

UPMC Health Plan

<http://www.upmchealthplan.com>

UPMC HEALTH PLAN
Where you belong.

2007

A Health Maintenance Organization (high option) and a High Deductible Health Plan

Serving: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington and Westmoreland.

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 9 for requirements.

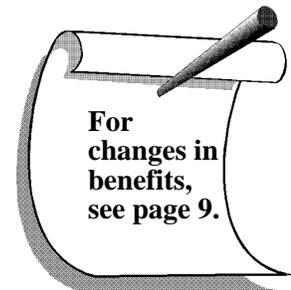
Enrollment code for this Plan:

8W1 High Option Health Maintenance Organization (HMO) – Self Only

8W2 High Option Health Maintenance Organization (HMO) – Self and Family

8W4 High Deductible Health Plan (HDHP) – Self Only

8W5 High Deductible Health Plan (HDHP) – Self and Family



This Plan has NCQA accreditation with a rating of Excellent. See the 2005 Guide for more information on accreditation.

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

**Important Notice from UPMC Health Plan About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the UPMC Health Plan prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of under our contract (CS 2856) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

UPMC Health Plan

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-888-876-2756 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

Ø www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option HMO or a High Deductible Health Plan (HDHP).

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Option HMO

Under the High Option HMO, you select a PCP from among the thousands of doctors who participate in the UPMC Health Plan network. You and each of your enrolled family members may select a different PCP. The goal of the PCP is to keep you and your family healthy, not merely to treat you when you are sick.

Female members may go to any obstetrician or gynecologist in our network for any female related services, not just routine annual exams. Referrals to specialists are not required.

You pay a copayment each time you visit the doctor. Most other medical and surgical services are covered at 100% as long as you use a Plan provider. These benefits include inpatient and outpatient hospital services, diagnostic services, medical therapy (such as radiation and dialysis), and other services prescribed by a participating physician such as home health care or durable medical equipment and supplies.

The High Option HMO covers emergency medical services at any medical facility, whether or not that medical facility participates in the UPMC Health Plan network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayment.

Preventive care services

Preventive care services are paid at 100% after a copayment.

General features of our High Deductible Health Plan (HDHP) Option

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the in-network benefits in this brochure. These Plan providers accept a negotiated payment from us.

Preventive care services

Preventive care services are paid as first dollar coverage when services are received from a Plan provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.

- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$4,000 for Self Only enrollment/\$8,000 self and family coverage when services are received from Plan providers; or \$5,500 for Self Only enrollment/\$11,000 Self and Family coverage when services are received from non-Plan providers.

Health education resources and accounts management tools

We publish periodic newsletters to keep you informed on a variety of issues related to your good health. The newsletter is mailed to your home.

Visit our Web site at www.upmchealthplan.com for information on:

- **General health topics**
- **Links to health care news**
- **Cancer and other specific diseases**
- **Drugs/medication interactions**
- **Kids' health**
- **Patient safety information**
- **and several helpful Web site links.**

For each HSA and HRA account holder, we maintain a complete claims payment history online through www.upmchealthplan.com

Your balance will also be shown on your explanation of benefits (EOB) form.

You will receive an EOB after every claim.

If you have an **HSA**,

- You will receive a outlining your account balance and activity for the month.
- You may also access your account on-line at www.hsamember.com

If you have an **HRA**,

- Your HRA balance will be available online through www.upmchealthplan.com
- Your balance will also be shown on your EOB form.

Your rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence – 10 years
- Profit status – Non-profit

If you want more information about us, call 1-888-876-2756, or write to us at UPMC Health Plan Member Services, One Chatham Center, 112 Washington Place, Pittsburgh, PA 15219. You may also contact us by fax at 412-454-2519 or visit our Web site at www.upmchealthplan.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington and Westmoreland counties.

Under the High Option HMO, typically you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval. Under the HDHP option, there are out-of-network benefits available if you receive care from providers who do not contract with us.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 How we change for 2007

Do not rely on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to our High Option Health Maintenance Organization (HMO)

- Your share of the non-Postal premium will increase by 6.7% for Self Only or 5.8% for Self and Family.
- Referrals to specialists are no longer required. Specialist office visits have a \$20 copayment per visit, regardless of whether or not you have obtained a referral.
- Adult routine physical examinations have a \$10 copayment per visit.
- Pediatric routine physical examinations have a \$10 copayment per visit.
- Well-baby office visits have a \$10 copayment per visit.
- Women's routine gynecological examinations have a \$10 copayment per visit.
- Physician office visits for illness or injury have a \$20 copayment per visit.
- Physical, speech, and occupational therapy have a \$20 copayment per visit.
- Therapeutic manipulation (chiropractic) has a \$25 copayment for the first visit, then a \$20 copayment for each subsequent visit.
- Outpatient mental health services have a \$20 copayment per visit.
- Specialty drugs now have a \$40 copayment for a 30-day supply.
- Retail pharmacy Plan providers now include Eckerd, K-mart, Rite Aid, Sam's Club, Target, Wal-Mart, and Walgreens. Giant Eagle and certain independent pharmacies will continue to be Plan providers. Express Scripts is the pharmacy benefits manager for retail and mail order pharmacy benefits.

Changes to our High Deductible Health Plan (HDHP)

This plan is new to the FEHB program. The HDHP is offered for the first time during the 2006 Open Season.

Section 3. How you get care

Identification cards We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-888-876-2756 or write to us at UPMC Health Plan Member Services, One Chatham Center, 112 Washington Place, Pittsburgh, PA 15219. You may also request replacement cards through our Web site: www.upmchealthplan.com

Where you get covered care You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance. If you enroll in the HDHP, you can also get care from non-Plan providers, but it will cost you more.

- **Plan providers** Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site. Plan providers are also referred to as Participating providers and In-network providers in this brochure.

- **Plan facilities** Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site. Plan facilities are also referred to as Participating providers, Plan providers and In-network providers in this brochure.

What you must do to get covered care It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care** Your primary care physician can be an internist, pediatrician, family practitioner, or general practitioner. Your primary care physician will provide most of your health care, or refer you to a specialist. We encourage you to build a long-term relationship with your primary care physician. Your primary care physician performs routine and preventive care, and coordinates specialist care. Most important, your primary care physician is in the best position to become familiar with your medical profile. Women may select an ob/gyn to provide or coordinate all covered gynecological/obstetrical care. However, women are not required to see the same ob/gyn on a regular basis.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care** Your primary care physician will refer you to a specialist for needed care. However, a referral is not required to see a specialist.

Here are some other things you should know about specialty care:

If you are seeing a specialist when you enroll in our Plan and your current specialist does not participate with us, you must receive treatment from a specialist who does. If you are enrolled in the HMO option, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who can recommend another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are hospitalized when your enrollment begins

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-888-876-2756. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment .

How to get approval for...

• **Your hospital stay**

Plan providers are responsible for contacting us to obtain the approval. If you are admitted to a non-Plan facility, you need to contact us at 1-888-876-2756.

• **How to precertify an admission**

Plan providers are responsible for contacting us to pre-certify. If you are admitted to a non-network facility, you need to contact us at 1-888-876-2756 to pre-certify your hospital stay.

• **Maternity care**

You do not need to pre-certify a normal delivery at a network facility.

What happens when you do not follow the precertification rules when using non-network facilities

If you enrolled in the HMO, you are responsible for the cost of any admission to a non-network facility except for emergency care and specialized care that has been pre-certified by UPMC Health Plan because the necessary care is not available from a Plan provider.

If you enrolled in the HDHP, a \$500 penalty applies when you use a out-of-network facility that has not been pre-certified, except for emergency care or highly specialized care that has been pre-certified by UPMC Health Plan because the necessary care is non available from a network provider.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior authorization. Your physician must obtain prior authorization for:

- Abdominoplasty/Panniculectomy
- Bone Growth Stimulator, Non-Invasive
- Breast Reduction (Female only, excluding Reconstruction for Breast Cancer)
- Carotid Angioplasty with Stenting
- Endovascular Stent for Abdominal Aortic Aneurysm
- Enteral/Parenteral Feedings/Nutritional Supplements
- Lymphedema Pumps and Appliances
- Microprocessor Knee (C Leg)
- Negative Pressure Wound Therapy
- Private Duty Nursing
- Rhinoplasty/Septoplasty
- Organ Transplants

Bone Marrow

Stem Cell

Solid Organ

- Weight Reduction Surgery
- Wheelchair Accessories, Repairs, Replacement
- Hospital Admissions (Elective and Acute, excludes Deliveries)
- Extended Care Facility Admissions
- Rehabilitation Facility Admissions
- Skilled Nursing Facility (SNF) Admissions
- Therapeutic manipulation (chiropractic care) for children under age 13
- Growth Hormones and certain other prescription drugs (contact us at 1-888-876-2756 or visit www.upmchealthplan for a current list of prescription drugs that require prior authorization)

If you are considering an artificial insemination procedure, see requirements on page 23 or 66.

Section 4 Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: Under the HMO option, you pay a copayment of \$20 when you visit a physician for an illness or injury.

