schedule of Benefits describes what you pay for those services.

For Covered Services to be paid at the level described in your Schedule of Benefits, they must be Medically Necessary. They must also meet all other criteria described in your Policy. Criteria may include Prior Authorization requirements.

Please note that your plan may not cover all of your health care expenses, such as copayments and coinsurance. To understand what your plan covers, review your Policy. You may also have service area documents that expand or restrict your benefits.

If you have any questions about your benefits, or would like to find a Participating Provider near you, visit **www.upmchealthplan.com**. You can also call UPMC Health Plan Member Services at the phone number on the back of your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider
Benefit Period	Calendar Year
Primary Care Provider (PCP) Required	Encouraged, but not required
Pre-Certification Requirements	Provider Responsibility

Member Cost Sharing	Participating Provider
Annual Deductible	
Individual	[ ]
Family	[ ]
[Your plan has an embedded Deductible, which means the plan pays for covered benefits in these two scenarios — whichever comes first: *When an individual within a family reaches his or her individual Deductible. At this point, only that person on the plan is considered to have met the Deductible; OR *When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible.]	
Deductible applies to all Covered Services you receive during the Benefit Period, unless that service is specifically	

Member Cost Sharing	Participating Provider
Coinsurance	
	[ ]
	Copayments may apply to certain Participating Provider services.
Total Annual Out-of-Pocket Limit	
Individual	[ ]
Family	[ ]
[Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit is satisfied in one of two ways — whichever comes first: *When an individual within a family reaches his or her individual Out-of-Pocket Limit. At this point, only that person will have benefits covered at 100% for the remainder of the Benefit Period; OR *When a combination of family members' expenses reaches the family Out-of-Pocket Limit. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and will have benefits covered at 100% for the remainder of the Benefit Period.]	
Out-of-Pocket costs such as Copayments, Coinsurance, and Deductibles apply toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits.	

Preventive Services	Participating Provider
Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.	
Pediatric Care and Immunizations	
Preventive/health screening examination	[ ]
Pediatric immunizations	[ ]

Well-baby visits	[ ]
Pediatric dental services	[ ]
Pediatric vision services	[ ]
Adult Care and Immunizations	
Preventive/health screening examination	[ ]
Adult immunizations required by the ACA to be covered at no cost-sharing	[ ]
Women's Care	
Screening gynecological exam	[ ]
Screening Pap test and screening mammogram	[ ]

Covered Services	**Participating Provider**
Hospital Services	
Semi-private room, private room (if Medically Necessary and appropriate), surgery, pre-admission testing	[ ]
Outpatient/ambulatory surgery	[ ]
Observation stay	[ ]
Maternity	[ ]
Emergency Services	
[If you would like to speak to a registered nurse about a specific health concern, call our MyHealth Advice Line at 1-866-918-1591. Members may also submit email inquiries using the Web Nurse Request system available at www.upmchealthplan.com.]	
Emergency department	[ ]
Emergency transportation	[ ]
Urgent care facility	[ ]
Physician Surgical Services	
	[ ]
Provider Medical Services	
Inpatient medical care visits, intensive medical care, consultation, and newborn care	[ ]
Adult immunizations not required to be covered by the ACA	[ ]
Primary care provider office visit	[ ]
Specialist office visit	[ ]
Convenience care visit	[ ]
eVisit	[ ]
Allergy Services	
Treatment, injections, and serum	[ ]
Diagnostic Services	
Advanced imaging (e.g., PET, MRI, etc.)	[ ]
Other imaging (e.g., x-ray, sonogram, etc.)	[ ]
Lab	[ ]

Diagnostic testing	[ ]
Rehabilitation/Habilitation Therapy Services	
Physical and occupational therapy	[ ]
	[Covered up to 30 visits per Benefit Period for both therapies combined.]
Speech therapy	[ ]
	[Covered up to 30 visits per Benefit Period.]
Cardiac rehabilitation	[ ]
	[Covered up to 12 weeks per Benefit Period.]
Pulmonary rehabilitation	[ ]
	[Covered up to 24 visits per Benefit Period.]
Covered Services	**Participating Provider**
Medical Therapy Services	
Chemotherapy, radiation therapy, dialysis therapy	[ ]
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	[ ]
Pain Management	
Pain management program	[ ]
Behavioral Health and Substance Abuse Services [Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083]	
Inpatient (e.g., detoxification, etc.)	[ ]
Inpatient non-hospital residential services	[ ]
Outpatient (e.g., rehabilitation, therapy, etc.)	[ ]
Other Medical Services	
Acupuncture	[ ]
	[Covered up to 12 visits per Benefit Period.]
Corrective appliances	[ ]
Dental services related to accidental injury	[ ]
Durable medical equipment	[ ]
Fertility testing	[ ]
Home health care	[ ]
	[Benefit Limit of 60 days per Benefit Period.]
Hospice care	[ ]
Medical nutritional therapy	[ ]
	[Refer to Policy for specific Benefit Limitations.]
Nutritional counseling	[ ]
	[Limited to two visits per Benefit Period. Refer to the Policy for specific Benefit Limitations.]
Nutritional products	[ ]
	[Refer to the Policy for specific Benefit Limitations. Nutritional Supplements for the treatment of PKU and related disorders are covered at 100%, not subject to Deductible.]
Oral surgical services	[ ]
	[Refer to Policy for specific Benefit Limitations.]

