UPMC Health Plan

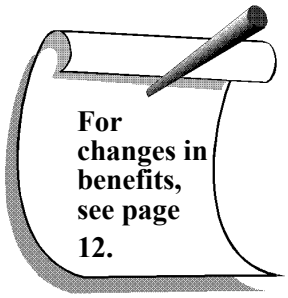
www.upmchealthplan.com/FEHB

UPMC HEALTH PLAN **2012**

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

Serving: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, 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 11 for requirements.



Enrollment code for this Plan:

8W1 High Option – Self Only

8W2 High Option – Self and Family

UW4 Standard Option – Self Only

UW5 Standard Option – 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 2012 Guide for more information on accreditation.

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-797

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, expected to payout as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. 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 your FEHB plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that 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 many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) 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 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 1-877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of UPMC Health Plan 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 UPMC Health Plan's administrative office 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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 11. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means UPMC Health Plan.
- 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 fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 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:

- Do not give 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) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- 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 1-877-648-9641 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, DC 20415-1100

- 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)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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.
- Contact your doctor or pharmacist if you have any questions.

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.

Patient Safety Links

- www.ahrq.gov/consumer/. 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.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- 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.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

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

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use UPMC Health Plan preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

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, a Standard Option, 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 practices 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.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at 1-877-648-9641. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High and Standard HMO Options

Under the High and Standard HMO Options, 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.

We have Open Access benefits

Our HMO offers Open Access benefits. This means that you can receive covered services from a participating provider without a referral from your primary care physician or by another participating provider in the network.

You pay a copayment each time you visit the doctor. Under the High Option HMO, most medical and surgical services are payable at 90% after you meet the plan deductible. Under the Standard Option HMO, most medical and surgical services are payable at 80% after you meet the plan deductible. 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.

For non-emergency services, you must use a participating provider. The High and Standard HMO Options cover emergency 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 copayments or coinsurance.

Preventive care services

Preventive care services are generally paid at 100% without application of the deductible.

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. FEHB program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

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, not received VA benefits within the last three months, not covered by your own or your spouse's flexible spending accounts, 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 an 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 20% 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. 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 $6,050 for Self Only enrollment, or $12,100 Self and Family coverage.

Health education resources and account 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/FEHB and log in to *My*Health OnLine to access tools to help you learn more about your health, including information about specific diseases and conditions you might want to know about. It also helps you learn about your health plan benefits, and it can even help you track your personal health information. You can view personalized information about your physicians, prescriptions, and important reminders for preventive screenings, and have three options to help you manage your health:

- **Online tools for maximizing your health and wellness** and reaching your personal health goals. You can check your symptoms online, update your medical history, and refill your prescriptions.

- **Benefits information that helps you manage your health care finances** and maintain control over your health care dollars. You will find links to plan benefits, prescription savings, spending summaries, and claims review.
- **Expanded online services.** You'll be able to order a new member ID card and change your PCP. You'll also be able to read frequently asked questions.

If you have an **HSA**,

- You can receive a monthly statement mailed to your home outlining your account balance and activity for a minimal monthly fee.
- You can 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/FEHB.
- 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 – 15 years
- Profit status – For-profit subsidiary under a non-profit parent company

If you want more information about us, call 1-877-648-9641, 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/FEHB.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

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, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington and Westmoreland counties.

Under the High and Standard HMO Options, 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 UPMC Health 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 2012

Do not rely only 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.

Program wide changes

- Sections 3, 7, and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148

Changes to our High Option Health Maintenance Organization (HMO)

- Your share of the non-Postal premium will decrease for Self-only and for Self and Family. See page 139.
- The Vision Benefits of America network is replaced with the UPMC Vision *Advantage* network.

Changes to our Standard Option Health Maintenance Organization (HMO)

- Your share of the non-Postal premium will decrease for Self-only and increase for Self and Family. See page 139.
- The Vision Benefits of America network is replaced with the UPMC Vision *Advantage* network.

Changes to our High Deductible Health Plan (HDHP)

- Your share of the non-Postal premium will increase for Self-only and for Self and Family. See page 139.
- The Vision Benefits of America network is replaced with the UPMC Vision *Advantage* network.

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 1-877-648-9641 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 at www.upmchealthplan.com/FEHB.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. You can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. 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. 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 are enrolled in the High or Standard HMO option, you must register your selected primary care physician with us. If you want to change your primary care physician, you may do so at any time by contacting Member Services at 1-877-648-9641. If your primary care physician leaves the Plan, call us and 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 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 the 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**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-877-648-9641. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services 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.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

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

- Abdominoplasty/panniculectomy
- Acupuncture for nausea and vomiting
- Bone growth stimulator, non-invasive
- Breast reduction (excluding reconstruction for breast cancer)
- Carotid angioplasty with stenting
- Cochlear implants and osseointegrated bone stimulators (BAHA)
- Continuous Glucose Monitoring, Long term, Interstitial
- Cranial remolding orthosis

- Dental Anesthesia
- Endovascular stent for abdominal aortic aneurysm
- External insulin pumps (for under 13 years old)
- Genetic testing for Long QT Syndrome
- Growth hormones and certain other prescription drugs (our Your Choice Pharmacy Benefit Guide includes a list of drugs that require prior authorization — contact us at 1-877-648-9641 to request a copy or visit www.upmchealthplan.com/FEHB to view a copy)
- Home telemonitoring
- Long-term acute care (LTAC) admissions
- Lymphedema pumps and appliances
- Microprocessor knee (C Leg)
- Molecular susceptibility testing for breast cancer and/or ovarian cancer (BRCA)
- Negative pressure wound therapy
- Nutritional products
- Oncotype Dx assay for breast cancer
- Organ transplants
- Outpatient/mobile real time cardiac surveillance
- Parenteral nutrition
- Power mobility devices (PMDs)
- Pressure reducing support surfaces - Groups 2 and 3
- Private duty nursing
- Prophylactic mastectomy
- Referrals to non-participating providers (applies to HMO options only)
- Rehabilitation facility admissions
- Selective Internal Radiation Therapy (SIRT)
- Skilled nursing facility (SNF) admissions
- ThAIRapy vests
- Wearable cardiac defibrillator
- Weight reduction surgery
- Wheelchair accessories, repairs, and replacement
- Wheelchair seating
- Wireless capsule endoscopy

If you are considering an artificial insemination procedure, see requirements on page 25 or 73.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 1-877-648-9641 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and

- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

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

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

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

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

   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.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

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 High and Standard HMO Options, you pay a copayment of $20 when you visit a primary care physician for treatment of illness or injury.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.

Deductible

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 High Option HMO is $250 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $500.
- The calendar year deductible under the Standard Option HMO is $350 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $700.
- The calendar year deductible under the HDHP is $2,500 for Self Only 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.

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

Coinsurance is the percentage of our allowance that you must pay for your care. With the exception of preventive care services, coinsurance does not begin until you meet your deductible.

- Under the High Option HMO, you pay 10% of our allowance for covered services.
- Under the Standard Option HMO, you pay 20% of our allowance for covered services.
- Under the HDHP, you pay 20% of our allowance for services received from non-Plan providers.

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 allowance (reasonable and customary charge).

Your catastrophic protection out-of-pocket maximum

Under the High Option HMO, after your deductible and coinsurance totals $1,800 per person or $3,600 per family enrollment in any calendar year, you do not have to pay any more coinsurance for covered services for the remainder of the calendar year. Under the Standard Option HMO, after your deductible and coinsurance totals $3,000 per person or $6,000 per family enrollment in any calendar year, you do not have to pay any more coinsurance for covered services for the remainder of the calendar year. Copayments are not included in the out-of-pocket maximum and must continue to be paid once the out-of-pocket maximum is met. The deductible is included in the catastrophic out-of-pocket maximum.

Under the HDHP, after your out-of-pocket expense (deductible and copayments) 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 (deductible, coinsurance, and copayments) 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 allowance (reasonable and customary charge).

Carryover

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.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Services are entitled to seek reimbursement for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

High and Standard Option Benefits

See page 12 for how our benefits changed this year. Page 132 and page 134 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

The Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. 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 *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 filing advice, or more information about HMO option benefits, contact us at 1-877-648-9641 or at our Web site at www.upmchealthplan.com/FEHB.