Deductible(applies to HDHP option only)

A deductible is a fixed expense you must incur for covered services and supplies before we start paying benefits for them.

- The calendar year deductible under the HDHP is \$2,500 for self enrollment. Under a self and family enrollment, the deductible under the HDHP is \$5,000. The family deductible must be met by one or more members of the family before any benefits will be paid. The deductible is combined for services received from both Plan and non-Plan providers.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance(applies to HDHP option only)

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance applies only for services received from non-Plan providers under the HDHP.

Example: In our Plan, you pay 20% of our allowance for services received from non-Plan providers. Except for preventive care, the deductible must be met before coinsurance begins

Differences between our Plan allowance and the bill (applies to HDHP option only)

Under the HDHP, if you receive care from non-Plan providers, benefits are paid at the out-of-network level. Except for preventive care, the deductible must be satisfied before benefits are paid. If you receive services from a non-Plan provider, you may also have to pay the difference between the provider's charge and the UPMC Health Plan's payment (reasonable and customary charge).

Your catastrophic protection out-of-pocket maximum(applies to HDHP option only)

Under the HDHP, after your out-of-pocket expense totals \$4,000 per person or \$8,000 per family enrollment in any calendar year, you do not have to pay any more for covered services when you utilize Plan providers. If you utilize non-Plan providers, you do not have to pay any more for covered services after your out-of-pocket expense totals \$5,500 per person or \$11,000 per family enrollment in any calendar year. The family out-of-pocket maximum, for Plan or non-Plan providers, must be met by one or more members of the family before benefits are payable at 100%. When you utilize non-Plan providers, you will continue to have to pay the difference between the provider's charge and the UPMC Health Plan's payment (reasonable and customary charge).

Carryover(applies to HDHP option only)

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

High Option Benefits

See page 10 for how our benefits changed this year. Page 115 is a benefits summary for the HMO option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5 High Option Benefits Overview

This Plan offers a High Option HMO benefit. Make sure that you review the benefits that are available under the option in which you are enrolled.

The HMO Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about HMO option benefits, contact us at 1-888-876-2756 or at our Web site at www.upmchealthplan.com.

The UPMC Health Plan High Option HMO offers the following unique features:

<ul style="list-style-type: none"> • HMO Option 	<p>We serve as a gateway to the University of Pittsburgh Medical Center (UPMC) and to our other quality network providers. Our affiliation with the UPMC makes us one of the nation’s few totally integrates health care delivery systems. This relationship gives us unique access to premier provider resources as well as to essential Health Plan member data not available to other non-integrated health insurance companies.</p> <p>The Accountable Provider model</p> <p>We work closely with our network physicians to determine the most effective health care practices for our members. UPMC Health Plan gives our physicians great flexibility in making decisions about your care. Moreover, we work together to with our physician partners ensure that you get the regular preventive care needed to maintain your health.</p> <p>Referrals to specialists are no longer required</p> <p>Your primary care physician will provide most of your health care, or refer you to a specialist. However, a referral is not required to see a specialist and you will not pay a higher copayment to see a specialist if you self-refer. We encourage you to build a long-term relationship with your primary care physician. Your primary care physician performs routine and preventive care, and coordinates specialist care. Most important, your primary care physician is in the best position to become familiar with your medical profile.</p>
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Section 5(a) Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.	
Diagnostic and treatment services	High Option
Professional services of physicians In physician’s office	\$20 per office visit (PCP or specialist)
Professional services of physicians In an urgent care center	\$20 per office visit
During a hospital stay	Nothing
In a skilled nursing facility	Nothing
Office medical consultations	\$20 per office visit
Second surgical opinion	\$20 per office visit
At home	Nothing
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing

Benefit Description	You pay After the calendar year deductible...
Preventive care, adult	High Option
Routine physical every 12 months which includes: Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	\$10 per visit to primary care physician Nothing Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	Nothing
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	Nothing
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Preventive care, children	High Option
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction 	\$10 per visit to primary care physician

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible...
Preventive care, children (cont.) High Option	
<ul style="list-style-type: none">- Ear exams through age 17 to determine the need for hearing correction- Examinations done on the day of immunizations (up to age 22)	\$10 per visit to primary care physician
Maternity care High Option	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none">• Prenatal care• Delivery• Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none">• You do not need to precertify your normal delivery• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
<i>Not covered:</i>	<i>All charges.</i>
Family planning High Option	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none">• Voluntary sterilization (See Surgical procedures Section 5 (b))• Surgically implanted contraceptives• Injectable contraceptive drugs (such as Depo provera)• Intrauterine devices (IUDs)• Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$20 per office visit
<i>Not covered:</i> <ul style="list-style-type: none">• <i>Reversal of voluntary surgical sterilization</i>• Genetic counseling	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
Infertility services	High Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) <p>For Artificial Insemination Procedures, you must utilize Plan providers who are credentialed by UPMC Health Plan in Reproductive Endocrinology. In the event that you do not have reasonable access to a Plan provider who is credentialed in Reproductive Endocrinology, you may submit a request to utilize another Plan provider.</p> <p>To obtain a list of Plan providers who are credentialed by UPMC Health Plan in Reproductive Endocrinology, please contact Member Services at 1-877-381-3764 or visit www.upmchealthplan.com. To request prior approval to utilize a Plan provider who is not Board Certified in Reproductive Endocrinology, please contact Member Services at 1-877-381-3764.</p>	\$20 per office visit
<p>Not covered:</p> <p>Assisted reproductive technology (ART) procedures, such as:</p> <ul style="list-style-type: none"> • in vitro fertilization • embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) <p>Services and supplies related to ART procedures</p> <p>Cost of donor sperm</p> <p>Cost of donor egg.</p> <p>Fertility drugs</p>	<i>All charges.</i>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$20 per office visit
<i>Allergy serum</i>	<i>Nothing</i>

Benefit Description	You pay After the calendar year deductible...
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 32.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	Nothing
Physical and occupational therapies	High Option
<p>Limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year, for speech, occupational and physical therapy combined.</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 weeks of sessions.</p>	<p>\$20 per office visit/outpatient visit</p> <p>Nothing for therapy received during a covered inpatient admission</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
Speech therapy	High Option
<p>Limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year, for speech, occupational and physical therapy combined.</p>	<p>\$20 per office visit/outpatient visit Nothing for therapy received during a covered inpatient admission</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>Speech therapy provided for developmental delays</i> 	<p><i>All charges</i></p>
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	<p>Nothing</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<p><i>All charges.</i></p>
Vision services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye examination once every 24 months for adults and once every 12 months for children <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>Nothing</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<p><i>All charges.</i></p>
Foot care	High Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>\$25 per office visit</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> 	<p><i>All charges.</i></p>

Foot care - continued on next page

Benefit Description	You pay After the calendar year deductible...
Foot care (cont.)	High Option
<ul style="list-style-type: none"> Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All charges.</i>
Orthopedic and prosthetic devices	High Option
<ul style="list-style-type: none"> Artificial limbs and eyes; stump hose Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> <p>Prosthetic replacements provided less than 3 years after the last one we covered</p>	<i>All charges</i>
Durable medical equipment (DME)	High Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> Oxygen; Dialysis equipment; Hospital beds; Wheelchairs; 	Nothing

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	
<ul style="list-style-type: none"> • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call us at 1-888-876-2756 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Motorized wheelchairs. • Repair, replacement or duplication except when necessitated due to a change in the patient's medical condition. 	<i>All charges.</i>
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. 	<i>All charges.</i>
Chiropractic	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities . Limited to 25 visits per calendar year. • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Children under the age of 13 must receive prior authorization for chiropractic care. 	\$25 for the first office visit, then \$20 for each visit thereafter.

Benefit Description	You pay After the calendar year deductible...
Alternative treatments	High Option
<i>Not covered:</i> <ul style="list-style-type: none">• Naturopathic services• Hypnotherapy• Biofeedback• Acupuncture	<i>All charges.</i>
Educational classes and programs	High Option
Coverage is limited to: <ul style="list-style-type: none">• Diabetes self management• Nutrition counseling for patients undergoing covered surgical treatment of morbid obesity (bariatric surgery)	\$20 per office visit

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions , limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary .
- Plan physicians must provide or arrange your care.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about t h ow cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital , surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>Nothing</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All Charges.</i>
Reconstructive surgery	High Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and • the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> • surgery to produce a symmetrical appearance of breasts; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All Charges.</i>

Benefit Description	You pay After the calendar year deductible...
Oral and maxillofacial surgery High Option	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges.</i>
Organ/tissue transplants High Option	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • <u>Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis</u> • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	Nothing
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma 	Nothing

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none">• Chronic myelogenous leukemia• Severe combined immunodeficiency• Severe or very severe aplastic anemia <p>Autologous transplants for</p> <ul style="list-style-type: none">- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia- Advanced Hodgkin’s lymphoma- Advanced non-Hodgkin’s lymphoma- Advanced neuroblastoma <p>Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</p> <p>Blood or marrow stem cell transplants for</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none">• Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)• Advanced forms of myelodysplastic syndromes• Advanced neuroblastoma of the central nervous system• Kostmann’s syndrome• Leukocyte adhesion deficiencies <p>Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy)</p> <ul style="list-style-type: none">• Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants)• Myeloproliferative disorders• Sickle cell anemia• Thalassemia major (homozygous beta-thalassemia) <p>Autologous transplants for</p> <ul style="list-style-type: none">• Multiple myeloma• Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors• Breast cancer• Epithelial ovarian cancer• Amyloidosis• Ependyoblastoma• Ewing’s sarcoma• Medulloblastoma	Nothing

