UPMC Health Plan

www.upmchealthplan.com/FEHB
Customer Service 1-877-648-9641

2016

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

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 17
- Summary of benefits: Page 153

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 13 for requirements.

Enrollment codes for this Plan:

8W1 High Option – Self Only
8W3 High Option – Self Plus One
8W2 High Option – Self and Family

UW4 Standard Option – Self Only
UW6 Standard Option – Self Plus One
UW5 Standard Option – Self and Family

8W4 High Deductible Health Plan (HDHP) – Self Only
8W6 High Deductible Health Plan (HDHP) – Self Plus One
8W5 High Deductible Health Plan (HDHP) – Self and Family

This plan has NCQA accreditation with a rating of Excellent. See the 2016 Guide for more information on accreditation.

Authorized for distribution by the:

United States
Office of Personnel Management

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

UPMC Health Plan
RI 73-797

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

Office of Personnel Management 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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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 Medicare Part D 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 will 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 15 through December 7) 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).

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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. Customer Service may be reached at 1-877-648-9641 or through our website: www.upmchealthplan.com/FEHB. The address for UPMC Health Plan's administrative office is:

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

This brochure is the official statement of benefits. No verbal 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. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 17. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- 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

1-877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also 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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- 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 or nutritional supplements 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

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 to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs neither your FEHB plan nor you will incur costs to correct the medical error.

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 participating providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.
• **Minimum essential coverage (MEC)**	Coverage under the plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
• **Minimum value standard**	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
• **Where you can get information about enrolling in the FEHB Program**	See www.opm.gov/healthcare-insurance 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 that 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 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 Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. 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 or Self Plus One 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 Plus One or 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 Plus One or 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.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **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. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, 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/healthcare-insurance.

- **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 Plus One or 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 Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, 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. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 2016 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 2015 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 additional-information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/ .

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, regardless of marital status, etc. Under TCC, you no longer receive a government contribution, but instead pay the entirety of your premium plus an administration service charge.

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

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

- **Finding replacement coverage**

  In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1-877-648-9641 or visit our website at www.upmchealthplan.com.

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

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 or visit our website at www.upmchealthplan.com/FEHB. We give you a choice of enrollment in a High Option, a Standard Option, or a High Deductible Health Plan (HDHP).

All plans 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 a 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.

All of our Plan options include a Health Incentive opportunity

HealthyU.

HealthyU is an insurance plan that rewards you for making healthy choices. By completing healthy activities, you earn reward dollars in a Health Incentive Account (HIA). There are several activities to choose from, each with a reward dollar value. Every time you complete an eligible activity, UPMC Health Plan deposits those reward dollars into your HIA. The reward dollars you earn in your HIA help pay your out-of-pocket medical expenses such as deductible, coinsurance, and pharmacy copayments. You can earn up to $250 for yourself or $500 for your family during the plan year. Any unused reward dollars — at a value up to two times your annual deductible —will roll over to the next year.

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.

Preventive care services

Preventive care services are generally covered with no cost-sharing when received from a participating provider.

Calendar year deductible

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

Catastrophic protection

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, copayments and deductibles total $4,000 for Self Only, or $8,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year and prescription drug copayments are waived for the remainder of the calendar year. Under the Standard Option, after your share of coinsurance, copayments and deductibles total $5,000 for Self Only, or $10,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year and prescription drug copayments are waived for the remainder of the calendar year. Funds paid from the HIA apply to the annual out-of-pocket maximum period.

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 coinsurance each time you visit the doctor. Under the High Option HMO, most medical and surgical services are payable at 85% 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.

Using your Health Incentive Account with the High and Standard HMO Options

Reward dollars earned in your health incentive account are automatically applied to your deductible, copayments and coinsurance. Any unused reward dollars at the end of the plan year carry over from year to year, up to two times the annual deductible.

How we pay providers

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

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 (HSA) or Health Reimbursement Arrangements (HRA). Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally covered with no cost-sharing when received from a participating provider.

Calendar year deductible

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

This plan option is Preferred Provider Organization (PPO)

Our HDHP is a PPO. In-network benefits apply only when you use a participating provider, when a non-participating provider is utilized, out-of-network benefits apply.

You pay a coinsurance each time you visit the doctor. Under the HDHP, most medical and surgical services are payable at 90% after you meet the Plan deductible. If you receive care from an out-of-network provider, coinsurance is 70%. 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.

Using your Health Incentive Account with the HDHP Option

Reward dollars earned in your health incentive account (HIA) are automatically applied to your out-of-pocket-expenses: copayments and coinsurance once your plan deductible is met. Any unused reward dollars at the end of the plan year carry over from year to year, up to two times the annual deductible.

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

Health Savings Account (HSA)

You are eligible for a HSA if you are enrolled in an HDHP, not covered by any other health plan that is not a 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 or Indian Health Services (HIS) 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 a HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although a HRA is similar to a 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 in-network covered services, including deductibles, coinsurance and copayments, cannot exceed $5,000 for a Self Only enrollment, or $10,000 for a Self Plus One or Self and Family enrollment. Your annual out-of-pocket expenses for out-of-network covered services, including deductibles, coinsurance and copayments cannot exceed $8,000 for a Self Only enrollment or $16,000 for Self Plus One and Self and Family coverage. Funds paid from the HIA apply to the out-of-pocket maximum.

Health education resources and account management tools

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

Visit our website 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 can also 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, view an electronic explanation of benefits (EOB), review prescriptions, receive important reminders for preventive screenings, and review 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. You can also complete your MyHealth Questionnaire, This is *HealthyU*'s health assessment. Your answers will automatically customize *My*Health OnLine for you. You will receive a summary of your current health status, and practical, personalized recommendations to improve your health and earning reward dollars. You will also earn 50 reward dollars in your HIA for completing the *My*Health Questionnaire.
- **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. You can also sign up to receive electronic explanation of benefits (EOBs).
- **Expanded online services.** You'll be able to order a new member ID card and select or change your PCP. You'll also be able to read frequently asked questions to popular health 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 through *My*Health OnLine. Visit www.upmchealthplan.com/FEHB and login to *My*Health OnLine using the member identification number on your member ID card.

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 website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence – 18 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 UPMC Health Plan Member Services, U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219. You may also contact us by fax at 412-454-8519 or visit our website 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.

Covered dependents (up to age 26) residing outside of the western Pennsylvania service area have access to UPMC Health Plan's contracted networks. This network includes Medical Mutual of Ohio's SuperMed PPO network and Multiplan's Private Healthcare Systems (PHCS) network. Covered dependents receive the highest level of benefits when utilizing participating providers in one of these networks. Please go to https://www.upmchealthplan.com/find/ to find the providers in the area. 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. Changes for 2016

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

Program-wide changes

- Self Plus One enrollment type has been added effective January 1, 2016.
- We have removed the exclusion for services, drugs, or supplies related to sex transformations. See page 130.