Each option offers unique features:

High Option:

This option includes office visit, emergency room, and prescription copayments. Benefits are paid at 100% after the applicable copayment is applied. For most other services, there is an annual deductible applied before any benefits are paid. Once the deductible is met, you pay 10% of the allowable expense. When your out-of-pocket expense for coinsurance and deductible exceeds $1,800 for an individual member, or $3,600 for a family, in any calendar year, your 10% coinsurance is eliminated for the remainder of the calendar year.

The deductible is waived for preventive X-rays and laboratory services.

If you are retired and covered by Medicare Part A as the primary payer of benefits, the annual deductible does not apply to any services under the High Option HMO.

Standard Option:

This option includes office visit, emergency room, and prescription copayments. Benefits are paid at 100% after the applicable copayment is applied. For most other services, there is an annual deductible applied before any benefits are paid. Once the deductible is met, you pay 20% of the allowable expense. When your out-of-pocket expense for coinsurance and deductible exceeds $3,000 for an individual member, or $6,000 for a family, in any calendar year, your 20% coinsurance is eliminated for the remainder of the calendar year.

Deductible and coinsurance is waived for preventive X-ray and laboratory services.

If you are retired and covered by Medicare Parts A and/or B, some cost-sharing is waived under the Standard Option. See page 114.

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.
- The calendar year deductible is $250 individual/$500 family under the High Option and $350 individual/$700 family under the Standard Option. The deductible is waived for services that require a copayment, as well as X-ray and laboratory services for preventive screenings. We added "(No deductible)" to show when the calendar year deductible does not apply.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under the High Option, after your share of coinsurance and deductibles total $1,800 for an individual, or $3,600 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. Under the Standard Option, after your share of coinsurance and deductibles total $3,000 for an individual or $6,000 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. 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 copayments, expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- 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 many of the benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians In physician's office	$20 per office visit for a PCP (No deductible)	$20 per office visit for a PCP (No deductible)
	$35 per office visit for a specialist (No deductible)	$35 per office visit for a specialist (No deductible)
Professional services of physicians		
During a hospital stay	10% of the Plan allowance	20% of the Plan allowance
In a skilled nursing facility	10% of the Plan allowance	20% of the Plan allowance
Office medical consultations Second surgical opinion	$35 per office visit for a specialist (No deductible)	$35 per office visit for a specialist (No deductible)
In an urgent care center	$35 per urgent care center visit (No deductible)	$35 per urgent care center visit (No deductible)
At home	Nothing	20% of the Plan allowance

Benefit Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	10% of the Plan allowance	20% of the Plan allowance
Preventive care, adult	**High Option**	**Standard Option**
Routine physical every 12 months by your PCP, which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening , including - 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	Nothing (No deductible)	Nothing (No deductible)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing (No deductible)	Nothing (No deductible)
Routine Pap test	Nothing (No deductible)	Nothing (No deductible)
Routine mammogram - covered for women age 35 and older, as follows: • 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 (No deductible)	Nothing (No deductible)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing (No deductible)	Nothing (No deductible)
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• *Immunizations, boosters, and medications for travel.*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing (No deductible)	Nothing (No deductible)
• Well-child care charges for routine examinations by the PCP, immunizations and care (up to age 22) • Examinations, such as: - Annual eye exams through age 18 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing (No deductible)	Nothing (No deductible)
Not Covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Immunizations, boosters, and medications for travel*	*All Charges*	*All Charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • 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.	10% of the Plan allowance	20% of the Plan allowance

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Maternity care (cont.)	**High Option**	**Standard Option**
• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits* (Section 5c) and *Surgery benefits* (Section 5b).	10% of the Plan allowance	20% of the Plan allowance
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$20 per office visit (No deductible)	$20 per office visit (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) 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. To obtain a list of Plan providers who are credentialed by UPMC Health Plan in Reproductive Endocrinology, please contact Member Services at 1-877-648-9641 or visit www.upmchealthplan.com/FEHB. To request prior approval to utilize a Plan provider who is not Board Certified in Reproductive Endocrinology, please contact Member Services at 1-877-648-9641.	10% of the Plan allowance	20% of the Plan allowance
Not covered:	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	**High Option**	**Standard Option**
Assisted reproductive technology (ART) procedures, such as: • *In vitro fertilization* • *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$20 per visit to PCP (No deductible)	$20 per visit to PCP (No deductible)
• Allergy injections	$35 per visit to specialist (No deductible)	$35 per visit to specialist (No deductible)
Allergy serum	10% of the Plan allowance	20% of the Plan allowance
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 36. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Medical nutrition therapy to treat a chronic illness or condition; includes nutrition assessment and nutritional counseling by a dietitian or facility-based program which is ordered by a participating physician. - Chronic Renal Disease, Diabetes Mellitus, and High Risk Obstetrical Symptomatic Conditions: unlimited number of visits when medically necessary. - Morbid Obesity: limited to an initial assessment and five follow-up visits for a total of six visits per calendar year. - Heart Disease, Symptomatic HIV/AIDS, and Celiac Disease: limited to two visits per calendar year. • Growth hormone therapy (GHT)	10% of the Plan allowance	20% of the Plan allowance

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: Growth hormone is covered under the prescription drug benefit. 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. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* on Section 3.	10% of the Plan allowance	20% of the Plan allowance
Not covered: *None related to this benefit*	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**
Limited to the greater of 60 consecutive days of coverage or 25 visits per outpatient condition, per calendar year. • Qualified physical therapists • Occupational therapists 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. Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction is provided for up to 12 weeks of sessions.	$20 per outpatient visit (No deductible) For therapy received during a covered inpatient admission — 10% of the Plan allowance 10% of the Plan allowance	$20 per outpatient visit (No deductible) For therapy received during a covered inpatient admission — 20% of the Plan allowance 20% of the Plan allowance
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Limited to the greater of 60 consecutive days of coverage or 25 outpatient visits per condition, per calendar year.	$20 per outpatient visit (No deductible) For therapy received during a covered inpatient admission — 10% of the Plan allowance	$20 per outpatient visit (No deductible) For therapy received during a covered inpatient admission — 20% of the Plan allowance
Not covered: • *Speech therapy provided for developmental delays*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	10% of the Plan allowance	20% of the Plan allowance
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	10% of the Plan allowance	20% of the Plan allowance
Not covered: • *Hearing aid batteries* • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One pair of standard 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 under age 19 To use your eye examination benefit, call us at 1-877-648-9641 or visit www.upmchealthplan.com to locate a vision care provider.	10% of the Plan allowance Nothing (No deductible)	20% of the Plan allowance Nothing (No deductible)
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$25 per office visit (No deductible)	$25 per office visit (No deductible)
Not covered: • *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)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids up to a benefit limit of $1,500 per ear. For newborns and children through age 17, the benefit is available once in every 24-month period. For patients age 18 or older, the benefit is available once in every 36-month period. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility*, and *Ambulance services*.	10% of the Plan allowance (plus any amount in excess of the benefit limit for hearing aids)	20% of the Plan allowance (plus any amount in excess of the benefit limit for hearing aids)
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads, and heel cups (covered only with a diagnosis of diabetes or peripheral vascular disease)* • *Lumbosacral supports*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Corsets, trusses, elastic stockings, support hose, and other supportive devices (gradient compression stockings may be covered for certain diagnoses)* • *Prosthetic replacements when it is determined by us that a repair costs less than 50% of a replacement* • *Hearing aid batteries*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Insulin pumps Note: Call us at 1-877-648-9641 as soon as your Plan physician prescribes this equipment. We can assist you in locating a participating supplier.	10% of the Plan allowance	20% of the Plan allowance
Not covered: • *Audible prescription reading devices* • *Replacement or duplication except when necessitated due to a change in the patient's medical condition or the cost to repair the item exceeds 50% of the price of a new item* • *Comfort or convenience items, for your comfort or convenience or the comfort or convenience of your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty services, guest service or similar items, even if recommended by a professional provider.* • *Medical equipment and supplies that are:*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
- *expendable in nature (i.e. disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and* - *primarily used for non-medical purposes, regardless of whether recommended by a professional provider*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), or home health aide • Services include oxygen therapy, intravenous therapy, and medications	10% of the Plan allowance	20% of the Plan allowance
Not covered: • *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*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• 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 covered visit thereafter. (No deductible)	$35 for the first office visit, then $20 for each covered visit thereafter. (No deductible)
Alternative treatments	**High Option**	**Standard Option**
We cover acupuncture for the following conditions: • Nausea and vomiting of pregnancy (hyperemesis gravidarum) • Post-operative nausea and vomiting • Post-chemotherapy nausea and vomiting	10% of the Plan allowance	20% of the Plan allowance
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture, other than listed above*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Educational classes and programs	**High Option**	**Standard Option**
Lifestyle Modification Program for Reversing Heart Disease - a comprehensive lifestyle modification program designed to assist in the management of coronary artery disease by emphasizing nutritional counseling, therapeutic exercise, stress management techniques, and regular participation in a professionally supervised support group, on an outpatient basis. Coverage will be provided if patient meets specific benefit eligibility criteria and is certified for participation by his/her attending physician. The program requires a one-year minimum participation commitment and must be provided by a Lifestyle Modification Program participating provider. Coverage is limited to one-time enrollment in the program per lifetime, regardless of whether the patient completes the program. This program is only offered at selected participating sites; class size may be limited.	10% of the Plan allowance	20% of the Plan allowance
Nutritional Counseling - the assessment of a person's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or nutritional therapies to treat a chronic illness or condition. Services must be delivered by a dietitian or facility-based program, ordered by a participating physician and offered by a participating provider. Coverage is limited to two visits per calendar year. Also see *Medical nutrition therapy* under *Treatment therapies* on page 27.	10% of the Plan allowance	20% of the Plan allowance
Tobacco Cessation - individual/group telephone counseling provided by UPMC Health Plan (call 1-800-807-0751), and over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. You must have a written prescription from your doctor for all medications, including OTC, in order to obtain coverage. See *Prescription drug benefits*.	Nothing (No deductible)	Nothing (No deductible)