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none">• Pineoblastoma <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for.</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none">• Chronic lymphocytic leukemia• Early stage (indolent or non-advanced) small cell lymphocytic lymphoma• Multiple myeloma <p>Nonmyeloablative allogeneic transplants for</p> <ul style="list-style-type: none">• Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia• Advanced forms of myelodysplastic syndromes• Advanced Hodgkin's lymphoma• Advanced non-Hodgkin's lymphoma• Breast cancer• Chronic lymphocytic leukemia• Chronic myelogenous leukemia• Colon cancer• Early stage (indolent or non-advanced) small cell lymphocytic lymphoma• Multiple myeloma• Myeloproliferative disorders• Non-small cell lung cancer• Ovarian cancer• Prostate cancer• Renal cell carcinoma• Sarcomas <p>Autologous transplants for</p> <ul style="list-style-type: none">• Chronic lymphocytic leukemia• Chronic myelogenous leukemia• Early stage (indolent or non-advanced) small cell lymphocytic lymphoma• Multiple sclerosis• Systemic lupus erythematosus• Systemic sclerosis	Nothing

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<p>UPMC Health Plan utilizes the top transplant centers in Western Pennsylvania . Should care not be available in Western Pennsylvania , UPMC Health Plan will arrange for services out of the area.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All Charges</i>
Anesthesia	High Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	\$10 per office visit

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies only when we say below: “(calendar year deductible applies)”.	
Inpatient hospital	High Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing \$100 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen 	Nothing
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools 	<i>All Charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	High Option
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Nothing
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits	High Option
Extended care benefit:	Nothing
Skilled nursing facility (SNF):	Nothing
<i>Not covered: Custodial care</i>	<i>All Charges.</i>
Hospice care	High Option
Supportive and palliative care is covered for terminally ill patients, either in the home or in a hospice facility. Services include inpatient and outpatient care, and family counseling. These services are provided under the direction of a physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>

Benefit Description	You pay
Ambulance	High Option
Local professional ambulance service when medically appropriate	Nothing

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area

If you feel you need emergency care and you are able, you should attempt to call your Primary Care Physician (PCP) to explain the symptoms and provide any other information necessary to help determine the appropriate action. You should go to the nearest emergency facility for the following situations:

- Your PCP tells you to
- You cannot reach your PCP or another physician and you believe that your health is in jeopardy

You have the right to summon emergency help by calling 911, any other emergency telephone number, and a licensed ambulance service without getting any prior approvals.

After your receive emergency room treatment or are admitted to the hospital, contact your PCP or our Member Services Department at 1-888-876-2756 within 48 hours.

Emergencies outside our service area

If you are outside of the Plan's service area (outside of Western Pennsylvania) at the time you need emergency care, you should seek emergency care immediately from the nearest emergency facility. You have the right to summon emergency help by calling 911, any other emergency telephone number, and a licensed ambulance service without getting any prior approvals.

After your receive emergency room treatment or are admitted to the hospital, contact our Member Services Department at 1-888-876-2756 within 48 hours.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital , including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$20 per doctor’s office visit</p> <p>\$20 per urgent care center visit</p> <p>\$50 per hospital emergency room visit</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>
Emergency outside our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$20 per doctor’s office visit</p> <p>\$20 per urgent care center visit</p> <p>\$50 per hospital emergency room visit</p>
<p>Not covered:</p> <p><i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i></p> <p><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></p>	<i>All Charges.</i>
Accidental injury	High Option
Ambulance	High Option
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Mental health and substance abuse benefits	High Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$20 per visit</p>
<p>Diagnostic tests</p> <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing Nothing</p>
<p>Not covered</p> <ul style="list-style-type: none"> • Any psychotherapy, psychiatric care, or treatment services for substance abuse or dependency which are court-ordered, unless such services are medically necessary and appropriate for the treatment of a treatable mental disorder (behavioral health or substance-related). 	<p><i>All Charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	High Option
<ul style="list-style-type: none">• Inpatient or outpatient treatment related to: mental retardation, pervasive developmental disorder, or autism, which extends beyond traditional medical management.• Treatment for personality disorders as the primary diagnosis, learning disabilities, or behavioral problems and those conditions for which an individual is eligible for Social Security disability benefits for a mental or emotional disability.• Any services related to disorders that are not treatable DSM-IV-TR defined mental disorders. Examples include, but are not limited to, nicotine dependence, caffeine intoxication, stuttering, tension headache, stress reactions, reading disorder, mathematics disorder, pathological gambling, disorder of written expressions, expressive/receptive language disorders, phonological disorder, developmental coordination disorder, learning disorders, sleep disorders, and V-codes.• Any treatment/services, including motivational training programs, related to personal or professional growth/development, educational or professional training or certification, or for investigative purposes related to employment.• Any services related to purposes of obtaining or maintaining employment, insurance or for purposes related to judicial or administrative proceedings such as adjudication of marital, child support, or custody cases.• Treatment for organic disorders, including, but not limited to organic brain disease.• Behavioral Health Services not expected to result in demonstrable improvement in the member's condition and/or level of functioning, and chronic maintenance therapy, except in the case of serious mental illness/ disorders.• Treatment for chronic behavioral conditions, once the individual has been restored to the pre-crisis level of function.• Treatment for stress and treatment for co-dependency.• Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder (behavioral health or substance related).• Treatment for chronic pain management programs or any related services.	<i>All Charges.</i>

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	High Option
<ul style="list-style-type: none"> • 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 oxygen therapy. • Acupuncture and accupressure for the treatment of behavioral health disorders. • Aromatherapy, Ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation and yoga. • Sex therapy, without a DSM-IV-TR diagnosis and treatment for sexual addiction. • Sedative action electrostimulation therapy. • Sensitivity training. • Twelve step model programs as sole therapy for problems such as eating disorders or addictive gambling. • Treatment or consultation provided by the members' parents, siblings, children, current or former spouse or domiciliary partner. • Truancy or disciplinary problems alone. • Psychoanalysis or other therapies that are not short-term or crisis-oriented. • Psychiatric/Psychological and Neuro-psychological testing for: a.) learning disabilities/problems; b.) school related issues; c.) the purposes of obtaining or maintaining employment; and d.) the purpose of submitting a disability application for a mental or emotional condition. • Long term residential treatment services for substance- related disorders such as substance abuse or substance dependency. <p>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</p>	<p><i>All Charges.</i></p>
<p>Preauthorization</p>	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>Call Western Behavioral Health at 1-888-251-0083 to locate a Plan provider and for assistance with required preauthorization.</p>

Limitation	We may limit your benefits if you do not obtain a treatment plan.
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Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a participating retail pharmacy, or by mail for maintenance and specialty drugs. Participating retail pharmacies include most national chains as well as many independent pharmacies. Call Member Services at 1-888-876-2756 or visit www.upmchealthplan for assistance in locating a participating pharmacy near you.
- **We use a formulary.** The *Your Choice* formulary applies. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. Most non-preferred brand name drugs are also included on the formulary, but you will pay a higher copayment for non-preferred brand name drugs. To request a prescription drug brochure, call Member Services at 1-888-876-2756. You can also visit www.upmchealthplan; our website includes a prescription drug look up feature. UPMC Health Plan makes changes to its formulary each January 1 and July 1. Changes are outlined in a newsletter we will mail to your home. You will be notified by a separate letter if the prescription drug you are taking is affected by a formulary change.
- **Certain prescription drugs require preauthorization.** Call Member Services at 1-888-876-2756 to request a prescription drug brochure or visit www.upmchealthplan for a current list of prescription drugs that require prior authorization.
- **These are the dispensing limitations.** Covered prescription drugs obtained at a participating retail pharmacy and specialty prescription drugs obtained through the Plan's specialty mail order pharmacy will be dispensed for up to a 30-day supply or one commercially prepared unit (e.g., one inhaler). Prescriptions for maintenance drugs obtained through the Plan's mail order pharmacy will be dispensed for up to a 90-day supply. Medications will be dispensed based on FDA guidelines.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available you have to pay the difference in cost between the name brand drug and the generic.

If your physician has specified "Dispense as Written" for a brand name drug when a generic is available, your physician must submit information to UPMC Health Plan stating that the brand name drug is medically necessary and the reasons why the generic equivalent was ineffective. If approved by UPMC Health Plan, you will pay the non-preferred brand name copayment for your brand name medication.
- **Why use generic drugs?** A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs, so the copayment is lower. You can lower your out-of-pocket expense by using generic drugs, when available.
- **When you do have to file a claim.** Members typically pay their copayment at the point of purchase. However, if there is a circumstance in which you pay the full cost out-of-pocket, you can be reimbursed by completing a prescription drug reimbursement form. You will be reimbursed 100% of the prescription cost less the applicable copayment as long as you used a participating pharmacy. Call Member Services at 1-888-876-2756 or visit www.upmchealthplan to obtain a prescription drug reimbursement form.