Changes to all UPMC Health Plan options

- Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 159
- Retail prescription drug copayment for generic drugs has increased to $10 for a 30-day supply. Mail order prescription drug copayment for generic drugs has increased to $20 for a 90-day supply. See page 63.
- Retail prescription drug copayment for preferred brand drugs has increased to $40 for a 30-day supply. Mail order prescription drug copayment for preferred brand drugs has increased to $80 for a 90-day supply. See page 63.
- Retail prescription drug copayment for non-preferred brand drugs has increased to $100 for a 30-day supply. Mail order prescription drug copayment for non-preferred brand drugs has increased to $200 for a 90-day supply. See page 63.
- HealthyU offers a more personalized approach to help members focus on healthy activities that are the most important to understanding and improving their health. In addition to choosing from a standard list of healthy activities, members can also choose from a customized list of healthy activities that are important for their specific health and wellness goals.
- Covered dependents (up to age 26) residing outside of the western Pennsylvania service area have access to UPMC Health Plan's contracted networks. See page 13.

Changes to our High Option only

- Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 159
- The calendar year deductible is $650 for a Self Only enrollment and $1,300 for a Self Plus One or Self and Family enrollment.
- After the calendar year deductible is met, the Plan pays 85% coinsurance for covered in-network services and you pay 15%.
- The annual Out-of-Pocket maximum is $4,000 for a Self Only enrollment and $8,000 for a Self Plus One or Self and Family enrollment. See page 26.

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 159
- For retired FEHB members who are enrolled in Medicare Part A and B, the coinsurance is waived and deductible is reduced to $650 Self Only enrollment and $1,300 Self Plus One or Self and Family enrollment. Previously, only coinsurance was waived for retired FEHB members enrolled in Medicare Parts A and B.
- The calendar year deductible is $800 for a Self Only enrollment and $1,600 for a Self Plus One or Self and Family enrollment.
- The annual Out-of-Pocket maximum is $5,000 for a Self Only enrollment and $10,000 for a Self Plus One or Self and Family enrollment. One person in a family can meet the individual Out-of-Pocket maximum and receive benefits at 100%.

Changes to our HDHP only

- Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 159
- The annual in-network Out-of-Pocket maximum is $5,000 for an individual and $10,000 for a family. See page 26.

- The Out of Network coinsurance is 40% after the calendar year deductible is met. See page 25.

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 participating 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, U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219. You may also request replacement cards through our website at www.upmchealthplan.com/FEHB.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay prescription drug 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 website: www.upmchealthplan.com/FEHB.

- **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 website. 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 or by visiting the website at www.upmchealthplan.com/FEHB. 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 Member Services 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, your 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. Your physician must obtain prior authorization for:

- Abdominoplasty/Panniculectomy
- Acupuncture for Nausea and Vomiting
- Bone Growth Stimulators, Non-Invasive
- Breast Reduction (excluding reconstruction for breast cancer)
- Canaloplasty for Primary Open-Angle Glaucoma
- Carotid Angioplasty with Stenting
- Chiropractic Services (Under 13 years old)
- Clinical Trials Transcatheter Occluders (Amplatzer and Starflex) for Patent Foramen Ovale (PFO)

- Cochlear Implants and Osseointegrated Bone Stimulators (BAHA)
- Continuous Glucose Monitoring, Long Term, Interstitial
- Cranial Remolding Orthosis
- Dental Anesthesia
- External insulin Pumps (for under 13 years old)
- Genetic Testing for Long QT Syndrome
- High Frequency Chest Wall Oscillating Device (formerly called "ThAIRapy Vest")
- Humanitarian Device Exemption (HDE)
- Implantable Miniature Telescope (IMT) for Macular Degeneration
- Investigational Device Exemption (IDE)
- Lumbar Laminectomy/Hemi-Laminectomy/Discectomy
- Lumbar Spinal Fusion
- Lymphedema Pump 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
- Outpatient/Mobile Real Time Cardiac Surveillance
- Parenteral Nutrition
- Power Mobility Devices (PMDs)
- Pressure Reducing Support Surfaces – Groups 2 and 3
- Private Duty Nursing
- Referrals to Non-Participating Providers
- Selective Internal Radiation Therapy (SIRT)
- Specialized Manual Wheelchairs
- Total Ankle Replacement
- Total Hip Replacement/Arthroplasty
- Total Knee Replacement/Arthroplasty
- Transcatheter Aortic Valve Implantation (TAVI)/Replacement (TAVR)
- Transcatheter Occluder (Amplatzer) for Atrial Septal Defect (ASD)/Ostium Secundum diagnosis
- Transplants (bone marrow, stem cell, and solid organ)
- Ventricular Assist Devices
- Vertebral Augmentation (Percutaneous Kyphoplasty)
- 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 35 or 90.

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 days requested for hospital stay.

- **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 let you know that information we need to complete our review of the claim. You will then have up to 48 hours from to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to 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.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-877-648-9641. You may also call OPM's Health Insurance at (202) 606-0727 between 8 a.m. and 5 p.m. Eastern Standard Time to ask for a simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you do not indicate that your claim was a claim for urgent care, call us at 1-877-648-9641. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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.

- **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

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

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

Circumstances beyond our control

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

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.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite 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 cost for covered services

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

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. Available funds in your Health Incentive Account will reduce your cost-sharing.

Copayments

A copayment is a fixed amount of money you pay to the participating pharmacy when you receive covered medications. There are no other copayments associated with this Plan.

Example: When you visit a participating retail pharmacy, you pay $10 per prescription for generic drugs after the deductible is satisfied.

Deductible

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

- The calendar year deductible under the High Option HMO is $650 for a Self Only enrollment. Under the Self Plus One or Self and Family enrollment, the deductible under the High Option HMO is $1,300. For a Self Plus One or Self and Family enrollment, if one member meets the individual deductible, the Plan begins to pay benefits for that family member.
- The calendar year deductible under the Standard Option HMO is $800 for a Self Only. Under Self Plus One or Self and Family enrollment, the deductible under the Standard Option HMO is $1,600. For a Self Plus One or Self and Family enrollment, if one member meets the individual deductible, the Plan begins to pay benefits for that family member.
- The calendar year deductible under the HDHP is $2,000 for a Self Only enrollment. Under Self Plus One or Self and Family enrollment, the deductible under the HDHP is $4,000. Under Self Plus One or Self and 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 reaches $4,000. The deductible is combined for services received from both Plan and non-Plan providers.
- The calendar year deductible will be prorated for any mid-year member enrollment.

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 have met your calendar year deductible.

- Under the High Option HMO, you pay 15% 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 10% of our allowance for services received from participating providers; 40% for non-participating 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 in-network 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 UPMC Health Plan's allowance (reasonable and customary charge).

Your catastrophic protection out-of-pocket maximum

Under the High Option HMO, after your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $4,000 for Self Only, or $8,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $4,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Under the Standard Option HMO, after your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $5,000 for Self Only, or $10,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $5,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Under the HDHP, after your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $5,000 for Self Only, or $10,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $5,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $4,000 Self Only maximum out-of-pocket limit and a $8,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $4,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $8,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $4,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Dental Discount benefits
- Eyeglasses or contact lenses
- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses for non-covered medical services
- Expenses from utilizing out-of-network providers
- Expenses for non-formulary medications

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

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 17 for how our benefits changed this year. Pages 153 and 155 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.

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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 on our website at www.upmchealthplan.com/FEHB.

Your Health Incentive Account

Reward dollars earned in your health incentive account are automatically applied to out-of-pocket-expenses like copays and coinsurance once your plan deductible is met. The reward dollars you earn carry over from year to year, up to two times the annual deductible. See page 67 for more details on earning reward dollars in your Health Incentive Account.