Podiatry care	[ ]
	[Refer to the Policy for specific Benefit Limitations.]
Skilled nursing facility	[ ]
	[Benefit limit of 120 days per Benefit Period.]
Therapeutic manipulation	[ ]
	[Benefit Limit of 20 visits per Benefit Period. Prior authorization must be obtained for dependent children 13 years of age or younger.]
Diabetic Equipment, Supplies, and Education	
Diabetic equipment and supplies	
Glucometer, test strips, and lancets, insulin and syringes	[Must be obtained at a Participating Pharmacy. See applicable Prescription Schedule of Benefits for coverage information.]
Diabetic education	[ ]

Prescription Drug Coverage

For additional information on your pharmacy benefits, please reference your Prescription Drug Schedule of Benefits.

The Advantage Choice pharmacy program will apply (mandatory generic).

[ ]

[ ]

Retail prescription drug • Prescriptions must be dispensed by a participating pharmacy • 30-day supply	[ ] [ ] [ ] 90-day maximum retail supply available for 3 copayments
Specialty prescription drug • Specialty medications are limited to a 30-day supply • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request)	[ ] 30-day maximum supply
Mail-order prescription drug • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy	[ ] [ ] [ ] 90-day maximum mail-order supply
If the brand-name drug is dispensed instead of the generic equivalent, you must pay the copayment associated with the brand-name drug as well as the price difference between the brand-name drug and the generic drug.	

[The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your Policy. Also, the headings under the Covered Services section are the same as those in your Policy.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail.

Your plan documents will always include the Schedule of Benefits, the Policy, and the Summary of Benefits and Coverage (SBC). You'll find your documents at **www.upmchealthplan.com**. If you have questions, call Member

Services.

In this document, the term "UPMC Health Plan" refers to benefit plans offered by UPMC Health Network, Inc., UPMC Health Options, Inc., UPMC Health Coverage, Inc. and/or UPMC Health Plan, Inc.]

UPMC Health Plan
U.S. Steel Tower 600 Grant Street
Pittsburgh, PA 15219
www.upmchealthplan.com

F. Exceptions, Reductions, and Limitations of the Policy

1. Medical Necessity or Medically Necessary – Health care services covered under Insured's benefit plan must be determined by UPMC Health Plan to be:
   - Commonly recognized throughout the provider's specialty as appropriate for the diagnosis and/or treatment of the Insured's condition, illness, disease, or injury.
   - Provided in accordance with standards of good medical practice and consistent with scientifically based guidelines of medical, research, or health care coverage organizations, or governmental agencies that are accepted by UPMC Health Plan.
   - Reasonably expected to improve an individual's condition or level of functioning.
   - In conformity, at the time of treatment, with medical management criteria/guidelines adopted by UPMC Health Plan or its designee.
   - Provided not only as a convenience or comfort measure or to improve physical appearance.
   - Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

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

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

   A. The intervention does not have FDA approval to be marketed for the specific relevant indication(s); or
   B. 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
   C. 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
   D. The intervention has not been shown to improve health outcomes; or
   E. The effectiveness of the intervention has not been replicated outside of the research setting.

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

2. Managing Health Care – Certain Covered Services require Prior Authorization from UPMC Health Plan's Medical Management Department. This means that the Insured, along with his or her attending provider must

obtain approval for coverage of these services from UPMC Health Plan **before** services are received. All Health Plan Participating Providers are educated about Prior Authorization.

3. Outpatient Prescription Drug Coverage from Pharmacy Providers – Prescription drugs can be purchased from a Participating Pharmacy or through a mail-order program. The Insured is responsible for any cost-sharing up to benefit maximums outlined in the Prescription Schedule of Benefits. There is no coverage provided for prescription drugs purchased at a Non-Participating Provider.