Benefit Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none">• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.• Insulin• Diabetic supplies limited to• Disposable needles and syringes for the administration of covered medications• Drugs for sexual dysfunction• Contraceptive drugs and devices	<p><u>Retail (up to a 30-day supply)</u></p> <p>\$10 copayment for generic drugs</p> <p>\$20 copayment for preferred brand name drugs</p> <p>\$40 copayment for non-preferred brand name drugs</p> <p><u>Specialty Prescription Drugs (up to a 30-day supply)</u></p> <p>\$40 copayment</p> <p><u>Mail Order (up to a 90-day supply)</u></p> <p>\$20 copayment for generic drugs</p> <p>\$40 copayment for preferred brand name drugs</p> <p>\$80 copayment for non-preferred brand name drugs</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p>Not covered:</p> <ul style="list-style-type: none">• Drugs and supplies for cosmetic purposes• Drugs to enhance athletic performance• Fertility drugs• Drugs obtained at a non-Plan pharmacy• Vitamins, nutrients, and food supplements even if a physician prescribes or administers the. These nutritional foods or formulas are not covered, except as medically necessary formulas that are equivalent to a prescription drug for the treatment of phenylketonuria (PKU) branched-chain ketonuria, galactosemia, and homocystinuria as administered under the direction of a physician.• Nonprescription medicines	<p><i>All Charges.</i></p>

Section 5(g) Special features

Feature	Description
Feature	High Option
Pediatric Advice Line (PAL)	UPMC Health Plan offers a Pediatric Advice Line (PAL). This service is for members with children age 18 or younger for use when their pediatrician's office is closed. PAL is available through a partnership with Children's Hospital of Pittsburgh and is staffed with pediatric registered nurses.
Services for hearing impaired members	UPMC Health Plan communicates by telephone with our hearing impaired members through TTY. If you are hearing impaired, call our TTY number at 1-800-361-2629.
High risk pregnancies	If your physician has identified your pregnancy as high risk, your physician may refer you to our case management department for care coordination. You may also self-refer by calling 1-888-876-2756 and ask to be connected with our care management area. You will be assigned to a UPMC Health Plan nurse case manager who can assist in coordinating your care with specialists, facilities and community resources.
Health Management Programs	<p>UPMC operates health management programs for members who have been diagnosed with diabetes, asthma, or heart disease. Based on the kinds of treatment you receive, we may contact you and suggest that you would benefit from one of these programs. Your participation is voluntary. Through our health management programs, we offer education, support, and other information that can help you manage your condition.</p> <p>We can contact your physician and other clinicians to help coordinate your care. We will send our notices to remind you about routine physicals, lab tests and other care. Our goal is to help you follow your physician's plan to maintain your health, help you better understand and manage your medical condition, and help you prevent complications.</p> <p>Your physician may call us and recommend that you participate in one of these programs, or you may call our Health Management Department directly at 1-866-778-6073 (TTY: 1-800-361-2629) if you are interested in participating.</p>
Healthy Living Rewards	<p>We offer members savings through our exclusive Healthy Living Rewards program. Show your UPMC Health Plan member ID card at the time of purchase and receive discounts at participating businesses that encourage a healthy lifestyle: gyms, spas, salons, dance studios, martial arts schools, health food stores sporting goods stores and more. The discounted services offered by these companies are, for the most part, not covered benefits.</p> <p>You can find a listing of businesses that participate in our Healthy Living Rewards program in your provider directory or on our website at www.upmchealthplan.com</p>

Feature - continued on next page

Feature	Description
Feature (cont.)	High Option
Travel benefits/services	UPMC Health Plan offers a travel assistance plan through Assist America, a global emergency assistance program for members who are traveling more than 100 miles from home. Assist America can help locate qualified doctors and hospitals, replace forgotten prescriptions, provide emergency medical evacuation and arrange for transportation so family members can be with injured relatives. This service is available 24 hours a day, 7 days a week. You can contact Assist America at 1-800-872-1414 in the USA, or at 1-609-986-1234 outside of the USA. The Assist America reference number for UPMC Health Plan members is 01-AA-UP-156243.

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- There is no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing

Dental benefits

We have no other dental benefits.

High Deductible Health Plan Benefits

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Section 5 High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 1-888-876-2756 or visit our Web site at www.upmchealthplan.com.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or HRA based upon your eligibility.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page xx. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100%. Note that some services require you to use a Plan provider in order to be covered. The coverage is fully described in Section 5 *Preventive care*. *You do not have to meet the deductible before using these services*

- **Traditional medical coverage** After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 100% for in-network and 80% for out-of-network care.

Covered services include:

Medical services and supplies provided by physicians and other health care professionals

Surgical and anesthesia services provided by physicians and other health care professionals

Hospital services; other facility or ambulance services

Emergency services/accidents

Mental health and substance abuse benefits

Prescription drug benefits

Dental benefits.

- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 54 for more details).

- **Health Savings Accounts (HSA)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2007, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$83 per month for a Self Only enrollment or \$167 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law. See maximum contribution information on page 57. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by Mellon/ACS
- Your contributions to the HSA are tax deductible
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible

Spending Account: If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Instead, when you inform us of your coverage in an FSA, we will establish an HRA for you.

- **Health Reimbursement Arrangements (HRA)**

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2007, we will give you an HRA credit of \$1,000 per year for a Self Only enrollment and \$2,000 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

For our HDHP option, the HRA is administered by UPMC Health Plan

Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment

Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP

Unused credits carryover from year to year

HRA credit does not earn interest

HRA credit is forfeited if you leave Federal employment or switch health insurance plans.

An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements. See *Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS*.

- **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual limit for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$4,000 for Self or \$8,000 for Self and Family enrollment. When you use out-of-network providers, your annual limit for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$5,500 for Self or \$11,000 for Self and Family enrollment. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Also, the family out of pocket maximum must be met by one or more members of the family before benefits are payable at 100%. Refer to Section 4, *Your catastrophic protection out-of-pocket maximum* and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5 Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Mellon/ACS, this HDHP’s fiduciary (an administrator, trustee, or custodian as defined by Federal tax code and approved by IRS.)	UPMC Health Plan is the HRA fiduciary for this Plan.
Fees	Set-up fee is paid by the HDHP. \$3.50 per month administrative fee charged by the fiduciary and taken out of the account balance until it reaches \$1,000.	None.
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare Part A or Part B • Not be claimed as a dependent on someone else’s tax return • Must not have received VA benefits in the last three months • Complete and return all banking paperwork. <p>Eligibility for contributions is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.</p>	<p>You must enroll in this HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• Self Only enrollment	For 2007, a monthly premium pass through of \$83 will be made by the HDHP directly into your HSA each month.	For 2007, your HRA annual credit is \$1,000 (prorated for length of enrollment).
• Self and Family enrollment	For 2007, a monthly premium pass through of \$167 will be made by the HDHP directly into your HSA each month.	For 2007, your HRA annual credit is \$2,000 (prorated for length of enrollment).
• Self and Family enrollment	For 2007, a monthly premium pass through of \$xx will be made by the HDHP directly into your HSA each month.	For 2007, your HRA annual credit is \$xxx (prorated for length of enrollment).

<p>Contributions/credits</p>	<p>The maximum that can be contributed to your HRA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the deductible, which is \$2,500 for an individual and \$5,000 for self and family. This amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA.</p> <p>For each month you are eligible for HSA contributions, if you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> • The maximum allowable contribution is a combination of employee and employer funds up to the amount of the deductible of \$2,500 for Self Only or \$5,000 for Self and Family. To determine the maximum allowable contribution, take the amount of your deductible divided by 12, times the number of full months enrolled in the HDHP. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute. • You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). • HSAs earn tax-free interest (does not affect your annual maximum contribution). <p>Catch-up contribution discussed on page 59.</p>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.</p>
<p>Self Only enrollment</p>	<p>You may make an annual maximum contribution of \$2,500.</p>	<p>You cannot contribute to the HRA.</p>
<p>Self and Family enrollment</p>	<p>You may make an annual maximum contribution of \$5,000.</p>	<p>You cannot contribute to the HRA.</p>
<p>Access funds</p>	<p>You can access your HSA by the following methods:</p> <p>Debit card</p> <p>Withdrawal form</p> <p>Checks</p>	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. The only exception is for prescription drugs. Until you meet the deductible, you must file a reimbursement form for prescription expenses. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form must also be submitted.</p>
<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical 	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p>

	See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.	<p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> • Non-medical 	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. <p>The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.</p>	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If You Have an HSA

If you have an HSA

- **Contributions**

All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was effective after January 1, 2007, you would need to deduct 1/12 of the annual maximum contribution. Contact Mellon ACS member service at 1- 866-274-2195 for more details..
- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2007, you may contribute up to \$800 in catch-up contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.
- **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.
- **Qualified expenses**

You can pay for “qualified medical expenses,” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase any health insurance other than a Medigap policy. You can no longer contribute to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on “Forms and Publications.” Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.
- **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- **Tracking your HSA balance**

You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.
- **Minimum reimbursements from your HSA**

You can request reimbursement in any amount. There is no minimum reimbursement amount. However, disbursements not processed through a debit card transaction or check will be assessed a \$25 disbursement fee.