Each option offers unique features:

High Option:

For all services, there is an annual deductible applied before any benefits are paid. Once the deductible is met, you pay 15% of the allowable expense. When your out-of-pocket expense for deductible, prescription drug copayments and coinsurance exceeds $4,000 for Self Only, or $8,000 for Self and Family, in any calendar year, your 15% coinsurance and prescription drug copayments are eliminated for the remainder of the calendar year.

The deductible is waived for preventive care services.

Standard Option:

For all 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 deductible, prescription drug copayments and coinsurance exceeds $5,000 for Self Only, or $10,000 for Self Plus One or Self and Family, in any calendar year, your 20% coinsurance and prescription drug copayments are eliminated for the remainder of the calendar year.

The deductible is waived for preventive care services.

If you are retired and covered by Medicare Parts A and B, your coinsurance cost-sharing is waived under the Standard Option. Your deductible will also be reduced to that of a High Option HMO.

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.
- A facility charge applies to services that appear in this section if the services are performed in an ambulatory surgical center, outpatient department of a hospital, or an outpatient clinic owned by a hospital.
- The calendar year deductible is $650 Self Only or $1,300 Self Plus One or Self and Family under the High Option, and $800 Self Only $1,600 Self Plus One or Self and Family under the Standard Option. Your actual deductlble may be reduced by your participation in activities that fund your Health Incentive Account (HIA). Preventive screenings are covered at 100% and not subject to the deductible. 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 deductibles, prescription drug copayments and coinsurance total $4,000 for Self Only, or $8,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year. Under Standard Option, after your share of deductibles, prescription drug copayments and coinsurance total $5,000 for Self Only, or $10,000 for Self Plus One or Self and Family in any calendar year, benefits 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 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	15% of the Plan allowance	20% of the Plan allowance
Professional services of physicians During a hospital stay In a skilled nursing facility. Limited to 100 days per calendar year combined with Extended care facility admissions. Office medical consultations Second surgical opinion In an urgent care center	15% of the Plan allowance	20% of the Plan allowance

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
At a convenience care clinic eVisit At home	15% of the Plan allowance	20% of the Plan allowance
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	15% 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 - 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)
Well woman care including but not limited to: • Routine Pap test • Human papillomavirous testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus	Nothing (No deductible)	Nothing (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Contraceptive methods and counseling as prescribed • Screening and counseling for interpersonal and domestic violence	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)
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ And HHS at https://www.healthcare.gov/preventive-care-benefits/		
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*
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	Nothing (No deductible)	Nothing (No deductible)

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, children (cont.)	**High Option**	**Standard Option**
- 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)
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ And HHS at https://www.healthcare.gov/preventive-care-benefits/children/		
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 • Screening for gestational diabetes for pregnant women between 24-48 weeks gestation or first prenatal visit for women at high risk • Delivery • Postnatal care	Nothing (No deductible)	Nothing (No deductible)
Breastfeeding support, supplies and counseling for each birth	Nothing (No deductible)	Nothing (No deductible)
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.	Nothing (No deductible)	Nothing (No deductible)

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Maternity care (cont.)	**High Option**	**Standard Option**
• 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 Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery).	Nothing (No deductible)	Nothing (No deductible)
Family planning	**High Option**	**Standard Option**
Contraceptive counseling as prescribed	Nothing (No deductible)	Nothing (No deductible)
Voluntary family planning services, limited to: • Tubal ligation • Injectable contraceptive drugs (such as Depo Provera) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Nothing (No deductible)	Nothing (No deductible)
Voluntary family planning services, limited to: • Vasectomy	15% of the Plan allowance	20% of the Plan allowance
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Infertility is the documented inability of a woman under the age of 35 years to conceive a child within a 12month period or a woman 35 years or older to conceive a child within a six month period: (a) of unprotected coitus (sexual intercourse); or (b) after at least six episodes of artificial insemination. **Medical Description**	15% of the Plan allowance	20% of the Plan allowance

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	**High Option**	**Standard Option**
Infertility is the documented inability of a woman to conceive a child. Infertility may be caused by female factors (e.g. pelvic adhesions, ovarian dysfunction, function or transport, or prior ligation); male factors (e. g. abnormalities in sperm production, function or transport or prior vasectomy), a combination of both male and female factors, and unknown causes. Once infertility is diagnosed, treatments for infertility may begin. The focus of this policy is the diagnosis of infertility. Treatment of the ***causes*** of infertility is not addressed in this policy. Refer to PAY.018 – Infertility – Treatment policy. **Specific Indications for Diagnosis** • Member must fit the definition for infertility (as indicated in Section II Definitions) • Females must be pre-menopausal and reasonably expect fertility as a natural state; or if menopausal, should have experienced it at an early age **Diagnosis of Infertility** Depending on the member's unique medical situation, the following diagnostic tests to diagnose fertility in males and females may be considered medically necessary: • History & Physical • Sperm function tests • Hysterosalpingogram • Hysteroscopy • Sonohysterogram • Prediction of Ovarian Reserve Hormone Evaluation • Evaluation of folliculogenesis • Endometrial biopsy • Diagnostic laparoscopy • Follow-up Conference **Limitations/Contraindications** Normal physiological causes of infertility such as menopause	15% of the Plan allowance	20% of the Plan allowance

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	**High Option**	**Standard Option**
• Infertility resulting from voluntary sterilization • The following diagnostic tests are considered investigational: - Tests to assess/improve sperm movement, or computer-assisted sperm analysis (CASA) - Analysis of adenosine triphosphate (ATP) in ejaculation - Tubaloscopy - Anti-zona pellucida antibodies - Hyaluronan binding assay (HBA) - Sperm washing and swim-up when performed at part of insemination In order to assess medical necessity for infertility services, adequate information must be furnished by the treating physician. Necessary documentation includes, but is not limited to the following: • Member's age, clinical history, physical and functional status; • Documentation of infertility, testing if done, and treatment history • Documentation of any history of substance abuse, including smoking; • Social Service evaluation • Lab results: HIV antibody Diagnostic tests for infertility may be ordered by a participating provider. However, most anti-retroviral therapy (ART) drugs and procedures should only be ordered or performed by credentialed Reproductive Endocrinologists. If a member lives in an out-of-network area, then the credentials of the nearest Reproductive Endocrinologist or OB/Gynecologist must be reviewed by the Credentials Specialist prior to approval for coverage. Refer to plan-specific infertility riders.	15% 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**
Member acting as a surrogate mother and all services and supplies associated with surrogate motherhood and supplies and services related to the following: • *Pre-pregnancy evaluations* • *Prenatal care* • *Perinatal care* • *Postnatal care* *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 • Allergy injections	15% of the Plan allowance	20% of the Plan allowance
Allergy serum	15% 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 45. • Respiratory and inhalation therapy • Dialysis - hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	15% 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**
• 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) 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. • Pain management Note: Pain management is covered if you are diagnosed with refractory chronic pain of at least six months duration. The provider must demonstrate that he or she anticipates these services to result in substantial improvement to your medical condition.	15% of the Plan allowance	20% of the Plan allowance

Benefit Description	You pay After the calendar year deductible...	
Physical and occupational therapies	**High Option**	**Standard Option**
Rehabilitation and Habiliation services are 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 when a provider orders the care Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction is provided for up to 12 weeks of sessions.	15% 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.	15% of the Plan allowance	20% of the Plan allowance
Not covered: • *Speech therapy provided for developmental delays*	*All charges*	*All charges*
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.*	15% 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.*	15% of the Plan allowance	20% of the Plan allowance
Not covered:	*All charges*	*All charges*