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.
- The calendar year deductible under the High Option is $250 individual/$500 family. The calendar year deductible under the Standard Option is $350 individual/$700 family.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under the High Option, after your share of coinsurance and deductibles total $1,800 for an individual or $3,600 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. Under the Standard Option, after your share of coinsurance and deductibles total $3,000 for an individual or $6,000 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. 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 copayments, expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- 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 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 PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES**. Please refer to the prior authorization 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...	
Note: The calendar year deductible applies to all of the benefits in this Section.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • 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 *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery)	10% of the Plan allowance	20% of the Plan allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 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.	10% of the Plan allowance	20% of the Plan allowance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All Charges*	*All Charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - 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: - 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*) 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.	10% of the Plan allowance	20% of the Plan allowance
Not covered:	*All Charges*	*All Charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• *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* • *Surgeries related to sex transformation*	*All Charges*	*All Charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • 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 • Other surgical procedures that do not involve the teeth or their supporting structures	10% of the Plan allowance	20% of the Plan allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	10% of the Plan allowance	20% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologus tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	10% of the Plan allowance	20% of the Plan allowance
Blood or marrow stem cell transplants are limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's PNH, Pure Red Cell Aplasia)	10% of the Plan allowance	20% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucupolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	10% of the Plan allowance	20% of the Plan allowance
Mini-transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogenic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed)	10% of the Plan allowance	20% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma	10% of the Plan allowance	20% of the Plan allowance
These 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. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessaary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major	10% of the Plan allowance	20% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Sickle Cell anemia	10% of the Plan allowance	20% of the Plan allowance
• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia		
• Autologous Transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis 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. *Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.*	10% of the Plan allowance	20% of the Plan allowance
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*	*All Charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient)	10% of the Plan allowance	20% of the Plan allowance
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	10% of the Plan allowance	20% of the Plan allowance

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.
- The calendar year deductible is $250 individual/$500 family under the High Option and $350 individual/$700 family under the Standard Option.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under the High Option, after your share of coinsurance and deductibles total $1,800 for an individual or $3,600 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. Under the Standard Option, after your share of coinsurance and deductibles total $3,000 for an individual or $6,000 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. 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 copayments, expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- 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 PRIOR AUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to all of the benefits in this section.		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • 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.	10% of the Plan allowance	20% of the Plan allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services	10% of the Plan allowance	20% of the Plan allowance

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Medical supplies and equipment, including oxygen	10% of the Plan allowance	20% of the Plan allowance
• 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	10% of the Plan allowance	20% of the Plan allowance
Not covered: • *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*	*All Charges*	*All Charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• 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 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.	10% of the Plan allowance	20% of the Plan allowance
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Extended care benefit: Limited to 100 days per calendar year combined with Skilled nursing facility admissions	10% of the Plan allowance	20% of the Plan allowance
Skilled nursing facility (SNF): Limited to 100 days per calendar year combined with Extended care facility admissions.	10% of the Plan allowance	20% of the Plan allowance
Not covered: Custodial care	*All Charges*	*All Charges*

Benefit Description	You pay After the calendar year deductible...	
Hospice care	**High Option**	**Standard 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.	10% of the Plan allowance	20% of the Plan allowance
Not covered: Independent nursing, homemaker services	*All Charges*	*All Charges*
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate	10% of the Plan allowance	20% of the Plan allowance

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 calendar year deductible is $250 individual/$500 familyunder the High Option and $350 individual/$700 family under the Standard Option. The deductible is waived for services that require a copayment. We added "(No deductible)" to show when the calendar year deductible does not apply.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under the High Option, after your share of coinsurance and deductibles total $1,800 for an individual or $3,600 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. Under the Standard Option, after your share of coinsurance and deductibles total $3,000 for an individual or $6,000 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. 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 copayments, expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- 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 physician 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 personal 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 you receive emergency room treatment or are admitted to the hospital, contact your personal physician as soon as possible**.**

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 you receive emergency room treatment or are admitted to the hospital, contact your PCP to arrange for any necessary follow-up care when you return to the service area.

Benefit Description	You pay After the calendar year deductible…	
Emergency within our service area	**High Option**	**Standard Option**
• 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 Note: We waive the ER copay if you are admitted to the hospital.	$20 per doctor's office visit (No deductible) $35 per office visit for a specialist (No deductible) $35 per urgent care center visit (No deductible) $75 per hospital emergency room visit (No deductible)	$20 per doctor's office visit (No deductible) $35 per office visit for a specialist (No deductible) $35 per urgent care center visit (No deductible) $75 per hospital emergency room visit (No deductible)
Not covered: • *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* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges*	*All Charges*
Emergency outside our service area	**High Option**	**Standard Option**
• 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 Note: We waive the ER copay if you are admitted to the hospital.	$20 per doctor's office visit (No deductible) $35 per office visit for a specialist (No deductible) $35 per urgent care center visit (No deductible) $75 per hospital emergency room visit (No deductible)	$20 per doctor's office visit (No deductible) $35 per office visit for a specialist (No deductible) $35 per urgent care center visit (No deductible) $75 per hospital emergency room visit (No deductible)
Not covered: • *Elective care, 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* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All Charges*	*All Charges*

Benefit Description	You pay After the calendar year deductible…	
Ambulance	**High Option**	**Standard Option**
Professional ambulance service when medically appropriate Note: See 5(c) for non-emergency service.	10% of the Plan allowance	20% of the Plan allowance

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are 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.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- 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 FOR THESE SERVICES.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
  - **Prior authorization:** To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes. Call UPMC Health Plan Behavioral Health Services at 1-888-251-0083 to locate a Plan provider and for assistance with required prior authorization.
  - **Limitation:** We may limit your benefits if you do not obtain a treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members, or providers upon request or as otherwise required.
- 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.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to some of the benefits in this Section. We added "(No deductible)" when it does not apply.		
Professional services	**High Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes	$20 per office visit (No deductible) 10% of the Plan allowance for other covered services	$20 per office visit (No deductible) 20% of the Plan allowance for other covered services