If You Have an HRA

• **Why an HRA is established** If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

• **How an HRA differs** Please review the chart on page 56 which details the differences between an HRA and an HSA. The major differences are:

- **You cannot make contributions to an HRA,**
- **Funds are forfeited if you leave the HDHP,**
- **An HRA does not earn interest, and**

HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP.

Section 5 Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible.
- For adult routine physicals and well child office visits you must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay High Option
<p>Preventive care, adult</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening — every five years starting at age 50, - Double contrast barium enema — every five years starting at age 50; - Colonoscopy screening — every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • Routine mammogram — covered for women age 35 and older, as follows: <ul style="list-style-type: none"> - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years 	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older <p>Routine physicals which include:</p> <ul style="list-style-type: none"> • One exam every 24 months up to age 65 	<p>In-Network: Nothing</p> <p>Out-of-Network routine physicals: All charges</p> <p>Other Out-of-Network services: 20%</p>

Benefit Description	You pay
Preventive care, adult (cont.)	
<ul style="list-style-type: none"> One exam every 12 months age 65 and older <p>Routine physicals are covered only in network.</p> <ul style="list-style-type: none"> Routine exams limited to one routine OB/GYN exam every 12 months, including 1 Pap smear and related services 	<p>High Option</p> <p>In-Network: Nothing</p> <p>Out-of-Network routine physicals: All charges</p> <p>Other Out-of-Network services: 20%</p>
<p>Not covered:</p> <ul style="list-style-type: none"> Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel. Immunizations, boosters, and medications for travel or work-related exposure. Routine physical exams by an out-of-network provider. 	<p><i>All Charges.</i></p>
Preventive care, children	
<p>Professional services, such as:</p> <ul style="list-style-type: none"> Well-child visits for routine examinations, immunizations and care (up to age 22) <p>Well-child visits are covered only in-network.</p> <ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	<p>High Option</p> <p>In-Network: Nothing</p> <p>Out-of-Network well child visits: All charges</p> <p>Other Out-of-Network services: 20%</p>
<p>Not covered:</p> <ul style="list-style-type: none"> Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel. Immunizations, boosters, and medications for travel. Well-child visits for routine examinations by an out-of-network provider. 	<p><i>All Charges.</i></p>
Dental Preventive Care	
<p>Preventive care limited to:</p> <ul style="list-style-type: none"> Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year Fluoride applications (limited to 1 treatment per calendar year and for children under age 16) Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) Space maintainer (primary teeth only) Bitewing x-rays (one set per calendar year) 	<p>High Option</p>

Dental Preventive Care - continued on next page

Benefit Description	You pay
Dental Preventive Care (cont.)	High Option
<ul style="list-style-type: none">• Complete series x-rays (one complete series every 3 years)• Periapical x-rays• Routine oral evaluations (limited to 2 per calendar year)	

Section 5 Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 61) and is not subject to the calendar year deductible.
- The deductible is \$2,500 for Self enrollment or \$5,000 Self and Family enrollment. The family deductible can be satisfied by one or more members of the family.
- You must pay your annual deductible before your Traditional medical coverage begins.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses. Coinsurance applies to services you receive from out-of-network providers.
- When you use network providers, you are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. After your coinsurance, prescription copayments and deductibles total \$4,000 for Self enrollment or \$8,000 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. After your coinsurance and deductibles total \$5,500 for Self enrollment or \$11,000 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from out-of-network providers. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance). Note that the family out-of-pocket maximum must be met by one or more members of the family before benefits will be paid at 100%.
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Out-of-network benefits have a lifetime maximum of \$1,000,000.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	High Option
The deductible applies to almost all benefits in this Section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$2,500 for Self enrollment or \$5,000 for Self and Family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	<p>In-network: After you meet the deductible, you pay only the copayment for covered services. You may choose to pay the copayments from your HSA or HRA, or you can pay for them out-of-pocket.</p> <p>Out-of-network: After you meet the deductible, you pay the indicated coinsurance and copayments based on our Plan allowance and any difference between our allowance and the billed amount.</p>

**Section 5(a) Medical services and supplies
provided by physicians and other health care professionals**

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,500 for Self enrollment only or \$5,000 Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members.
- After you have satisfied your annual deductible, coverage begins for traditional medical services.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses. Coinsurance applies only to services you receive from out-of-network providers. You are also responsible for copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	High Option
Professional services of physicians In physician's office In an urgent care center During a hospital stay In a skilled nursing facility Office medical consultations Second surgical opinion	In-Network: Nothing Out-of-Network: 20%
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap test s • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	In-Network: Nothing Out-of-Network: 20%

Benefit Description	You pay After the calendar year deductible...
Maternity care	High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery as long as an in-network providers are used. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgerybenefits</i> (Section 5b). 	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
Family planning	High Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptive s • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> 	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Infertility services	High Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) <p>For Artificial Insemination Procedures, you must utilize Plan providers who are credentialed by UPMC Health Plan in Reproductive Endocrinology. In the event that you do not have reasonable access to a Plan provider who is credentialed in Reproductive Endocrinology, you may submit a request to utilize another Plan provider.</p> <p>To obtain a list of Plan providers who are credentialed by UPMC Health Plan in Reproductive Endocrinology, please contact Member Services at 1-877-381-3764 or visit www.upmchealthplan.com. To request prior approval to utilize a Plan provider who is not Board Certified in Reproductive Endocrinology, please contact Member Services at 1-877-381-3764.</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> - in vitro fertilization - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • Services and supplies related to ART procedures • Cost of donor sperm • Cost of donor egg. • Fertility drugs 	<p><i>All Charges.</i></p>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p>Allergy serum</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>

Benefit Description	You pay After the calendar year deductible...
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 74.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
Physical and occupational therapies	High Option
<p>Limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year, for speech, occupational and physical therapy combined.</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 sessions. 	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Speech therapy	High Option
<p>Limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year, for speech, occupational and physical therapy combined.</p>	<p>In-Network: Nothing <i>Out-of-Network: 20%</i></p>
<p>Not covered: <i>Speech therapy for developmental delays.</i></p>	<p><i>All Charges.</i></p>
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury 	<p>In-Network: Nothing Out-of-Network: 20%</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	<p><i>All Charges.</i></p>
Vision services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions 	<p>In-Network: Nothing Out-of-Network: 20%</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Eyeglasses or contact lenses, except as shown above • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<p><i>All Charges.</i></p>
Foot care	High Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>In-Network: Nothing <i>Out-of-Network: 20%</i></p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above • Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices High Option	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. 	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p><i>Not covered:</i></p> <p><i>Orthopedic and corrective shoes</i></p> <p><i>Arch supports</i></p> <p><i>Foot orthotics</i></p> <p><i>Heel pads and heel cups</i></p> <p><i>Lumbosacral supports</i></p> <p><i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></p> <p>Prosthetic replacements provided less than {X} years after the last one we covered</p>	<p><i>All Charges.</i></p>
Durable medical equipment (DME) High Option	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <p>Oxygen;</p> <p>Dialysis equipment;</p> <p>Hospital beds;</p> <p>Wheelchairs;</p> <p>Crutches;</p> <p>Walkers;</p> <p>Blood glucose monitors; and</p> <p>Insulin pumps.</p> <p>Note: Call us at 1-888-876-2756 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs.</i> 	<p><i>All Charges.</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	High Option
<ul style="list-style-type: none"> Repair, replacement or duplication except when necessitated due to a change in the patient's medical condition. 	All Charges.
Home health services	High Option
<ul style="list-style-type: none"> Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include oxygen therapy, intravenous therapy and medications. 	In-Network: Nothing Out-of-Network: 20%
Not covered: <ul style="list-style-type: none"> Nursing care requested by, or for the convenience of, the patient or the patient's family; Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. 	All Charges.
Chiropractic	High Option
<ul style="list-style-type: none"> Manipulation of the spine and extremities limited to 25 visits per calendar year. Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Children under the age of 13 must receive prior authorization for chiropractic care.	In-Network: Nothing Out-of-Network: 20%
<i>Not covered:</i>	<i>All Charges.</i>
Alternative treatments	High Option
<i>Not covered:</i> <ul style="list-style-type: none"> Naturopathic services Hypnotherapy Biofeedback Acupuncture 	<i>All charges</i>
Educational classes and programs	High Option
Coverage is limited to: <ul style="list-style-type: none"> Diabetes self management Nutrition counseling for patients undergoing covered surgical treatment of morbid obesity (bariatric surgery) 	In-Network: Nothing Out-of-Network: 20%

**Section 5(b) Surgical and anesthesia services
provided by physicians and other health care professionals**

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,500 for Self or \$5,000 Self and Family enrollment. The family deductible can be met by one or more members of the family.
- After you have satisfied your annual deductible, coverage begins for traditional medical services.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses. Coinsurance applies only to services you receive from out-of-network providers. You are also responsible for copayments for eligible prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices . See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<i>Not covered:</i>	<i>All Charges.</i>