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

Benefit Description	You pay After the calendar year deductible...	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• *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)	15% of the Plan allowance	20% of the Plan allowance
• 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/FEHB/ to locate a vision care provider.	Nothing (No deductible)	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*
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	15% of the Plan allowance	20% of the Plan allowance
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*

Benefit Description	You pay After the calendar year deductible...	
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*.	15% 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* • *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*

Benefit Description	You pay After the calendar year deductible...	
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.	15% 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:* - *expendable in nature (i.e. disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and*	*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**
- *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	15% 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.	15% of the Plan allowance	20% of the Plan allowance
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	15% 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.	15% 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 35.	15% 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 is $650 Self Only or $1,300, Self Plus One or Self and Family under the High Option and $800 Self Only $1,600 Self Plus One or Self and Family under the Standard Option. Your actual deductlble may be reduced by your participation in activities that fund your Health Incentive Account (HIA). Preventive screenings are covered at 100% and not subject to the deductible. 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 deductibles, prescription drug copayments and coinsurance total $4,000 for Self Only, or $8,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year. Under Standard Option, after your share of deductibles, prescription drug copayments and coinsurance total $5,000 for Self Only, or $10,000 for Self Plus One or Self and Family in any calendar year, benefits 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 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See 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...	
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*)	15% 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**
• 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 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.	15% 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.	15% of the Plan allowance	20% of the Plan allowance

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
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*	*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 leukoplasia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Surgery for TMJ disorder. Note: In order for surgery to be covered, documentation in the medical record must support that treatment of TMJ disorder with conventional non-surgical therapy has not resulted in adequate improvement. • Other surgical procedures that do not involve the teeth or their supporting structures	15% 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 - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	15% 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**
• Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	15% of the Plan allowance	20% of the Plan allowance
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)	15% 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)	15% 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**
- 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) - 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	15% 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.	15% 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**
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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	15% 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.	15% 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**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (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. • Allogenic 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: - Myelodysplasia/myelodysplastic syndromes - Myeloproliferative disorders • Autologous Transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - 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) - 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.	15% 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**
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.	15% 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)	15% of the Plan allowance	20% of the Plan allowance
Professional services provided in – • Hospital outpatient department • Skilled nursing facility. Limited to 100 days per calendar year combined with Extended care facility admissions. • Ambulatory surgical center • Office	15% 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 $650 Self Only or $1,300, Self Plus One or Self and Family under the High Option and $800 Self Only or $1,600 Self Plus One or Self and Family under the Standard Option. Your actual deductlble may be reduced by your participation in activities that fund your Health Incentive Account (HIA).
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under the High Option, after your share of deductibles, prescription drug copayments and coinsurance total $4,000 for Self Only, or $8,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year. Under Standard Option, after your share of deductibles, prescription drug copayments and coinsurance total $5,000 for Self Only, or $10,000 for Self Plus One or Self and Family in any calendar year, benefits 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 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.	15% of the Plan allowance	20% of the Plan allowance
Other hospital services and supplies, such as: • Operating, recovery and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services	15% 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	15% 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	15% 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.	15% 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	15% 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	15% 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.	15% 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	15% 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 $650 Self Only or $1,300, Self Plus One and Self and Family under the High Option and $800 Self Only or $1,600 Self Plus One and Self and Family under the Standard Option. Your actual deductible may be reduced by your participation in activities that fund your Health Incentive Account (HIA).
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under the High Option, after your share of deductibles, prescription drug copayments and coinsurance total $4,000 for Self Only, or $8,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year. Under Standard Option, after your share of deductibles, prescription drug copayments and coinsurance total $5,000 for Self Only, or $10,000 for Self Plus One or Self and Family in any calendar year, benefits 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 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…	
Note: The calendar year deductible applies to all of the benefits in this Section.		
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	15% of the Plan allowance	20% of the Plan allowance
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	15% of the Plan allowance	20% of the Plan allowance
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*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service when medically appropriate Note: See 5(c) for non-emergency service.	15% of the Plan allowance	20% of the Plan allowance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The 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.
- 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 all of the benefits in this Section.		
Professional services	**High Option**	**Standard Option**
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) • 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	15% of the Plan allowance	20% of the Plan allowance

Benefit Description	You pay After the calendar year deductible...	
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	15% 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, residential treatment, and other hospital services	15% 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, full-day hospitalization, or facility-based intensive outpatient treatment	15% of the Plan allowance	20% of the Plan allowance
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 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 diagnoses listed in the most recent edition of the diagnostic and Statistical manual of 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*	*All charges*	*All charges*

Not covered - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Not covered (cont.)	**High Option**	**Standard Option**
• *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, listed in the most recent edition of the diagnostic and Statistical manual of Mental Disorders 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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- The calendar year deductible is $650 Self Only or $1,300, Self Plus One or Self and Family under the High Option and $800 Self Only or $1,600 Self and Family under the Standard Option. Your actual deductible may be reduced by your participation in activities that fund your Health Incentive Account (HIA).
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under the High Option, after your share of deductibles, prescription drug copayments and coinsurance total $4,000 for Self Only, or $8,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year. Under Standard Option, after your share of deductibles, prescription drug copayments and coinsurance total $5,000 for Self Only, or $10,000 for Self Plus One or Self and Family in any calendar year, benefits 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 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.
- 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. See *Other services* under *You need prior Plan approval for certain services* on page 20.
- Some drugs may require step therapy. This means that you must try specific medications first before we will cover the drug that requires step therapy. Step therapy is built into the electronic system that checks your medication history. A drug with step therapy will be automatically approved if there is a record that you have already tried the preferred drug(s). If there is no record that you tried the preferred drug(s) in your medication history, your physician must submit relevant clinical information to the UPMC Health Plan Pharmacy Services Department before it will be covered.

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

- **Who can write your prescription?** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **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 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?** You typically pay your 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 deductible and/or 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 after the calendar year deductible	
Covered medications and supplies (The Your Choice Formulary Applies)	**High Option**	**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 • Tobacco cessation drugs, including over-the-counter (OTC) drugs approved by the FDA to treat tobacco dependence (See page 41)	Retail (up to a 30-day supply) $10 copayment for generic drugs $40 copayment for preferred brand-name drugs $100 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) $100 copayment	Retail (up to a 30-day supply) $10 copayment for generic drugs $40 copayment for preferred brand-name drugs $100 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) $100 copayment

Covered medications and supplies (The Your Choice Formulary Applies) - continued on next page