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Professional services (cont.)	**High Option**	**Standard Option**
• Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 per office visit (No deductible) 10% of the Plan allowance for other covered services	$20 per office visit (No deductible) 20% of the Plan allowance for other covered services
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	10% of the Plan allowance	20% of the Plan allowance
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	10% of the Plan allowance	20% of the Plan allowance
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	10% of the Plan allowance	20% of the Plan allowance

Benefit Description	You pay After the calendar year deductible...	
Not covered	**High Option**	**Standard Option**
• *Inpatient or outpatient treatment related to mental retardation, pervasive developmental disorder, or autism, which extends beyond traditional medical management* • *Treatment for personality disorders where that is the primary diagnosis* • *Treatment for learning disabilities, behavioral problems, or conditions in which an individual is eligible for Social Security disability benefits for a mental or emotional disability* • *Services related to disorders that are not treatable DSM-IV-TR-defined mental disorders* • *Treatment for organic disorders, including, but not limited, to organic brain disease* • *Services not expected to result in substantial improvement in a member's condition and/or level of function* • *Chronic maintenance therapy, except in the case of serious mental illness* • *Treatment for chronic behavioral conditions, once the member has been restored to the pre-crisis level of function* • *Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder* • *Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies such as art or psychodrama, and hyperbaric or other therapy* • *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 conditions, including, but not limited to, eating disorders or addictive gambling* *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.*	*All Charges*	*All Charges*

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 for prescription drug benefits.
- 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.
- Some drugs may require prior authorizations. If a drug requires prior authorization, your doctor must consult with the Plan before prescribing it. Prior authorizations are set on a drug-by-drug basis and require specific criteria for appoval based upon FDA and manufacturer guidelines, medical literature, safety concerns, and appropriate use.

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 1-877-648-9641 or visit www.upmchealthplan.com/FEHB 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. 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 Pharmacy Benefit Guide, call Member Services at 1-877-648-9641. You can also visit www.upmchealthplan.com/FEHB. 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.
- **There are dispensing limitations.** Covered prescription drugs obtained at a participating retail pharmacy will be dispensed for a 30-day supply for one copayment or a 90-day supply for three copayments. Controlled substance medications are limited to a 30-day supply. Specialty prescription drugs obtained through the Plan's specialty mail order pharmacy will be dispensed for up to a 30-day supply. Prescriptions for maintenance drugs obtained through the Plan's mail order pharmacy will be dispensed up to a 90-day supply. Medications will be dispensed based on FDA guidelines.

  If you will be away from home for an extended period of time, or if you will be traveling outside of the country, consider using mail-order so that you can receive a 90-day supply prior to traveling. If you need an emergency supply of medication, call Member Services at 1-877-648-9641.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a brand-name. If you receive a brand-name drug when a federally-approved generic drug is available, you have to pay the difference in cost between the brand-name 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 then 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 1-877-648-9641 or visit www.upmchealthplan.com/FEHB to obtain a prescription drug reimbursement form.

Benefit Description	You pay
Covered medications and supplies (The Your Choice Formulary Applies)	**High and Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail-order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • 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 • Tobacco cessation drugs, including over-the-counter (OTC) drugs approved by the FDA to treat tobacco dependence (See page 33).	Retail (up to a 30-day supply) $5 copayment for generic drugs $35 copayment for preferred brand-name drugs $70 copayment for non-preferred brand-name drugs 90-day maximum retail supply available at certain retail outlets for three copayments. Specialty Prescription Drugs (up to a 30-day supply) $70 copayment Mail Order (up to a 90-day supply) $10 copayment for generic drugs $70 copayment for preferred brand-name drugs $140 copayment for non-preferred brand-name drugs Notes: • If there is no generic equivalent available, you will still have to pay the brand name copay. • Copayments are waived for tobacco cessation drugs
Not covered: • *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 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 phenylketonuris (PKU) branched-chain ketonuris, galactosemia, and homocystinuria as administered under the direction of a physician.* • *Nonprescription medicines, except those listed on the Your Choice Formulary* • *Medications prescribed for foreign travel*	*All Charges*

Important telephone numbers:

For questions about your pharmacy benefits and participating retail locations, call UPMC Health Plan at: **1-877-648-9641**

For specialty drug orders, call CuraScript at **1-877-787-6279.**

For mail-order maintenance drug orders, call Express Scripts at **1-877-787-6279.**

Section 5(g). 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
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- The calendar year deductible is $250 individual/$500 family under the High Option and $350 individual/$700 family under the Standard Option.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under the High Option, after your share of coinsurance and deductibles total $1,800 for an individual or $3,600 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. Under the Standard Option, after your share of coinsurance and deductibles total $3,000 for an individual or $6,000 for a family in any calendar year, coinsurance for covered services increases to 100% for the remainder of the calendar year. 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 copayments, expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- 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 After the calendar year deductible...	
Accidental injury benefit	**High Option**	**Standard 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.	10% of the Plan allowance	20% of the Plan allowance

Dental benefits

We have no other dental benefits.

Section 5(h). Special features

Feature	Description
Feature	**High Option**
***My*Health Advice Line**	Members now have immediate access to health care advice through the *My*Health Advice Line at **1-866-918-1591**. The service, available at no additional cost, allows members to address their health care concerns when their doctor is out of the office. Members seeking general health advice or information regarding a specific medical issue can call the *My*Health Advice Line to speak with experienced registered nurses trained to provide members with prompt and efficient service.
Services for members who have a hearing impairment	UPMC Health Plan communicates by telephone with our members who have a hearing impairment through TTY. If you have a hearing impairment, call our TTY number at 1-800-361-2629.
Maternity program	Our maternity program can help you have a healthy pregnancy. Enrolling in our program will allow our health coaches and care managers to help you: • Identify the goals that are important to you and your baby. • Create a plan to achieve your goals. • Reach your goals by providing education and resources about your pregnancy. • Get answers about your pregnancy and newborn care. Call 1-877-648-9641 to enroll. 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 1-877-648-9641 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	UPMC operates health management programs for members who have been diagnosed with diabetes, heart or respiratory 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. 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. 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.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
***My*Health Community**	We offer members savings through our exclusive *My*Health Community 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. You can find a listing of businesses that participate in our *My*Health Community program in your provider directory or on our website at www.upmchealthplan.com/FEHB.
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.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
Lifestyle Health Coaching Program	Our health coaches can provide telephone support and guidance to help you stay motivated. They can work with you to set goals and design action plans that will lay the foundation for long-term success. Our health coaches are experienced professionals who stay abreast of the most recent health research and coaching techniques. They are knowledgeable about the most effective ways to help you make healthy lifestyle changes and to sustain these changes over a lifetime. The coaches' goal is to empower you to make wise choices daily to achieve and maintain your optimal level of health. Health coaches encourage participants to set realistic, timely goals and to develop action plans to: • Lose weight • Be more active • Eat healthier • Reduce stress • Quit tobacco use Hours of operation are 7 a.m. to 7 p.m. Monday through Friday, and 8 a.m. to 3 p.m. on Saturdays. Call 1-800-807-0751.

High Deductible Health Plan Benefits

See page 12 for how our benefits have changed this year and page 136 for a benefits summary

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 *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 1-877-648-9641 or visit our Web site at www.upmchealthplan.com/FEHB.

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 credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

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 71. 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 for the preventive care 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 65 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 2012, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $104 per month for a Self Only enrollment or $208 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, which is $3,100 for an individual and $6,250 for a family. See maximum contribution information on page 64. 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 ACS/BNY Mellon
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits, using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- 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 (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, 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 2012, we will give you an HRA credit of $1,250 per calendar year for a Self Only enrollment and $2,500 per calendar 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.

• **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 ACS | BNY Mellon, this HDHP's fiduciary (an administrator, trustee, or custodian as defined by Federal tax code and approved by the IRS.)	UPMC Health Plan is the HRA fiduciary for this Plan.
Fees	Set-up and monthly service fee is paid by the HDHP.	None.
Eligibility	You must: • 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 • Not be claimed as a dependent on someone else's tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork. 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.	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
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. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	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 2012, a monthly premium pass-through of $104 will be made by the HDHP directly into your HSA each month.	For 2012, your HRA annual credit is $1,250 (prorated for midyear enrollment).
• **Self and Family enrollment**	For 2012, a monthly premium pass-through of $208 will be made by the HDHP directly into your HSA each month.	For 2012, your HRA annual credit is $2,500 (prorated for midyear enrollment).