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.) High Option	
<ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All Charges.</i>
Reconstructive surgery High Option	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All Charges.</i>
Oral and maxillofacial surgery High Option	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; 	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Oral and maxillofacial surgery (cont.)	
<ul style="list-style-type: none"> Excision of cysts and incision of abscesses when done as independent procedures; and Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>High Option</p> <p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Oral implants and transplants Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) 	<p><i>All Charges.</i></p>
Organ/tissue transplants	
<p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> Cornea Heart Heart/lung Single, double or lobar lung Kidney Liver Pancreas Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis Intestinal transplants <ul style="list-style-type: none"> Small intestine Small intestine with the liver Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>High Option</p> <p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia Advanced Hodgkin’s lymphoma Advanced non-Hodgkin’s lymphoma Chronic myleogenous leukemia Severe combined immunodeficiency Severe or very severe aplastic anemia <p>Autologous transplants for</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Advanced neuroblastoma <p>Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</p> <p>Blood or marrow stem cell transplants for</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Advanced forms of myelodysplastic syndromes • Advanced neuroblastoma • Kostmann’s syndrome • Leukocyte adhesion deficiencies • Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Sickle cell anemia • Thalassemia major (homozygous beta-thalassemia) 	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p>Autologous transplants for</p> <ul style="list-style-type: none"> • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer • Amyloidosis • Ependymoblastoma • Ewing’s sarcoma • Medulloblastoma • Pineoblastoma 	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • Chronic lymphocytic leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma <p>Nonmyeloablative allogeneic transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced forms of myelodysplastic syndromes • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Myeloproliferative disorders • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas <p>Autologous transplants for</p> <ul style="list-style-type: none"> • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple sclerosis • Systemic lupus erythematosus • Systemic sclerosis <p>UPMC Health Plan utilizes the top transplant centers in Western Pennsylvania. Should care not be available in Western Pennsylvania, UPMC Health Plan will arrange for services out of the area.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
Not covered:	<i>All Charges.</i>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<i>All Charges.</i>
Anesthesia	High Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	In-Network: Nothing Out-of-Network: 20%
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	In-Network: Nothing Out-of-Network: 20%

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,500 for Self enrollment or \$5,000 Self and Family enrollment. The family deductible can be satisfied by one or more members of the family.
- After you have satisfied your annual deductible, coverage begins for traditional medical services.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses. Coinsurance applies only to services you receive from out-of-network providers. You are also responsible for copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	High Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In-Network: Nothing Out-of-Network: 20%
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	In-Network: Nothing Out-of-Network: 20%
<i>Not covered:</i>	<i>All Charges.</i>

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	High Option
<ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<i>All Charges.</i>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All Charges.</i>
Extended care benefits/Skilled nursing care facility benefits	High Option
Extended care benefit:	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
Skilled nursing facility (SNF):	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<i>Not covered: Custodial care</i>	<i>All charges</i>
Hospice care	High Option
Supportive and palliative care is covered for terminally ill patients, either in the home or in a hospice facility. Services include inpatient and outpatient care, and family counseling. These services are provided under the direction of a physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	<p>In-Network: Nothing</p> <p>Out-of-Network: 20%</p>
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>

Benefit Description	You Pay
Ambulance	High Option
Local professional ambulance service when medically appropriate	In-Network: Nothing Out-of-Network: 20%

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,500 for Self enrollment or \$5,000 Self and Family enrollment. The family deductible can be satisfied by one or more members of the family.
- After you have satisfied your annual deductible, coverage begins for traditional medical services.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses. Coinsurance applies only to services you receive from out-of-network providers. You are also responsible for copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area

If you feel you need emergency care and you are able, you should attempt to call your PCP (if you have a PCP) to explain the symptoms and provide any other information necessary to help determine the appropriate action. You should go to the nearest emergency facility for the following situations:

- Your doctor tells you to
- You cannot reach your PCP or another doctor and you believe that your health is in jeopardy

You have the right to summon emergency help by calling 911, any other emergency telephone number, and a licensed ambulance service without getting any prior approvals.

After your receive emergency room treatment or are admitted to the hospital, contact our Member Services Department at 1-888-876-2756 within 48 hours.

Emergencies outside our service area

If you are outside of the Plan’s service area (outside of Western Pennsylvania) at the time you need emergency care, you should seek emergency care immediately from the nearest emergency facility.

After your receive emergency room treatment or are admitted to the hospital, contact our Member Services Department at 1-888-876-2756 within 48 hours.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	High Option
Emergency care at a doctor’s office Emergency care at an urgent care center Emergency care as an outpatient in a hospital, including doctors’ services	In-Network: Nothing Out-of-Network: 20%
Emergency outside our service area	High Option
Emergency care at a doctor’s office Emergency care at an urgent care center Emergency care as an outpatient in a hospital, including doctors’ services	In-Network: Nothing Out-of-Network: 20%
Accidental injury	High Option
Ambulance	High Option
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	In-Network: Nothing Out-of-Network: 20%

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,500 for Self enrollment or \$5,000 Self and Family enrollment. The family deductible can be satisfied by one or more members of the family.
- After you have satisfied your annual deductible, coverage begins for traditional medical services.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses. Coinsurance applies only to services you receive from out-of-network providers. You are also responsible for copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	High Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>In-Network: Nothing Out-of-Network: 20%</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>In-Network: Nothing Out-of-Network: 20%</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>In-Network: Nothing Out-of-Network: 20%</p>
<p>Not covered:</p>	<p><i>All Charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	High Option
<ul style="list-style-type: none"> • Any psychotherapy, psychiatric care, or treatment services for substance abuse or dependency which are court-ordered, unless such services are medically necessary and appropriate for the treatment of a treatable mental disorder (behavioral health or substance-related). • Inpatient or outpatient treatment related to: mental retardation, pervasive developmental disorder, or autism, which extends beyond traditional medical management. • Treatment for personality disorders as the primary diagnosis, learning disabilities, or behavioral problems and those conditions for which an individual is eligible for Social Security disability benefits for a mental or emotional disability. • Any services related to disorders that are not treatable DSM-IV-TR defined mental disorders. Examples include, but are not limited to, nicotine dependence, caffeine intoxication, stuttering, tension headache, stress reactions, reading disorder, mathematics disorder, pathological gambling, disorder of written expressions, expressive/receptive language disorders, phonological disorder, developmental coordination disorder, learning disorders, sleep disorders, and V-codes. • Any treatment/services, including motivational training programs, related to personal or professional growth/development, educational or professional training or certification, or for investigative purposes related to employment. • Any services related to purposes of obtaining or maintaining employment, insurance or for purposes related to judicial or administrative proceedings such as adjudication of marital, child support, or custody cases. • Treatment for organic disorders, including, but not limited to organic brain disease. • Behavioral Health Services not expected to result in demonstrable improvement in the member's condition and/or level of functioning, and chronic maintenance therapy, except in the case of serious mental illness/ disorders. • Treatment for chronic behavioral conditions, once the individual has been restored to the pre-crisis level of function. • Treatment for stress and treatment for co-dependency. 	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	High Option
<ul style="list-style-type: none"> • Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder (behavioral health or substance related). • Treatment for chronic pain management programs or any related services. • 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 oxygen therapy. • Acupuncture and accupressure for the treatment of behavioral health disorders. • Aromatherapy, Ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation and yoga. • Sex therapy, without a DSM-IV-TR diagnosis and treatment for sexual addiction. • Sedative action electrostimulation therapy. • Sensitivity training. • Twelve step model programs as sole therapy for problems such as eating disorders or addictive gambling. • Treatment or consultation provided by the members' parents, siblings, children, current or former spouse or domiciliary partner. • Truancy or disciplinary problems alone. • Psychoanalysis or other therapies that are not short-term or crisis-oriented. • Psychiatric/Psychological and Neuro-psychological testing for: a.) learning disabilities/problems; b.) school related issues; c.) the purposes of obtaining or maintaining employment; and d.) the purpose of submitting a disability application for a mental or emotional condition. • <i>Long term residential treatment services for substance-related disorders such as substance abuse or substance dependency.</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	High Option
	<i>All Charges.</i>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

Call Western Behavioral Health at 1-888-251-0083 to locate a Plan provider and for assistance with required preauthorization.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Here are some important things to keep in mind about these benefits:

We cover prescribed drugs and medications, as described in the chart beginning on the next page.