Benefit Description	You pay after the calendar year deductible	
Covered medications and supplies (The Your Choice Formulary Applies) (cont.)	**High Option**	**Standard Option**
	Mail Order (up to a 90-day supply) $20 copayment for generic drugs $80 copayment for preferred brand-name drugs $200 copayment for non-preferred brand-name drugs Notes: • If there is no generic equivalent available, you will still have to pay the brand name copayments • Deductible and Copayments are waived for tobacco cessation drugs	Mail Order (up to a 90-day supply) $20 copayment for generic drugs $80 copayment for preferred brand-name drugs $200 copayment for non-preferred brand-name drugs Notes: • If there is no generic equivalent available, you will still have to pay the brand name copayment • Deductible and Copayments are waived for tobacco cessation drugs
Women's contraceptive drugs and devices	Generic versions of contraceptives are available with no copayment or deductible Preferred and non-preferred brand name drugs will follow the plan payment level listed in the above section	Generic versions of contraceptives are available with no copayment or deductible Preferred and non-preferred brand name drugs will follow the plan payment level listed in the above section
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs for weight loss* • *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 except as required by the Affordable Care Act. 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*	*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 $650 Self Only or $1,300, Self Plus One or Self and Family under the High Option and $800 Self Only or $1,600 Self Plus One or Self and Family under the Standard Option. Your actual deductible may be reduced by your participation in activities that fund your Health Incentive Account (HIA).
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under the High Option, after your share of deductibles, prescription drug copayments and coinsurance total $4,000 for Self Only, or $8,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year. Under Standard Option, after your share of deductibles, prescription drug copayments and coinsurance total $5,000 for Self Only, or $10,000 for Self Plus One or Self and Family in any calendar year, benefits 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 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.	15% 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 and Standard Option**
Health Care Concierge Team	You and your family members can call Member Services with questions or concerns. Our Health Care Concierge team delivers fast, personal service, and strives to answer your question on the first call. To speak with a Health Care Concierge, call 1-877-648-9641. Our Health Care Concierge team is available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m. TTY/TDD users should call 1-800-361-2629.
Health Incentive Account	You and your family can earn reward dollars in a health incentive account by participating in healthy activities throughout the year. These activities have been specially designed by our team of doctors, nurses, nutritionists, exercise physiologists, and behavioral health experts. They will alert you to potential health issues and provide tools to help you address the issues. Activities include: • MyHealth Questionnaire: The confidential health risk assessment, powered by WebMD®, is a 20-minute online survey you take once a year. The results can help you understand your health status and suggest ways to make improvements. You can earn 50 reward dollars if completed in the 90 days of your effective date. You will earn 25 reward dollars if completed after 90 days. • Biometric Screening: This health screening measures your total cholesterol level and glucose level. Your doctor will also check your blood pressure, height, weight, and body mass index (BMI). It is a simple assessment that can be done at your doctor's office, a lab, or some convenience care clinics. Biometric screenings are recommended once every three years. You will earn 15-30 reward dollars for completing the LDL screening and $15 reward dollars for completing the glucose screening. • Condition or Lifestyle Management Coaching: A health coach for condition management will help you manage a chronic condition so you can live your healthiest life possible. Chronic conditions include heart disease, diabetes, asthma, COPD, and depression. Lifestyle programs include smoking cessation, stress management, physician activity, weight management, and nutrition. You can earn up to 150 reward dollars for completing a condition management program, and up to 145 reward dollars for completing a lifestyle management program. • You will also receive reward dollars for completing activities uniquely customized just for you. You will find a full list of eligible activities by logging in to *My*Health OnLine, the website that powers *HealthyU*, UPMC Health Plan's member website.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High and Standard Option**
	The reward dollars you earn automatically help pay your out-of-pocket medical expenses such as deductible, copayments and coinsurance. In one Plan year, you can earn up to $250 for Self Only coverage or $500 for Self and Family coverage. Any unused reward dollars — up to two times your annual deductible — automatically roll over to the next year. The Plan will prorate any mid-year member enrollment deductibles, out-of-pocket costs and Health Incentive Account funds. To learn more about *HealthyU,* visit www.upmchealthplan.com/FEHB or call a Health Care Concierge at 1-877-648-9641.
***My*Health Health and Wellness**	You and your family members have access to *My*Health, an integrated health and wellness program with online programs, tools, and over-the-phone advice. As a part of your coverage, health coaching is available for health conditions and lifestyle changes.
***My*Health OnLine**	*My*Health OnLine is where you can go every day for practical tips, tools, and strategies for better health. You can also find a doctor, view your medical history, and get information on your health plan benefits. The site keeps all your health information, all in one place. At *My*Health OnLine, you can: *Earn and track your reward dollars*, so you know exactly how much you have in your account to spend on health care. (Remember, with *HealthyU,* you earn reward dollars when you do healthy activities throughout the year.) *Discounts and savings*: Through *My*Health Community, you'll receive discounts at health-related businesses such as gyms, spas, salons, health food stores, sporting goods stores, and more. *Manage your health care information*: Access your doctor's contact information, plan benefits, research prescription and treatment options, savings information, and view your spending summary and claims. You can even order a new member ID card if you lose it. You can also chat online with a Health Care Concierge or Health Coach, read blogs from health experts, get advice on medical screenings and healthy activities, and set personal goals for managing your health. To get the most out of your benefits, log in to MyHealth OnLine at www.upmchealthplan.com/FEHB. To create an account click on Sign Up and use the number on your member ID card to register.
***My*Health Questionnaire**	Once you log in to *My*Health OnLine, complete your *My*Health Questionnaire. Not only will you earn reward dollars in your Health Incentive Account, but your answers generate a summary of your current health status and customize *My*Health OnLine with activities that benefit you the most.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High and Standard Option**
***My*Health Community**	You and your family can receive discounts through *My*Health Community. For participating facilities throughout western Pennsylvania, visit www.upmchealthplan.com/FEHB, log in to *My*Health OnLine, and select *My*Health Community. Use the online tool to enter your ZIP code and view discounts close to your home or work. To take advantage of the discounts, show your UPMC Health Plan member ID card at the time of purchase and save at participating businesses that encourage a healthy lifestyle: gyms, spas, health food stores, sporting goods stores and more.
Health Coaching	A UPMC Health Plan health coach can get you started on a healthy living plan today. Enroll in one of our six-week or eight-week lifestyle or chronic condition coaching programs and earn reward dollars in your Health Incentive Account. A health coach can help you manage a variety of conditions, including asthma, diabetes, hypertension and low back pain. They can also help you lose weight, quit smoking, eat healthier, reduce stress, and make other lifestyle changes to improve your health. You can also choose to do a one-time visit by phone or connect via live chat. Participating in these programs also give you the opportunity to earn reward dollars in your Health Incentive Account. To get started, call a health coach at 1-800-807-0751.
***My*Health Advice Line**	For immediate access to free health care advice 24 hours a day, seven days a week call the UPMC *My*Health 24/7 Nurse Line at 1-866-918-1591. From general health information to help with a specific sickness or injury, an experienced registered nurse will provide you with prompt and efficient service.
UPMC Anywhere Care	With UPMC Health Plan coverage, provider access becomes almost instantaneous. If you can't see your regular provider right away for such things as flu or cold symptoms, a sore throat, even pink eye or a bad sunburn, now you can e-visit a UPMC provider from your computer. It's convenient, affordable, and you don't have to wait. Any prescriptions will be sent to your directly to your local pharmacy. To access UPMC Anywhere Care: 1. Log in to UPMC AnywhereCare through upmcanywherecare.com. 2. Describe your symptoms in a brief questionnaire. 3. Receive a personalized care plan, and a prescription, if needed, from a UPMC provider — *usually within 30 minutes.*
Mobile Health Plan Mobile App	When you download this free app to your smartphone, you can: • Access your UPMC Health Plan member ID card. • Contact your providers from a personalized list.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High and Standard Option**
	• Check the status of your claims. • And much more.
Tobacco Cessation	UPMC Health Plan offers the *My*Health Ready to Quit™ health coaching program. The program will help you to quit using tobacco with a personal action plan that includes behavior modification strategies and tools based on the latest research. You will also receive reward dollars in your HIA by participating in the program.
Beating the Blues *US*	UPMC Health Plan offers Beating the Blues, US™, a free, eight session online program for members who are dealing with stress, mild depression, or anxiety. Making use of cognitive behavior therapy (CBT), Beating the Blues, US is based on the concept that changing your thoughts can change your feelings and behaviors as well. Beating the Blues will show you how to: • Better understand your feelings. • Identify negative thoughts, and replace them with more helpful, positive thoughts. • Focus on what is happening right now, rather than on the past. Beating the Blues *US* is completely confidential and available 24/7, so you can complete the program at your own pace. You will also receive reward dollars in your HIA by participating in the program.
Assist America	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. Support is accessible 24 hours a day, 365 days a year. For a complete list of Assist America services visit www.assistamerica.com. To receive services, 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.
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.
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High and Standard Option**
	• 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).