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Contributions/ credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass-through and enrollee contribution funds, which when combined do not exceed the maximum contribution amount set by the IRS, $3,100 for an individual and $6,250 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial-year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. 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). Catch-up contributions are discussed on page 67.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.
Self Only enrollment	You may make an annual maximum contribution of $1,850.	You cannot contribute to the HRA.
Self and Family enrollment	You may make an annual maximum contribution of $3,750.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit card • Checks	

		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.
Distributions/ withdrawals • **Medical**	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. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty; however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • 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. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 63 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. 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.
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 maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions of any amount at any time, but cannot 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. **Your own HSA** contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial-year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS, as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution will be $1,000 in 2010 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 and 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, physician prescribed 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 physician prescribed over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimburseable 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 20% 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. 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 you 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 63 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
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

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
Preventive care, adult	
Routine screenings, such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including - 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: - 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	In-Network: Nothing Out-of-Network: 20%
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): Routine physicals which include: • One exam every 24 months up to age 65 • One exam every 12 months age 65 and older Routine exams limited to: • One routine OB/GYN exam every 12 months, including 1 Pap smear and related services	In-Network: Nothing Out-of-Network routine physicals: *All charges* Other Out-of-Network services: 20%

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
• One routine hearing exam every 24 months • One routine eye exam every 12 months	In-Network: Nothing Out-of-Network routine physicals: *All charges* Other Out-of-Network services: 20%
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Immunizations, boosters, and medications for travel or work-related exposure* • *Routine physical exams by an out-of-network provider*	*All Charges*
Preventive care, children	
Professional services, such as: • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics Examinations such as: • Eye exam through age 18 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction	In-Network: Nothing Out-of-Network well child visits: *All charges* Other Out-of-Network services: 20%
Not covered: • *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*	*All Charges*

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 69) and is not subject to the calendar year deductible.
- The deductible is $2,500 for Self Only enrollment or $5,000 Self and Family enrollment. The family deductible can be satisfied by one or more members of the family. The deductible applies to almost all benefits under the Traditional medical coverage. You must pay the deductible before your traditional medical coverage may begin.
- 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, and 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.
- 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	
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 Only 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.	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. Out-of-network: After you meet the deductible, you pay coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.

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 Only enrollment only or $5,000 Self and Family enrollment each calendar year. The Self and Family deductible must be satisfied by one or more family members.
- The deductible applies to all benefits in this section unless we indicate differently.
- 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	
Professional services of physicians • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultants • Second surgical opinion	In-Network: Nothing Out-of-Network: 20%
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • 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	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • 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 *Hospital benefits* (Section 5c) and *Surgery benefits* (Section 5b).	In-Network: Nothing Out-of-Network: 20%
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 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. To obtain a list of Plan providers who are credentialed by UPMC Health Plan in Reproductive Endocrinology, please contact Member Services at 1-877-648-9641 or visit www.upmchealthplan.com/FEHB. To request prior approval to utilize a Plan provider who is not Board Certified in Reproductive Endocrinology, please contact Member Services at 1-877-648-9641.	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* • *in vitro fertilization* • *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All Charges*
Allergy care	
• Testing and treatment • Allergy injections	In-Network: Nothing Out-of-Network: 20%
Allergy serum	In-Network: Nothing Out-of-Network: 20%

Benefit Description	You pay After the calendar year deductible…
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 84. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Medical nutrition therapy to treat a chronic illness or condition; includes nutrition assessment and nutritional counseling by a dietitian or facility-based program which is ordered by a physician. - Chronic Renal Disease, Diabetes Mellitus, and High Risk Obstetrical Symptomatic Conditions: unlimited number of visits when medically necessary - Morbid Obesity: limited to an initial assessment and five follow-up visits for a total of six visits per calendar year - Heart Disease, Symptomatic HIV/AIDS, and Celiac Disease: limited to two visits per calendar year • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. 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. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* in Section 3.	In-Network: Nothing Out-of-Network: 20%
Physical and occupational therapies	
Limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year. • Qualified physical therapists • Occupational therapists 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.	In-Network: Nothing Out-of-Network: 20%

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies (cont.)	
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 sessions.	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All Charges*
Speech therapy	
Limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year.	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Speech therapy for developmental delays*	*All Charges*
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care, children.	In-Network: Nothing Out-of-Network: 20%
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Hearing aid batteries* • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of standard 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 under age 19. To use you eye examination benefit, call us at 1-877-648-9641 or visit www.upmchealthplan.com to locate a vision care provider.	In-Network: Nothing (No deductible) Out-of-Network: Any amount over $30 per examination (No deductible)

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies) (cont.)	
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All Charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	In-Network: Nothing Out-of-Network: 20%
Not covered: • *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)*	*All Charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids up to a benefit limit of $1,500 per ear. For newborns and children through age 17, the benefit is available once in every 24-month period. For patients age 18 or older, the benefit is available once in every 36-month period. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.	In-Network: Nothing Out-of-Network: 20%

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility*, and *Ambulance services*.	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads, and heel cups (covered only with a diagnosis of diabetes or peripheral vascular disease)* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices (gradient compression stockings may be covered for certain diagnoses)* • *Prosthetic replacements when it is determined by us that a repair costs less than 50% of a replacement* • *Hearing aid batteries*	*All Charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Insulin pumps Note: Call us at 1-877-648-9641 as soon as your physician prescribes this equipment. We can assist you in locating a participating supplier.	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Audible prescription reading devices* • *Replacement or duplication except when necessitated due to a change in the patient's medical condition or the cost to repair the item exceeds 50% of the price of a new item*	*All Charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	
• *Comfort or convenience items, for your comfort or convenience or the comfort or convenience of your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty services, guest service or similar items, even if recommended by a professional provider.* • *Medical equipment and supplies that are:* - *expendable in nature (i.e. disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and* - *primarily used for non-medical purposes, regardless of whether recommended by a professional provider*	*All Charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), or home health aide. • Services include oxygen therapy, intravenous therapy and medications	In-Network: Nothing Out-of-Network: 20%
Not covered: • *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	
• 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%

Benefit Description	You pay After the calendar year deductible…
Alternative treatments	
Coverage is limited to acupuncture for the following conditions: • Nausea and vomiting of pregnancy (hyperemesis gravidarum) • Post-operative nausea and vomiting • Post-chemotherapy nausea and vomiting	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture, other than listed above*	*All charges*
Educational classes and programs	
Lifestyle Modification Program for Reversing Heart Disease - a comprehensive lifestyle modification program designed to assist in the management of coronary artery disease by emphasizing nutritional counseling, therapeutic exercise, stress management techniques, and regular participation in a professionally supervised support group, on an outpatient basis. Coverage will be provided if patient meets specific benefit eligibility criteria and is certified for participation by his/her attending physician. The program requires a one-year minimum participation commitment and must be provided by a Lifestyle Modification Program participatin provider. Coverage is limited to one-time enrollment in the program per lifetime, regardless of whether the patient completes the program. This program is only offered at selected participating sites; class size may be limited.	In-Network: Nothing Out-of-Network: Not covered
Nutritional Counseling - the assessment of a person's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or nutrition therapies to treat a chronic illness or condition. Services must be delivered by a dietitian or facility-based program, ordered by a participating physician and offered by a participating provider. Coverage is limited to two visits per calendar year. Also see *Medical nutrition therapy* under *Treatment therapies* on page 75.	In-Network: Nothing Out-of-Network: 20% of the Plan allowance

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs (cont.)	
Tobacco Cessation - individual/group telephone counseling provided by UPMC Health Plan (call 1-800-807-0751), and over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. You must have a written prescription from your doctor for all medications, including OTC, in order to obtain coverage. See *Prescription drug benefits.*	Nothing (No deductible)