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,500 for Self enrollment or \$5,000 Self and Family enrollment. The family deductible can be satisfied by one or more members of the family.
- After you have satisfied your annual deductible, coverage begins for traditional medical services, including prescription drugs.
- Remember that in order for your covered prescription expense to be applied toward satisfaction of your deductible, you must use a participating pharmacy and present your UPMC Health Plan identification card at the point of purchase.
- You are responsible for copayments for eligible prescriptions after the deductible is met.
- There is no out-of-network coverage for prescription drugs. The prescription drug network is a nation wide network.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a participating retail pharmacy, or by mail for maintenance and specialty drugs. Participating retail pharmacies include most national chains as well as many independent pharmacies. Call Member Services at 1-888-876-2756 or visit www.upmchealthplan for assistance in locating a participating pharmacy near you.
- **We use a formulary.** The *Your Choice* formulary applies. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. Most non-preferred brand name drugs are also included on the formulary, but you will pay a higher copayment for non-preferred brand name drugs. To request a prescription drug brochure, call Member Services at 1-888-876-2756. You can also visit www.upmchealthplan; our website includes a prescription drug look up feature. UPMC Health Plan makes changes to it’s formulary each January 1 and July 1. Changes are outlined in a newsletter we will mail to your home. You will be notified by a separate letter if the prescription drug you are taking is affected by a formulary change.
- **These are the dispensing limitations.** Covered prescription drugs obtained at a participating retail pharmacy and specialty prescription drugs obtained through the Plan’s specialty mail order pharmacy will be dispensed for up to a 30-day supply or one commercially prepared unit (e.g., one inhaler). Prescriptions for maintenance drugs obtained through the Plan’s mail order pharmacy will be dispensed for up to a 90-day supply. Medications will be dispensed based on FDA guidelines.
- **A generic equivalent will be dispensed if it is available.,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available you have to pay the difference in cost between the name brand drug and the generic.

If your physician has specified “Dispense as Written” for a brand name drug when a generic is available, your physician must submit information to UPMC Health Plan stating that the brand name drug is medically necessary and the reasons why the generic equivalent was ineffective. If approved by UPMC Health Plan, you will pay the non-preferred brand name copayment for your brand name medication.

- **Why use generic drugs?** A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs, so the cost is lower. You can lower your out-of-pocket expense by using generic drugs, when available.

- When you do have to file a claim.** If you are enrolled in an HRA, you will need to file an HRA reimbursement form until you meet your deductible. Once your deductible is met, you will pay your copayment at the point of purchase. If you are enrolled in an HSA, you can use your debit card or HSA checkbook to pay for your prescription or copayment. Once your deductible is met, if there is a circumstance in which you pay the full cost out-of-pocket, you can be reimbursed by completing a prescription drug reimbursement form. You will be reimbursed 100% of the covered prescription cost less the applicable copayment as long as you used a participating pharmacy. Call Member Services at 1-888-876-2756 or visit www.upmchealthplan to obtain a prescription drug reimbursement form.

If you...	HSA	HSA	HSA	HRA	HRA	HRA
You must:	have not yet met the annual deductible	have met the annual self / self and family deductible	have met the annual-out-of-pocket maximum for self / self and family	have not yet met the annual deductible	have met the annual self / self and family deductible	have met the annual-out-of-pocket maximum for self / self and family
Use a participating pharmacy	yes	yes	yes	yes	yes	yes
Show your UPMC Health Plan identification card at point of purchase	yes	yes	yes	yes	yes	yes
Pay the entire cost of your covered prescription at the point of purchase	yes, you can use your checkbook or debit card	no	no	yes	no	no
Pay your copayment at the point of purchase for a covered prescription	n/a	yes	n/a	n/a	yes	n/a
Complete and submit an HSA/HRA reimbursement form	no, use your checkbook or debit card	no, use your checkbook or debit card	no	yes	no	no
Complete and submit a prescription drug reimbursement form.	Only if you did not show your UPMC Health Plan ID card at the point of purchase.	Only if you paid the entire cost at point of purchase.	Only if you paid the entire cost at point of purchase.	no	Only if you paid the entire cost at point of purchase.	Only if you paid the entire cost at point of purchase.

Benefit Description	You pay After the calendar year deductible...
Prescription Drugs	High Option
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetic supplies limited to: lancets, test strips, glucometers • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Contraceptive drugs and devices 	<p><u>Retail (up to a 30-day supply)</u></p> <p>\$15 copayment for generic drugs</p> <p>\$30 copayment for preferred brand name drugs</p> <p>\$50 copayment for non-preferred brand name drugs</p> <p><u>Specialty Prescription Drugs (up to a 30-day supply)</u></p> <p>\$50 copayment</p> <p><u>Mail Order (up to a 90-day supply)</u></p> <p>\$30 copayment for generic drugs</p> <p>\$60 copayment for preferred brand name drugs</p> <p>\$100 copayment for non-preferred brand name drugs</p> <p>Note: If there is no generic equivalent available, you will pay the brand name copayment.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Drugs and supplies for cosmetic purposes • Drugs to enhance athletic performance • Fertility drugs • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Vitamins, nutrients, and food supplements even if a physician prescribes or administers them. These nutritional foods or formulas are not covered except as medically necessary formulas that are equivalent to a prescription drug for the treatment of phenylketonuria (PKU) branched-chain ketonuria, galactosemia, and homocystinuria as administered under the direction of a physician. • Nonprescription medicines • Smoking cessation drugs 	<p><i>All charges.</i></p>

Section 5(g) Special features

Feature	Description
Feature	High Option
<p>Pediatric Advice Line (PAL)</p>	<p>UPMC Health Plan offers a Pediatric Advice Line (PAL). This service is for members with children age 18 or younger for use when their pediatrician’s office is closed. PAL is available through a partnership with Children’s Hospital of Pittsburgh and is staffed with pediatric registered nurses.</p>
<p>Services for hearing impaired members</p>	<p>UPMC Health Plan communicates by telephone with our hearing impaired members through TTY. If you are hearing impaired, call our TTY number at 1-800-361-2629.</p>
<p>High risk pregnancies</p>	<p>If your physician has identified your pregnancy as high risk, your physician may refer you to our case management department for care coordination. You may also self-refer by calling 1-888-876-2756 and ask to be connected with our care management area. You will be assigned to a UPMC Health Plan nurse case manager who can assist in coordinating your care with specialists, facilities and community resources.</p>
<p>Health Management Programs</p>	<p>UPMC operates health management programs for members who have been diagnosed with diabetes, asthma or heart disease. Based on the kinds of treatment you receive, we may contact you and suggest that you would benefit from one of these programs. Your participation is voluntary. Through our health management programs, we offer education, support, and other information that can help you manage your condition.</p> <p>We can contact your physician and other clinicians to help coordinate your care. We will send our notices to remind you about routine physicals, lab tests and other care. Our goal is to help you follow your physician’s plan to maintain your health, help you better understand and manage your medical condition, and help you prevent complications.</p> <p>Your physician may call us and recommend that you participate in one of these programs, or you may call our Health Management Department directly at 1-866-778-6073 (TTY: 1-800-361-2629) if you are interested in participating.</p>
<p>Healthy Living Rewards</p>	<p>We offer members savings through our exclusive Healthy Living Rewards program. Show your UPMC Health Plan member ID card at the time of purchase and receive discounts at participating businesses that encourage a healthy lifestyle: gyms, spas, salons, dance studios, martial arts schools, health food stores sporting goods stores and more. The discounted services offered by these companies are, for the most part, not covered benefits.</p> <p>You can find a listing of businesses that participate in our Healthy Living Rewards program in your provider directory or on our website at www.upmchealthplan.com</p>

Feature - continued on next page

Feature	Description
Feature (cont.)	High Option
<p>Travel benefit/services overseas</p>	<p>UPMC Health Plan offers a travel assistance plan through Assist America, a global emergency assistance program for members who are traveling more than 100 miles from home. Assist America can help locate qualified doctors and hospitals, replace forgotten prescriptions, provide emergency medical evacuation and arrange for transportation so family members can be with injured relatives. This service is available 24 hours a day, 7 days a week. You can contact Assist America at 1-800-872-1414 in the USA, or at 1-609-986-1234 outside of the USA. The Assist America reference number for UPMC Health Plan members is 01-AA-UP-156243.</p>

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,500 for Self enrollment or \$5,000 for Self and Family enrollment. The family deductible can be met by one or more members of the family.
- After you have satisfied your annual deductible, coverage begins for traditional medical services.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses. Coinsurance applies only to services you receive from out-of-network providers. You are also responsible for copayments for eligible prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-Network: Nothing Out-of-Network: 20%
Dental benefits	You Pay
We have no other dental benefits	

Section 5(i) Health education resources and account management tools

Special features	Description
<p>Health education resources</p>	<p>We publish periodic newsletters to keep you informed on a variety of issues related to your good health. The newsletter is mailed to your home.</p> <p>Visit our Web site at www.upmchealthplan.com for information on:</p> <ul style="list-style-type: none"> • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids’ health • Patient safety information • and several helpful Web site links.
<p>Account management tools</p>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through www.upmchealthplan.com</p> <p>Your balance will also be shown on your explanation of benefits (EOB) form.</p> <p>You will receive an EOB after every claim.</p> <p>If you have an HSA,</p> <ul style="list-style-type: none"> • You will receive a outlining your account balance and activity for the month. • You may also access your account on-line at www.hsamember.com <p>If you have an HRA,</p> <ul style="list-style-type: none"> • Your HRA balance will be available online through www.upmchealthplan.com • Your balance will also be shown on your EOB form.
<p>Consumer choice information</p>	<p>As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.upmchealthplan.com</p> <p>Link to online pharmacy through www.upmchealthplan.com</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.upmchealthplan.com</p>
<p>Care support</p>	<p>Patient safety information is available online at www.upmchealthplan.com</p> <p>Case managers may be contacted by calling Member Services at 1-888-876-2756 and asking to be connected with our care management area.</p>

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Dental Benefits - Limited dental coverage is included with your enrollment in the UPMC Health Plan HMO or HDHP through Doral Dental USA. The program provides full benefits for a defined list of preventive dental services. Discounts are available for other dental services. You must use a participating Doral dental provider in order to obtain preventive care benefits and discounts.