High Deductible Health Plan Benefits

See page 17 for how our benefits have changed this year and page 157 for a benefits summary

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Summary of benefits for the HDHP of UPMC Health Plan - 2016 157

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 on our website 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 83. 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 90% for in-network and 70% 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

- **Your Health Incentive Account**

  Reward dollars earned in your health incentive account are automatically applied to copays and coinsurance once your plan deductible is met. The reward dollars you earn carry over from year to year, up to two times the annual deductible. See page 122 for more details on earning reward dollars in your Health Incentive Account.

- **Savings**

  Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 77 for more details).

- **Health Savings Accounts (HSAs)**

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 and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2016, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $83 per month for a Self Only enrollment or $166 per month for a Self Plus One or 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 $3,350 for an individual and $6,750 for a family. See maximum contribution information on page 81.You can use funds in your HSA to help pay your coinsurance, copayments, and other qualified expenses**.** You own your HSA, so the funds can go with you if you change plans or employment. The Plan will establish an HSA for you with BenefitWallet, this HDHP's fiduciary (an administrator, trustee, or custodian as defined by Federal tax code and approved by the IRS.)

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 BenefitWallet
- 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 11), 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 2016, we will give you an HRA credit of $1,000 per calendar year for a Self Only enrollment or $2,000 per calendar year for a Self Plus One or 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 participating providers, your annual limit for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,000 for Self Only or $10,000 for Self Plus One or Self and Family enrollment. When you use out-of-network providers, your annual limit for out-of-pocket expenses (deductibles and coinsurance) for covered services is limited to $8,000 for Self -Onlyor $16,000 for Self Plus One or 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 BenefitWallet, this is the 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, including an FSA (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 and/or Indian Health Services (IHS) 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 2016, a monthly premium pass-through of $83 will be made by the HDHP directly into your HSA each month.	For 2016, your HRA annual credit is $1,000 (prorated for midyear enrollment).
• **Self Plus One or Self and Family enrollment**	For 2016, a monthly premium pass-through of $166 will be made by the HDHP directly into your HSA each month.	For 2016, your HRA annual credit is $2,000 (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, $3,350 for an individual and $6,750 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 81.	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 $2,350.	You cannot contribute to the HRA.
Self Plus One or Self and Family enrollment	You may make an annual maximum contribution of $4,750.	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

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 77 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.
Health Incentive Account	Reward dollars earned in your health incentive account are automatically applied to copays and coinsurance once your plan deductible is met. The reward dollars you earn carry over from year to year, up to two times the annual deductible. For the HDHP option, you must meet your deductible first, before you can use HIA dollars.	Reward dollars earned in your health incentive account are automatically applied to copays and coinsurance once your plan deductible is met. The reward dollars you earn carry over from year to year, up to two times the annual deductible. For the HDHP option, you must meet your deductible first, before you can use HIA dollars.

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 are newly enrolled in a 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 2015 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Website at **www.ustreas.gov/offices/public-affairs/hsa/**.

- **If you die**

  If you have not named a beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA 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 Website 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 77 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 - 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 Colonoscopy screening: *All charges* Other Out-of-Network services: 40%
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmited infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive menthods and counseling • Screening and counseling for interpersonal and domestic violence	In-Network: Nothing Out-of-Network: 40%

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ And HHS https://www.healthcare.gov/preventive-care-benefits/	
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 • 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: 40%
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: 40%
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at	

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ And HHS https://www.healthcare.gov/preventive-care-benefits/	
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 32) and is not subject to the calendar year deductible.
- The deductible is $2,000 for Self Only enrollment or $4,000 Self Plus One or 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 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 in- and 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 $5,000 for Self Only enrollment or $10,000 for Self Plus One or 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 $8,000 for Self Only enrollment or $16,000 for Self Plus One or 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. After you met the deductible, if you have available funds in your Health Incentive Account, your HIA will pay your out-of-pocket expenses to extent that funds are available.	100% of allowable charges until you meet the deductible of $2,000 for Self Only enrollment or $4,000 for Self Plus One or Self and Family enrollment In-network: After you meet the deductible, you pay only the coinsurance or copayment for covered services. If you have available funds in your Health Incentive Account (HIA), the coinsurance or copayment will be paid automatically from the funds available in your HIA. If your HIA has been exhausted, you may choose to pay the coinsurance or copayment from your HSA. If your HIA has been exhausted, your HRA will pay the coinsurance or copayment if funds are available.

Deductible before Traditional medical coverage begins - continued on next page

Benefit Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins (cont.)	
	Out-of-network: After you meet the deductible, you pay copayments or coinsurance on our Plan allowance and any difference between our allowance and the billed amount. If you have available funds in your Health Incentive Account (HIA), the coinsurance balance or copayment will be paid automatically from the funds available in your HIA. If your HIA has been exhausted, you may choose to pay the coinsurance or copayment from your HSA. If your HIA has been exhausted, your HRA will pay the coinsurance or copayment if funds are available.
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 coinsurance or copayments for covered services. If your HIA has been exhausted, you may choose to pay the coinsurance or copayments from your HSA. If your HIA has been exhausted, your HRA will pay the coinsurance or copayment if funds are available. You may also pay for these expenses out-of-pocket, with your HSA. Out-of-network: After you meet the deductible, you pay copayments or coinsurance on our Plan allowance and any difference between our allowance and the billed amount. If you have available funds in your Health Incentive Account (HIA), the coinsurance balance or copayment will be paid automatically from the funds available in your HIA. If your HIA has been exhausted, you may choose to pay the coinsurance or copayment from your HSA. If your HIA has been exhausted, your HRA will pay the coinsurance or copayment if funds are available.