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 Only or $5,000 Self and Family enrollment. The family deductible can be met by one or more members of the family. The deductible applies to all benefits in this section.
- After you have satisfied your annual deductible, coverage begins for Traditional medical services.
- Under Traditional medical coverage, you are responsible for your coinsurance amounts 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 PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES**. Please refer to the prior authorization 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	
A comprehensive range of services, such as: • 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 *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices . See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	In-Network: Nothing Out-of-Network: 20%

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
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.	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All Charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - 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: - 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*) 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.	In-Network: Nothing Out-of-Network: 20%
Not covered: • *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* • *Surgeries related to sex transformation*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • 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 • Other surgical procedures that do not involve the teeth or their supporting structures	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All Charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	In-Network: Nothing Out-of-Network: 20%
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologus tandem transplants for	In-Network: Nothing Out-of-Network: 20%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-Network: Nothing Out-of-Network: 20%
Blood or marrow stem cell transplants are limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucupolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants)	In-Network: Nothing Out-of-Network: 20%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	In-Network: Nothing Out-of-Network: 20%
Mini-transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogenic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis	In-Network: Nothing Out-of-Network: 20%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma	In-Network: Nothing Out-of-Network: 20%
These 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. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessaary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for:	In-Network: Nothing Out-of-Network: 20%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	In-Network: Nothing Out-of-Network: 20%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
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. *Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.*	In-Network: Nothing Out-of-Network: 20%
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	In-Network: Nothing Out-of-Network: 20%
Professional services provided in – • 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 Only enrollment or $5,000 Self and Family enrollment. The family deductible can be satisfied by one or more members of the family. The deductible applies to all benefits in this section.
- After you have satisfied your annual deductible, coverage begins for Traditional medical services.
- Under Traditional medical coverage, you are responsible for your coinsurance amounts 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 PRIOR AUTHORIZATION FOR HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require prior authorization.

Benefit Description	You Pay after the calendar year deductible...
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • 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: • 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	In-Network: Nothing Out-of-Network: 20%

Inpatient hospital - continued on next page

Benefit Description	You Pay after the calendar year deductible...
Inpatient hospital (cont.)	
• 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%
Not covered: • *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*	*All Charges*
Outpatient hospital or ambulatory surgical center	
• 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 blooc plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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.	In-Network: Nothing Out-of-Network: 20%
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: Limited to 100 days per calendar year combined with skilled nursing facility admissions.	In-Network: Nothing Out-of-Network: 20%
Skilled nursing facility (SNF): Limited to 100 days per calendar year combined with skilled nursing facility admissions.	In-Network: Nothing Out-of-Network: 20%
Not covered: Custodial care	*All charges*

Benefit Description	You Pay after the calendar year deductible...
Hospice care	
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.	In-Network: Nothing Out-of-Network: 20%
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
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 Only enrollment or $5,000 Self and Family enrollment. The family deductible can be satisfied by one or more members of the family. The deductible applies to all the benefits in this section.
- After you have satisfied your annual deductible, coverage begins for Traditional medical services.
- Under Traditional medical coverage, you are responsible for your coinsurance amounts 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 physician 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 personal 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 personal physician as soon as possible.

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.

If you are admitted to the hospital, contact our Member Services Department at 1-877-648-9641 within 48 hours.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	
• 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	Nothing
Not covered: Elective care or non-emergency care	*All Charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctor's services	Nothing
Not covered: • *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* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*In-network - all charges* Out-of-network - 20%
Ambulance	
Professional ambulance service when medically appropriate Note: See 5(c) for non-emergency service.	Nothing
Accidental injury	
Accidental injury	Nothing

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are 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.
- The calendar year deductible applies to all benefits in this Section.
- 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 FOR THESE SERVICES.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan
  - **Prior authorization:** To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes. Call UPMC Health Plan Behavioral Health Services at 1-888-251-0083 to locate a Plan provider and for assistance with required prior authorization.
  - **Limitation:** We may limit your benefits if you do not obtain a treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members, or providers upon request or as otherwise required.
- 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.

Benefit Description	You pay After the calendar year deductible…
Professional services	
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy)	In-Network: Nothing Out-of-Network: 20%

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional services (cont.)	
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-Network: Nothing Out-of-Network: 20%
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-Network: Nothing Out-of-Network: 20%
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	In-Network: Nothing Out-of-Network: 20%
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-Network: Nothing Out-of-Network: 20%
Not covered	
• *Inpatient or outpatient treatment related to mental retardation, pervasive developmental disorder, or autism, which extends beyond traditional medical management* • *Treatment for personality disorders where that is the primary diagnosis*	*All Charges*

Not covered - continued on next page

Benefit Description	You pay After the calendar year deductible…
Not covered (cont.)	
• *Treatment for learning disabilities, behavioral problems, or conditions in which an individual is eligible for Social Security disability benefits for a mental or emotional disability* • *Services related to disorders that are not treatable DSM-IV-TR-defined mental disorders* • *Treatment for organic disorders, including, but not limited, to organic brain disease* • *Services not expected to result in substantial improvement in a member's condition and/or level of function* • *Chronic maintenance therapy, except in the case of serious mental illness* • *Treatment for chronic behavioral conditions, once the member has been restored to the pre-crisis level of function* • *Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder* • *Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies such as art or psychodrama, and hyperbaric or other therapy* • *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 conditions, including, but not limited to, eating disorders or addictive gambling* *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.*	*All Charges*

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 on page 100.

- 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 Only enrollment or $5,000 Self and Family enrollment. The family deductible can be satisfied by one or more members of the family. The deductible applies to all benefits in this section.
- After you have satisfied your annual deductible, coverage begins for Traditional medical services, including prescription drugs.
- Your covered prescription expense can be applied toward satisfaction of the deductible, even if you use a non-participating pharmacy.
- Once you've met the deductible, there is no out-of-network coverage for prescription drugs. The prescription drug network is a nationwide network.
- You are responsible for copayments for eligible prescriptions after the deductible is met.
- 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.
- Some drugs may require prior authorization. If a drug requires prior authorization, your doctor must consult with the Plan before prescribing it. Prior authorizations are set on a drug-by-drug basis and require specific criteria for approval based upon FDA and manufacturer guidelines, medical literature, safety concerns, and appropriate use.

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?** Covered prescription drugs obtained from a non-participating pharmacy will apply toward the deductible. Once you've met the deductible, 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 1-877-648-9641 or visit www.upmchealthplan.com/FEHB for assistance in locating a participating pharmacy near you.
- **We use a formulary.** The ***Your Choice*** formulary applies. If your physician believes a brand-name product is necessary or there is no generic available, your physician may prescribe a brand-name drug from a formulary list. This list of brand-name drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. 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 Pharmacy Benefit Guide, call Member Services at 1-877-648-9641. You can also visit www.upmchealthplan.com/FEHB. 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 will be dispensed for a 30-day supply for one copayment or a 90-day supply for three copayments. Controlled substance medications are limited to a 30-day supply. Specialty prescription drugs obtained through the Plan's specialty mail order pharmacy will be dispensed for up to a 30-day supply. Prescriptions for maintenance drugs obtained through the Plan's mail order pharmacy will be dispensed up to a 90-day supply. Medications will be dispensed based on FDA guidelines.

  If you will be away from home for an extended period of time, or if you will be traveling outside of the country, consider using mail-order so that you receive a 90-day supply prior to traveling. If you need an emergency supply of medication, call Member Services at 1-877-648-9641.

- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a brand-name. If you receive a brand-name drug when a Federally-approved generic drug is available you have to pay the difference in cost between the brand-name 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 1-877-648-9641 or visit www.upmchealthplan.com/FEHB to obtain a prescription drug reimbursement form.