4. **Exclusions**

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

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

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

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

4. **Behavioral Health Services:** The following behavioral health services (unless provided elsewhere in this Policy):
    a. Any psychotherapy, psychiatric care, or treatment services for mental health or substance use that are court- ordered, unless such services are Medically Necessary.
    b. Inpatient or outpatient treatment related to mental retardation or pervasive developmental disorder or autism, which extends beyond traditional medical management.
    c. Eligibility for and maintenance of Social Security disability benefits does not determine whether UPMC Health Plan will cover specific behavioral health or substance abuse treatment services. Medical necessity criteria will be used to determine whether specific treatment services are covered.
    d. Any treatment/services related to personal or professional growth/development, educational or professional training or certification, or treatment services required for investigative purposes related to employment.
    e. Any services necessary to obtain or maintain employment or insurance or for judicial or administrative proceedings, including, but not limited to, adjudication of marital, child support, or custody cases.
    f. Methadone maintenance for the treatment of chemical dependency.
    g. Marriage or family counseling, unless such services are Medically Necessary.
    h. Chronic maintenance therapy, unless such services are Medically Necessary. Medical Necessity criteria will be used to determine whether specific treatment services are covered.
    i. Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies, such as art or psychodrama, and hyperbaric or other therapy.
    j. Sex therapy without a diagnosis as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
    k. Sedative action electrostimulation therapy.
    l. Sensitivity training.
    m. Twelve-step model programs as sole therapy for conditions, including, but not limited to, addictive gambling.

n. Twelve-step model programs as sole therapy for conditions, including, but not limited to, addictive gambling.
o. Truancy or disciplinary problems not associated with a treatable mental disorder.
p. Psychoanalysis or other therapies that are not short-term or crisis-oriented, unless such services are Medically Necessary. Medical Necessity criteria will be used to determine whether specific treatment services are covered.
q. Psychological and neuropsychological testing for learning disabilities or problems, other school-related issues, to obtain or maintain employment, to submit a disability application for a mental or emotional condition, and any other testing that does not require administration by a behavioral health professional, including self-test reports.
r. Intensive health coaching services, resource coordination activity, behavioral health rehabilitation services for children and adolescents, and summer camp programs are not covered services.
s. Respite services.

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

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

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

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

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

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

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

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

in an illegal act or occupation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31. **Nutritional Supplements:** Blenderized food, baby food, or regular shelf food when used with an enteral system; milk- or soy-based infant formula with intact proteins; any formula, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance; oral semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; food

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G. Terms and Conditions of the Policy

1. Guaranteed Renewable – UPMC Health Plan may adjust premiums after getting approval from the Pennsylvania Insurance Department. You will be notified in advance of any change in your premium. The Policy will remain in effect each month as long as you pay your premium. UPMC Health Plan will not terminate your Policy because of the deterioration of your mental or physical health, or that of any individual covered under this Policy.

2. Termination – There are a few reasons why your coverage with UPMC Health Plan may terminate. In addition, there are a few specific reasons for which your coverage with UPMC Health Plan may be rescinded. Please note that your coverage under this Policy will not be terminated or rescinded because of your health status or requirements for health services. This plan is guaranteed renewable and can only be terminated or rescinded by UPMC Health Plan in certain circumstances, including but not limited to those listed below:
    A. You may terminate your own coverage if you provide UPMC Health Plan with written notice of your intent to terminate. Termination may be effective on the last day of the month in which you make the request, or the last day of the next month. Requests for retroactive terminations will not be accepted.
    B. UPMC Health Plan may terminate this Policy in the following instances:
        - You are no longer an eligible dependent. In this case your coverage will terminate at the end of the policy year.

- You fail to pay your required premium contribution to UPMC Health Plan, subject to the grace period.
- You no longer live in UPMC Health Plan's Service Area.
- UPMC Health Plan intends to discontinue service in your Service Area and provides you with 180 days' written notice.
- UPMC Health Plan has credible evidence that you committed fraud or made a material misrepresentation in information submitted to UPMC Health Plan or in obtaining or using services under this Policy. This includes improper use of your ID card, such as allowing another person to use your ID card to obtain health care services.

C. UPMC Health Plan may rescind this Policy only where it has credible evidence that you (or a dependent) have committed fraud or intentionally misrepresented a material fact.

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

3. Conversion Privilege

In the event a Dependent becomes ineligible for coverage under this plan due to divorce or legal separation or reaching the maximum age (for children), coverage under the plan shall terminate. However, such Dependent may apply within thirty (30) days of such loss of eligibility as an individual policyholder under this benefit plan, without evidence of insurability.

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

4. Guaranteed Renewable/Premium Subject to Change

UPMC Health Plan may adjust premiums after getting approval from the Pennsylvania Insurance Department. You will be notified in advance of any change in your premium. The Policy will remain in effect each month as long as you pay your premium. UPMC Health Plan will not terminate your Policy because of the deterioration of your mental or physical health or that of any individual covered under this Policy. Subject to the right of UPMC Health Plan to terminate coverage and to any amendment permitted under applicable law, this Policy will remain in effect continually until you terminate it, or UPMC Health Plan terminates your coverage in accordance with Section 2. Termination or Rescission of Coverage.

5. Time Limit on Certain Defenses

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