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.
- A facility charge applies to services that appear in this section if the services are performed in an ambulatory surgical center, outpatient department of a hospital, or an outpatient clinic owned by a hospital.
- The deductible is $2,000 for Self Only enrollment only or $4,000 Self Plus One or Self and Family enrollment each calendar year. The Self Plus One or 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. 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 • In a convenience care clinic • eVisit • During a hospital stay • In a skilled nursing facility. Limited to 100 days per calendar year combined with Extended care facility admissions. • Office medical consultants • Second surgical opinion	In-Network: 10% Out-of-Network: 40%
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	In-Network: 10% Out-of-Network: 40%

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests (cont.)	
• Electrocardiogram and EEG	In-Network: 10% Out-of-Network: 40%
Maternity care	
Complete maternity (obstetrical) care, including: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk • Delivery • Postnatal care	In-Network: 10% Out-of-Network: 40%
Breastfeeding support, supplies and counseling for each birth	In-Network: 10% Out-of-Network: 40%
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 Plus One or 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: 10% Out-of-Network: 40%
Family planning	
Contraceptive counseling as prescribed	In-Network: Nothing (No deductible) Out-of-Network: 40%
Voluntary family planning services, limited to: • Tubal ligation • Injectable contraceptive drugs (such as Depo Provera) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Diaphragms	In-network: Nothing (No deductible) Out-of-Network: 40%

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible…
Family planning (cont.)	
Note: We cover oral contraceptives under the prescription drug benefit.	In-network: Nothing (No deductible) Out-of-Network: 40%
Voluntary family planning services, limited to: • Sterilization (vasectomy)	In-Network: 10% Out-of-Network: 40%
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	
Infertility is the documented inability of a woman under the age of 35 years to conceive a child within a 12month period or a woman 35 years or older to conceive a child within a six month period: (a) of unprotected coitus (sexual intercourse); or (b) after at least six episodes of artificial insemination. **Medical Description** Infertility is the documented inability of a woman to conceive a child. Infertility may be caused by female factors (e.g. pelvic adhesions, ovarian dysfunction, function or transport, or prior ligation); male factors (e.g. abnormalities in sperm production, function or transport or prior vasectomy), a combination of both male and female factors, and unknown causes. Once infertility is diagnosed, treatments for infertility may begin. The focus of this policy is the diagnosis of infertility. Treatment of the ***causes*** of infertility is not addressed in this policy. Refer to PAY.018 – Infertility – Treatment policy. **Specific Indications for Diagnosis** • Member must fit the definition for infertility (as indicated in Section II Definitions) • Females must be pre-menopausal and reasonably expect fertility as a natural state; or if menopausal, should have experienced it at an early age **Diagnosis of Infertility** Depending on the member's unique medical situation, the following diagnostic tests to diagnose fertility in males and females may be considered medically necessary: • History & Physical • Sperm function tests • Hysterosalpingogram	In-Network: 10% Out-of-Network: 40%

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
• Hysteroscopy • Sonohysterogram • Prediction of Ovarian Reserve Hormone Evaluation • Evaluation of folliculogenesis • Endometrial biopsy • Diagnostic laparoscopy • Follow-up Conference **Limitations/Contraindications** • Normal physiological causes of infertility such as menopause • Infertility resulting from voluntary sterilization • The following diagnostic tests are considered investigational: - Tests to assess/improve sperm movement, or computer-assisted sperm analysis (CASA) - Analysis of adenosine triphosphate (ATP) in ejaculation - Tubaloscopy - Anti-zona pellucida antibodies - Hyaluronan binding assay (HBA) - Sperm washing and swim-up when performed at part of insemination In order to assess medical necessity for infertility services, adequate information must be furnished by the treating physician. Necessary documentation includes, but is not limited to the following: • Member's age, clinical history, physical and functional status; • Documentation of infertility, testing if done, and treatment history • Documentation of any history of substance abuse, including smoking; • Social Service evaluation • Lab results: HIV antibody Diagnostic tests for infertility may be ordered by a participating provider. However, most anti-retroviral therapy (ART) drugs and procedures should only be ordered or performed by credentialed Reproductive Endocrinologists.	In-Network: 10% Out-of-Network: 40%

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
If a member lives in an out-of-network area, then the credentials of the nearest Reproductive Endocrinologist or OB/Gynecologist must be reviewed by the Credentials Specialist prior to approval for coverage. Refer to plan-specific infertility riders. Member acting as a surrogate mother and all services and supplies associated with surrogate motherhood are not covered by the UPMC Insurance Services Division, nor are supplies and services related to the following: • Pre-pregnancy evaluations • Prenatal care • Perinatal care • Postnatal care Procedure is covered if the couple has a relationship under which the FEHB Program recognizes each partner as a spouse of the other	In-Network: 10% Out-of-Network: 40%
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: 10% Out-of-Network: 40%
Allergy serum	In-Network: 10% Out-of-Network: 40%

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 45. • Respiratory and inhalation therapy • Dialysis - hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder • 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* on page 20. • Pain management Note: Pain management is covered if you are diagnosed with refractory chronic pain of at least six months duration. The provider must demonstrate that he or she anticipates these services to result in substantial improvement to your medical condition.	In-Network: 10% Out-of-Network: 40%

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies	
Rehabilitation and Habilitation services are 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 when a provider: • Orders the care Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 sessions.	In-Network: 10% Out-of-Network: 40%
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: 10% Out-of-Network: 40%
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: 10% Out-of-Network: 40%
• 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: 10% Out-of-Network: 40%
Not covered: • *Hearing aid batteries* • *Hearing services that are not shown as covered*	*All charges*

Benefit Description	You pay After the calendar year deductible…
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/FEHB/ to locate a vision care provider.	In-Network: Nothing (No deductible) Out-of-Network: Any amount over $30 per examination (No deductible)
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: 10% Out-of-Network: 40%
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.	In-Network: 10% Out-of-Network: 40%

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
• 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*.	In-Network: 10% Out-of-Network: 40%
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: 10% Out-of-Network: 40%
Not covered:	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	
• 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:* - *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: 10% Out-of-Network: 40%
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*

Benefit Description	You pay After the calendar year deductible…
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: 10% Out-of-Network: 40%
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: 10% Out-of-Network: 40%
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 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.	In-Network: 10% Out-of-Network: Not covered

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs (cont.)	
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 93.	In-Network: 10% Out-of-Network: 40%
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 $2,000 for Self Only or $4,000 Self Plus One or 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. You are also responsible for copayments for eligible prescriptions.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See 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., 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.	In-Network: 10% Out-of-Network: 40%

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
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: 10% Out-of-Network: 40%
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 leukoplasia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Surgery for TMJ disorder. Note: In order for surgery to be covered, documentation in the medical record must support that treatment of TMJ disorder with conventional non-surgical therapy has not resulted in adequate improvement. • Other surgical procedures that do not involve the teeth or their supporting structures	In-Network: 10% Out-of-Network: 40%
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 - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	In-Network: 10% Out-of-Network: 40%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
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)	In-Network: 10% Out-of-Network: 40%
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. • Allogenic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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	In-Network: 10% Out-of-Network: 40%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- 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) - 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 anemi - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	In-Network: 10% Out-of-Network: 40%
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	In-Network: 10% Out-of-Network: 40%

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 - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-Network: 10% Out-of-Network: 40%
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 necessary (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:	In-Network: 10% Out-of-Network: 40%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL - Early stage (indolent or non-advanced) small cell lymphocytic lymphom - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - 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 - Aggressive non-Hodgkin lymphomas	In-Network: 10% Out-of-Network: 40%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- 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) - 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.*	In-Network: 10% Out-of-Network: 40%
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: 10% Out-of-Network: 40%
Professional services provided in – • Hospital outpatient department • Skilled nursing facility. Limited to 100 days per calendar year combined with Extended care facility admissions. • Ambulatory surgical center • Office	In-Network: 10% Out-of-Network: 40%