How to use your prescription drug benefits:

If you...	HSA have not yet met the annual deductible	HSA have met the annual self/ self and family deductible	HSA have met the annual out-of-pocket maximum for self/ self and family	HRA have not yet met the annual deductible	HRA have met the annual self/ self and family deductible	HRA have met the annual out-of-pocket maximum for self/ self and family
You must:						
Use a participating pharmacy	no	yes	yes	yes	yes	yes
Show your UPMC Health Plan identification card at point of purchase	yes, if you use a participating pharmacy	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 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 used a non-participating pharmacy or did not show your UPMC Health Plan ID card at a participating pharmacy	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…
Covered medications and supplies (The Your Choice Formulary applies)	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail-order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • 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 • Tobacco cessation drugs including over-the-counter (OTC) drugs approved by the FDA to treat tobacco dependence. (See page 81).	**In-Network:** Retail (up to a 30-day supply) $5 copayment for generic drugs $35 copayment for preferred brand-name drugs $70 copayment for non-preferred brand-name drugs 90-day maximum supply available at certain retail outlets for three copayments. Specialty Prescription Drugs (up to a 30-day supply) $70 copayment Mail-Order (up to a 90-day supply) $10 copayment for generic drugs $70 copayment for preferred brand-name drugs $140 copayment for non-preferred brand-name drugs Notes: • If there is no generic equivalent available, you will pay the brand-name copayment. • Copayments are waived for tobacco cessation drugs. (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy (after the plan deductible is met)* • *Vitamins, nutrients, and food supplements even if a physician prescribers 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 phenylketonuris (PKU) branched-chain ketonuris, galactosemia, and homocystinuria as administered under the direction of a physician.* • *Non-prescription medicines, except those listed on the Your Choice formulary* • *Medications prescribed for foreign travel*	**Out-of-Network:** *All charges*

Important telephone numbers:

For questions about your pharmacy benefits and participating retail locations, call UPMC Health Plan at: **1-877-648-9641**

For specialty drug orders, call CuraScript at **1-877-787-6279.**

For mail-order maintenance drug orders, call Express Scripts at **1-877-787-6279.**

Section 5(g). Special features

Feature	Description
***My*Health Advice Line**	Members now have immediate access to health care advice through the *My*Health Advice Line at **1-866-918-1591**. The service, available at no additional cost, allows members to address their health care concerns when their doctor is out of the office. Members seeking general health advice or information regarding a specific medical issue can call the *My*Health Advice Line to speak with experienced registered nurses trained to provide members with prompt and efficient service. * Note: This Advice Line is not a substitute for medical care. If an emergency arises, call 911 or go to the emergency room.
Services for members who have a hearing impairment	UPMC Health Plan communicates by telephone with members who have a hearing impairment through TTY. If you have a hearing impairment, call our TTY number at 1-800-361-2629.
Maternity program	Our maternity program can help you have a healthy pregnancy. Enrolling in our program will allow our health coaches and care managers to help you: • Identify the goals that are important to you and your baby. • Create a plan to achieve your goals. • Reach your goals by providing education and resources about your pregnancy. • Get answers about your pregnancy and newborn care. Call 1-877-648-9641 to enroll.
Health Management Programs	UPMC operates health management programs for members who have been diagnosed with diabetes, heart or respiratory 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. 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. 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.
***My*Health Community**	We offer members savings through our exclusive *My*Health Community 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. You can find a listing of businesses that participate in our *My*Health Community program in your provider directory or on our website at www.upmchealthplan.com/FEHB.

Travel benefit/services overseas	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.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. It we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Lifestyle Health Coaching	Our health coaches can provide telephone support and guidance to help you stay motivated. They can work with you to set goals and design action plans that will lay the foundation for long-term success. Our health coaches are experienced professionals who stay abreast of the most recent health research and coaching techniques. They are knowledgeable about the most effective ways to help you make healthy lifestyle changes and to sustain these changes over a lifetime. The coaches' goal is to empower you to make wise choices daily to achieve and maintain your optimal level of health. Health coaches encourage participants to set realistic, timely goals and to develop action plans to: • Lose weight • Be more active • Eat healthier • Reduce stress • Quit tobacco use Hours of operation are 7 a.m. to 7 p.m. Monday through Friday, and 8 a.m. to 3 p.m. on Saturdays. Call 1-800-807-0751.

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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage*.
- The deductible is $2,500 for Self Only enrollment or $5,000 for Self and Family enrollment. The family deductible can be met by one or more members of the family. The deductible applies to all benefits in this section.
- 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, *Coordinating benefits with other coverage*, including with Medicare.

Accidental injury benefit	**You Pay after the calendar year deductible...**
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	
We have no other dental benefits.	

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

Special features	Description
Health education resources	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/FEHB and log in to *My*Health OnLine to access tools to help you learn more about your health, including information about specific diseases and conditions you might want to know about. It also helps you learn about your health plan benefits, and it can even help you track your personal health information. You can view personalized information about your physicians, prescriptions, and important reminders for preventive screenings, and have three options to help you manage your health: • **Online tools for maximizing your health and wellness** and reaching your personal health goals. You can check your symptoms online, update your medical history, and refill your prescriptions. • **Benefits information that helps you manage your health care finances** and maintain control over your health care dollars. You will find links to plan benefits, prescription savings, spending summaries, and claims review. • **Expanded online services.** You'll be able to order a new member ID card and change your PCP. You'll also be able to read frequently asked questions.
Account management tools	If you have an **HSA**, • You will receive a monthly statement outlining your account balance and activity. • You may also access your account online at www.hsamember.com. If you have an **HRA**, • Your HRA balance will be available online through www.upmchealthplan.com/FEHB. • Your balance will also be shown on your EOB form.
Consumer choice information	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/FEHB. Link to online pharmacy through www.upmchealthplan.com/FEHB. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.upmchealthplan.com/FEHB.
Care support	Patient safety information is available online at www.upmchealthplan.com. Case managers may be contacted by calling Member Services at 1-877-648-9641 and asking to be connected with our care management area.

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. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact the Plan at 1-877-648-9641 or visit their Web site at www.upmchealthplan.com/FEHB

Dental Benefits - Limited dental coverage is included with your enrollment in a UPMC Health Plan HMO or HDHP through Avesis. 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 UPMC Dental *Advantage* 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 UPMC Dental *Advantage* 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 visit the UPMC Dental Advantage Web site at www.upmchealthplan.com/dental or contact them by telephone at 1-877-648-9640 for information. Representatives are available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m.

Short-term coverage: If you or a family member is without coverage, UPMC Health Plan offers affordable short-term coverage. The coverage is a safety net that provides:

- Affordable preventive care
- Coverage for physical exams and office visits
- Hospital and emergency services
- A collection of other medical services, including diagnostic, behavioral health, and women's care
- Prescriptions — including generic medications for only $4

You can choose 30-, 60-, or 90-day coverage and cancel at any time. To apply or get more information, visit www.upmchealthplan.com, contact your insurance broker, or call 1-866-353-3598.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.***

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.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring prior Plan approval), including urgent care claims procedures. 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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 1-877-648-9641 or visit our Website, www.upmchealthplan.com/FEHB.

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

- Covered member's name, date of birth, address, phone number, 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)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

UPMC Health Plan
Claims Department
P.O. Box 2939
Pittsburgh, PA 15230-2939

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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.upmchealthplan.com/FEHB.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

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:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at:

UPMC Health Plan
Claims Department
P.O. Box 2939
Pittsburgh, PA 15230-2939

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

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

e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information

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.

If you do not agree with our decisions, you may ask OPM to review it.

3 You must write to OPM withing:

- 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, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance x, 1900 E Street, NW, Washington, DC 20415-xxxx.

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.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-877-648-9641. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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
- 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 (1-800-633-4227), (TTY 1-877-486-2048) 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 at 1-800-772-1213 (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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. To find out if you need to do something to file your claim, call us at 1-877-648-9641 or see our Web site at www.upmchealthplan.com/FEHB.

Under the High Option HMO, the calendar year deductible is waived if you are enrolled in Medicare Part A and Medicare is your primary payer. We do not waive any additional costs if you are enrolled in Medicare Part B.

Under the Standard Option HMO, we waive some costs if Original Medicare is your primary payer:

- If you are enrolled in Medicare Part A only, the calendar year deductible is waived;
- If you are enrolled in Medicare Parts A and B, the calendar year plan deductible, office visit copayments, emergency room copayment, and member coinsurance are waived.

Under the HDHP, we do not waive any costs if the Original Medicare Plan is your primary payer.