Discounts are based on a fee schedule, which is subject to change. Prior to receiving services, please contact your participating dentist or Doral Dental USA to determine what your financial responsibility will be.

You can present your UPMC Health Plan identification card at the time of service. There is no additional enrollment form or ID card needed. A complete listing of participating dentists description of the benefits is included in your UPMC Health Plan enrollment packet. You can also contact Doral Dental USA Member Services at 1-800-949-0574 for information. Representatives are available Monday through Friday, 8 a.m. to 6 p.m. ET and Saturdays from 9 a.m. to noon ET.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-888-876-2756.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

UPMC Health Plan

Claims Department

P.O. Box 2999

Pittsburgh, PA 15230-2999

Prescription drugs

See above

Other supplies or services

See above

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

- 1** Ask us in writing to reconsider our initial decision. You must:
- Write to us within 6 months from the date of our decision; and
 - Send your request to us at:

UPMC Health Plan

Claims Department

P.O. Box 2999

Pittsburgh, PA 15230-2999

and

- Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

- Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:

- Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
- Write to you and maintain our denial - go to step 4; or
- Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group x, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;

- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-888-876-2756 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

People 65 years of age or older;

Some people with disabilities under 65 years of age; and

People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at x1-888-876-2756 or see our Web site at www.upmchealthplan.com.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in UPMC Health Plan's Medicare Advantage plan (UPMC for Life) and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
B. When you or a covered family member?		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you?		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
Covered services	Care we provide benefits for, as described in this brochure.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.
Experimental or investigational service	<p>Experimental/Investigative is the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which 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/Investigative if, at the time of service:</p> <ul style="list-style-type: none">a. The intervention does not have FDA approval to market for the specific relevant indication(s); orb. Available scientific evidence and/or prevailing peer review medical literature do not indicate that the treatment is safe and effective for treating or diagnosing the relevant medical condition or illness; orc. 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; ord. The intervention does not improve health outcomes; ore. The intervention is not proven to be able to be replicated outside the research setting. <p>If an intervention as defined above is determined to be Experimental/Investigative at the time of service, it will not receive retroactive coverage even if it is found to be in accordance with the above criteria at a later date</p>
Group health coverage	Group health coverage is coverage offered through an employment relationship to employees or former employees of that organization and their eligible dependents or Medicare.
Medical necessity	<p>Medically necessary are services or supplies that are determined to be:</p> <ul style="list-style-type: none">a. Commonly recognized throughout the Physician's specialty as appropriate for the diagnosis and/or treatment of the Member's condition, illness, disease or injury; andb. 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; andc. Can reasonably be expected to improve an individual's condition or level of functioning; andd. In conformity, at the time of treatment, with medical management criteria/guidelines adopted by UPMC Health Plan or its designee; ande. Not provided only as a convenience or comfort measure or to improve physical appearance; and

f. 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 in its sole judgment whether a service meets these criteria and will be authorized for payment. Authorization for payment decisions shall be made by UPMC Health Plan with input from the Member's PCP, or other Physician providing service. Independent consultation with a Physician other than the PCP or attending Physician may be obtained at the discretion of UPMC Health Plan.

The fact that a Physician or other health care provider may order, prescribe, recommend, or approve a service, supply, or therapeutic regime does not, of itself, determine Medical Necessity and Appropriateness or make such a service, supply, or treatment a Covered Service.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Network providers accept the UPMC Health Plan allowance as payment in full.

Us/We

Us and We refer to UPMC Health Plan.

You

You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible A deductible is a fixed expense you must incur for covered services and supplies before we start paying benefits for them.

If you enroll for family coverage, the family deductible must be met by one or more members of the family before any benefits will be paid. The deductible is combined for services received from both network and out-of-network providers.

Catastrophic limit When you use network providers, you are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. After your coinsurance, prescription copayments and deductibles total the out-of-pocket limit, you do not have to pay any more for covered services. There are separate out-of-pocket limits for self only and family coverage, as well as network and out-of-network expenses. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance). The family out-of-pocket maximum must be met by one or more members of the family before benefits will be paid at 100%.

Health Savings Account (HSA) Health Savings Accounts provide a means to help you pay out-of-pocket expenses.

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In addition to the monthly contribution the HDHP will make to your HSA, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- a. Your contributions to the HSA are tax deductible
- b. Your HSA earns tax-free interest
- c. You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- d. Your unused HSA funds and interest accumulate from year to year
- e. It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- f. When you need it, funds up to the actual HSA balance are available.

Health Reimbursement Arrangement (HRA) Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses. If you enroll in the HDHP option and you are not eligible for a Health Savings Account (HSA), an HRA will be provided instead. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- a. Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- b. Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- c. Unused credits carryover from year to year
- d. HRA credit does not earn interest
- e. HRA credit is forfeited if you leave Federal employment or switch health insurance plans.

Premium contribution to HSA/HRA

When you enroll in an HDHP, a monthly contribution will be made to your HSA. If you are not eligible for an HSA, a contribution in the form of an annual credit will be made to an HRA (prorated for length of enrollment).

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election is of \$5,000.

Health Care FSA (HCFSA) – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.

Limited Expense Health Care FSA (LEX HCFSA) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.

Dependent Care FSA (DCFSA) – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA and LEN HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses (but not insurance premiums)

For the DCFSA – daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

What is an FSAFEDS Debit Card?

xxxxxxxxxxxxxxxxxxxxx (we will put in information the next round)

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDES?

BENEFEDES is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including the following:

Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.

Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

Self-only, which covers only the enrolled employee or annuitant;

Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and

Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Summary of benefits for the High Option of the - 2007

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Summary of benefits for the HDHP of the - 2007

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2007 for each month you are eligible for the HSA, will deposit \$83 per month for Self Only enrollment or \$167 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$2,500 for Self Only and \$5,000 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$1,000 for Self Only and \$2,000 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other health care professional.

HDHP Benefits	You Pay	You Pay
In-network medical preventive care	Nothing	61
Medical services provided by physicians:	In-Network: Nothing Out-of-Network: 20%	64
Diagnostic and treatment services provided in the office*	In-Network: Nothing Out-of-Network: 20%	64
Services provided by a hospital:		
• Inpatient	In-Network: Nothing Out-of-Network: 20%	78
• Outpatient	In-Network: Nothing Out-of-Network: 20%	78
Emergency benefits:		
• In-area	In-Network: Nothing Out-of-Network: 20%	81
• Out-of-area	In-Network: Nothing Out-of-Network: 20%	81
Mental health and substance abuse treatment:	In-Network: Nothing Out-of-Network: 20%	83
Prescription drugs:		87
• Retail pharmacy - up to a 30-day supply*	\$15 generic drugs \$30 preferred brand name drugs \$50 non-preferred brand name drugs	

• Specialty mail order - up to a 30-day supply*	\$50	
• Mail order - up to a 90-day supply*	\$30 generic drugs \$60 preferred brand name drugs \$100 non-preferred brand name drugs	
Dental care:	Limited Dental benefits and discounts under a non-FEHB benefit program.	93
Special features:	<ul style="list-style-type: none"> • Pediatric Advice Line • Health Management Programs • Healthy Living Rewards • Travel Benefits/Services 	88
Protection against catastrophic costs (out-of-pocket maximum):	In-Network: \$4,000 self/\$8,000 family Out-of-Network: \$5,500 self/\$11,000 family	15
Lifetime maximum benefit:	In-Network: Unlimited Out-of-Network: \$1,000,000	63

Summary of benefits for the High Option of the - 2007

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$20 copayment (referrals to specialists are not required)	19
Services provided by a hospital:		
• Inpatient	Nothing	37
• Outpatient	Nothing	38
Emergency benefits:		
• In-area	\$50 copayment for emergency room	40
• Out-of-area	\$50 copayment for emergency room	40
Mental health and substance abuse treatment:	Regular cost sharing	43
Prescription drugs:		
• Retail pharmacy	\$10 generic \$20 preferred brand-name \$40 non-preferred brand name	
• Special mail order - up to a 30-day supply	\$40	
• Mail order - up to a 90-day supply	\$20 generic \$40 preferred brand-name \$80 non-preferred brand name	
Dental care:	Limited Dental benefits and discounts under a non-FEHB benefit program.	93
Vision care:	Nothing for routine eye exam. Once every 24 months for over age 22/Once every 12 months for under age 22.	25
Special features:	<ul style="list-style-type: none"> • Pediatric Advice Line • Health Management Programs • Healthy Living Rewards • Travel Benefits/Services 	49

2007 Rate Information for -

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share