You can find more information about how our plan coordinates benefits with Medicare at www.upmchealthplan.com/FEHB.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare is we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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), (TTY 1-877-486-2048) 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
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.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, 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.

Clinical Trials

If you are a participant in a clinical trial, this health Plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan covers some of these costs, providing the Plan determines the services are medically necessary. For more specific information. We encourage you to contact us to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

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.

Clinical Trial Cost Categories

Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy

Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care

Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

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 18.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 18.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care that does not require the continuing services of a skilled medical facility or health care professional and which is furnished primarily to provide room and board, education, assistance with the activities of daily living, or other non-skilled care for mentally or physically disabled persons.

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 18.

Experimental or investigational service

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:

1. The intervention does not have FDA approval to market for the specific relevant indication(s); or
2. 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; or
3. The intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or
4. The intervention does not improve health outcomes; or
5. The intervention is not proven to be able to be replicated outside the research setting.

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.

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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Medically necessary are services or supplies that are determined to be:

1. Commonly recognized throughout the physician's specialty as appropriate for the diagnosis and/or treatment of the member's condition, illness, disease or injury
2. 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
3. Can reasonably be expected to improve an individual's condition or level of functioning; and
4. Is in conformity, at the time of treatment, with medical management criteria/guidelines adopted by UPMC Health Plan or its designee
5. Not provided only as a convenience or comfort measure or to improve physical appearance; and
6. 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 the 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. Participating providers accept our plan allowance, so you will be billed no more than the applicable cost-sharing amount when you utilize participating providers.

If you are enrolled in the HDHP, you may also obtain services from non-participating providers. If you utilize non-participating providers, you will be responsible for the out-of-network cost-sharing as well as any amounts in excess of the plan allowance.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

	Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Member Service Department at 1-877-648-9641. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
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, or 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:

1. Your contributions to the HSA are tax deductible
2. Your HSA earns tax-free interest
3. 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)
4. Your unused HSA funds and interest accumulate from year to year
5. It's portable — the HSA is owned by you and is yours to keep, even when you leave federal employment or retire
6. 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:

1. Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
2. Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
3. Unused credits carryover from year to year
4. HRA credit does not earn interest
5. 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 Benefits,* 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
  - What happens when your enrollment ends
  - 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. For information on your premium deductions, you must also contact your employing or retiring 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 dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

  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.

- **Family member coverage**

  Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children, and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **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.
- 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 2012 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 2011 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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
- 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 for 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 Benefits 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 at 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 26.

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 Benefits 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. Other Federal Programs

Important informationabout three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

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

- **Health Care FSA (HCFSA)** — Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any 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 tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** — Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

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., Eastern time. TTY: 1-800-952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- 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 and bridges, and prosthodontic services such as complete dentures
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

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

Additional Information

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

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY: 1-866-561-1604).

Index

Summary of benefits for the High Option HMO of UPMC Health Plan - 2012

- **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.
- Below, an asterisk (*) means the item is subject to the $250 individual/$500 family calendar year deductible.

High Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $35 specialist	23
Services provided by a hospital:*		
• **Inpatient**	10%	42
• **Outpatient**	10%	43
Emergency benefits:		
• **In-area**	$75 copay per emergency room visit	46
• **Out-of-area**	$75 copay per emergency room visit	46
Mental health and substance abuse treatment:*	Regular cost-sharing	48
Prescription drugs:		51
• Retail pharmacy — up to a 30-day supply (or up to a 90-day supply for three copayments)	$5 generic $35 preferred brand-name $70 non-prefered brand-name	
• Special mail order — up to a 30-day supply	$70	
• Mail-order — up to a 90-day supply	$10 generic $70 preferred brand-name $140 non-preferred brand-name	
Dental care:	Limited Dental benefits and discounts under a non-FEHB benefit program	54, 105
Vision care:	Nothing for routine eye exam. Once every 24 months for adults/Once every 12 months for children.	29
Special features:	• *My*Health Advice Line • Maternity Program • Health Management Programs • MyHealth Community	55

	• Travel Benefits/Services • Flexible Benefits Option • Lifestyle Health Coaching	
Protection against catastrophic costs (out-of-pocket maximum):	$1,800 individual or $3,600 family per year. Copayments do not count toward this protection.	19

Summary of benefits for the Standard Option HMO of UPMC Health Plan - 2012

- **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.
- Below, an asterisk (*) means the item is subject to the $350 individual/$700 family calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $35 specialist	23
Services provided by a hospital*:		
• Inpatient	20%	42
• Outpatient	20%	43
Emergency benefits:		
• In-area	$75 copay per emergency room visit	46
• Out-of-area	$75 copay per emergency room visit	46
Mental health and substance abuse treatment*:	Regular cost-sharing	48
Prescription drugs:		51
• Retail pharmacy — up to a 30-day supply (or up to a 90-day supply for three copayments)	$5 generic $35 preferred brand-name $70 non-preferred brand-name	
• Special mail order — up to a 30-day supply	$70	
• Mail order — up to a 90-day supply	$10 generic $70 preferred brand-name $140 non-preferred brand-name	
Dental care:	Limited Dental benefits and discounts under a non-FEHB benefit program.	54, 105
Vision care:	Nothing for routine eye exam. Once every 24 months for adults/Once every 12 months for children.	29
Special features:	• *My*Health Advice Line • Maternity Program • Health Management Programs • *My*Health Community	55

	• Travel Benefits/Services • Flexible Benefits Option • Lifestyle Health Coaching	
Potection against catastrophic costs (out-of-pocket maximum**):**	$3,000 individual or $6,000 family per year. Copayments do not count toward this protection.	19

Summary of benefits for the HDHP of UPMC Health Plan - 2012

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 2012 for each month you are eligible for the Health Savings Account (HSA), we will deposit $104 per month for Self Only enrollment or $208 per month for Self and Family enrollment to your HSA. For the HSA, you must use your HSA or pay out of pocket to satisfy your calendar year deductible of $2,500 for Self Only and $5,000 for Self and Family. 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 $1,250 for Self Only and $2,500 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	Page
In-network medical preventive care	Nothing	69
Medical services provided by physicians*:	In-Network: Nothing Out-of-Network: 20%	72
Diagnostic and treatment services provided in the office*	In-Network: Nothing Out-of-Network: 20%	72
Services provided by a hospital*:		
• Inpatient	In-Network: Nothing Out-of-Network: 20%	90
• Outpatient	In-Network: Nothing Out-of-Network: 20%	91
Emergency benefits*:		
• In-area	In-Network: Nothing Out-of-Network: 20%	94
• Out-of-area	In-Network: Nothing Out-of-Network: 20%	94
Mental health and substance abuse treatment*:	In-Network: Nothing Out-of-Network: 20%	95
Prescription drugs*:		98
• Retail pharmacy— up to a 30-day supply (or up to a 90-day supply for three copayments)	$5 generic drugs $35 preferred brand-name drugs $70 non-preferred brand-name drugs	
• Specialty mail-order — up to a 30-day supply	$70	

HDHP Benefits	You Pay	Page
• Mail-order— up to a 90-day supply	$10 generic drugs $70 preferred brand-name drugs $140 non-preferred brand-name drugs	
Dental care:	Limited Dental benefits and discounts under a non-FEHB benefit program.	105, 107
Special features:	• *My*Health Advice Line • Maternity Program • Health Management Programs • *My*Health Community • Travel Benefits/Services • Flexible Benefits Option • Lifestyle Health Coaching	103
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	19

Notes

2012 Rate Information for UPMC Health Plan

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

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:
Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

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 *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	8W1	$185.75	$89.70	$402.46	$194.35	$69.07	$66.49
High Option Self and Family	8W2	$414.35	$219.20	$897.76	$474.93	$173.16	$167.40
Standard Option Self Only	UW4	$185.75	$70.39	$402.46	$152.51	$49.76	$47.18
Standard Option Self and Family	UW5	$414.35	$174.79	$897.76	$378.71	$128.75	$122.99
HDHP Option Self Only	8W4	$164.54	$54.85	$356.51	$118.84	$36.20	$34.01
HDHP Option Self and Family	8W5	$368.59	$122.86	$798.61	$266.20	$81.09	$76.17