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 $2,000 for Self Only enrollment or $4,000 Self Plus One or 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. 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: 10% Out-of-Network: 40%
Other hospital services and supplies, such as: • Operating, recovery and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	In-Network: 10% Out-of-Network: 40%
Not covered:	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay after the calendar year deductible...
Inpatient hospital (cont.)	
• *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 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.	In-Network: 10% Out-of-Network: 40%
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: 10% Out-of-Network: 40%
Skilled nursing facility (SNF): Limited to 100 days per calendar year combined with skilled nursing facility admissions.	In-Network: 10% Out-of-Network: 40%
Not covered: Custodial care	*All charges*
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: 10% Out-of-Network: 40%
Not covered: Independent nursing, homemaker services	*All charges*

Benefit Description	You Pay after the calendar year deductible...
Ambulance	
Local professional ambulance service when medically appropriate	In-Network: 10% Out-of-Network: 40%

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 $650 Self Only or $1,300, Self Plus One and Self and Family under the High Option and $800 Self Only or $1,600 Self Plus One and Self and Family under the Standard Option. Your actual deductible may be reduced by your participation in activities that fund your Health Incentive Account (HIA).
- 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. 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	10%
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	10%
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*
Ambulance	
Professional ambulance service when medically appropriate Note: See 5(c) for non-emergency service	10%
Accidental injury	
Accidental injury	10%

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The 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.
- 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	**High Option**
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) • 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: 10% Out-of-Network: 40%

Benefit Description	You pay After the calendar year deductible…
Diagnostics	**High 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	In-Network: 10% Out-of-Network: 40%
Inpatient hospital or other covered facility	**High 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, residential treatment, and other hospital services	In-Network: 10% Out-of-Network: 40%
Outpatient hospital or other covered facility	**High 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, full-day hospitalization, or facility-based intensive outpatient treatment	In-Network: 10% Out-of-Network: 40%
Not covered	**High Option**
• *Inpatient or outpatient treatment related to mental retardation, pervasive developmental disorder, which extends beyond traditional medical management* • *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 diagnoses listed in the most recent edition of the diagnostic and Statistical manual of 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*	*All charges*

Not covered - continued on next page

Benefit Description	You pay After the calendar year deductible…
Not covered (cont.)	**High Option**
• *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, listed in the most recent edition of the diagnostic and Statistical manual of Mental Disorders 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 63.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- The deductible is $2,000 for Self Only enrollment or $4,000 Self Plus One or 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.
- 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.
- Some drugs may require step therapy. This means that you must try specific medications first before we will cover the drug that requires step therapy. Step therapy is built into the electronic system that checks your medication history. A drug with step therapy will be automatically approved if there is a record that you have already tried the preferred drug(s). If there is no record that you tried the preferred drug(s) in your medication history, your physician must submit relevant clinical information to the UPMC Health Plan Pharmacy Services Department before it will be covered.

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

- **Who can write your prescription?** A licensed physician or dentist, and in states allowing it, licensed or certified Physicial Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them?** Covered prescription drugs obtained from a 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 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 travel 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	yes	yes	yes	yes	yes	yes
Show your UPMC Health Plan identification card at point of purchase	yes	yes	yes	yes	yes	yes
Pay the entire cost of your covered prescription at the point of purchase	yes, you can use your checkbook or debit card	no	no	yes	no	no
Pay your copayment at the point of purchase for a covered prescription	n/a	yes	n/a	n/a	yes	n/a
Complete and submit an 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 • Tobacco cessation drugs including over-the-counter (OTC) drugs approved by the FDA to treat tobacco dependence. (See page 93).	**In-Network:** Retail (up to a 30 day supply) $10 copayment for generic drugs $40 copayment for preferred brand-name drugs $100 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) $100 copayment Mail-Order (up to a 90 day supply) $20 copayment for generic drugs $80 copayment for preferred brand-name drugs $200 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) **Out-of-Network:** *All charges*
Women's contraceptives drugs and devices	Generic versions of contraceptives are available with no copayment and no deductible. Preferred and non-preferred brand name drugs will follow the plan payment level listed in the above section.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs for weight loss* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy (after the plan deductible is met)*	*All charges*

Covered medications and supplies (The Your Choice Formulary applies) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (The Your Choice Formulary applies) (cont.)	
• *Vitamins, nutrients, and food supplements even if a physician prescribers or administers them except as required by the Affordable Care Act. 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*	*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 deductible is $2,000 for Self Only enrollment or $4,000 for Self Only or 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. 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: 10% Out-of-Network: 40%

Dental benefits	
We have no other dental benefits.	

Section 5(h). Special features

Feature	Description
Health Care Concierge Team	You and your family members can call Member Services with questions or concerns. Our Health Care Concierge team delivers fast, personal service, and strives to answer your question on the first call. To speak with a Health Care Concierge, call 1-877-648-9641. Our Health Care Concierge team is available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m. TTY/TDD users should call 1-800-361-2629.
Health Incentive Account	You and your family can earn reward dollars in a health incentive account by completing healthy activities throughout the year. These activities have been specially designed by our team of doctors, nurses, nutritionists, exercise physiologists, and behavioral health experts. They will alert you to potential health issues and provide tools to help you address the issues. Activities include: • MyHealth Questionnaire: The confidential health risk assessment, powered by WebMD®, is a 20-minute online survey you take once a year. The results can help you understand your health status and suggest ways to make improvements. You can earn 50 reward dollars if completed in the 90 days of your effective date. You will earn 25 reward dollars if completed after 90 days. • Biometric Screening: This health screening measures your total cholesterol level and glucose level. Your doctor will also check your blood pressure, height, weight, and body mass index (BMI). It is a simple assessment that can be done at your doctor's office, a lab, or some convenience care clinics. Biometric screenings are recommended once every three years. You will earn 15-30 reward dollars for completing the LDL screening and 15 reward dollars for completing the glucose screening. • Condition or Lifestyle Management Coaching: A health coach for condition management will help you manage a chronic condition so you can live your healthiest life possible. Chronic conditions include heart disease, diabetes, asthma, COPD, and depression. Lifestyle programs include smoking cessation, stress management, physician activity, weight management, and nutrition. You can earn up to 150 reward dollars for completing a condition management program, and up to 145 reward dollars for completing a lifestyle management program. • You will also receive reward dollars for completing activities uniquely customized just for you. You will find a full list of eligible activities by logging in to *My*Health OnLine, the website that powers *HealthyU*, UPMC Health Plan's member website.

	The reward dollars you earn apply to your copayments and coinsurance after your deductible is met. In one plan year, you can earn up to $250 for Self Only coverage or $500 for Self and Family coverage. Any unused reward dollars — at a value up to two times your annual deductible —automatically roll over to the next year. The Plan will prorate any mid-year member enrollment deductibles, out-of-pocket costs and Health Incentive Account funds. To learn more about *HealthyU,* visit www.upmchealthplan.com/FEHB or call a Health Care Concierge at 1-877-648-9641.
***My*Health Health and Wellness**	You and your family members have access to *My*Health, A nationally acclaimed health and wellness program. *My*Health guides and motivates you to live your healthiest life possible through online programs, tools, and over-the-phone advice. *My*Health was developed by UPMC, one of the nation's top hospital systems. This gives us in-house expertise in condition management and lifestyle behavior change that no other health plan can match. *My*Health includes: • *My*Health OnLine • *My*Health Questionnaire • *My*Health Community • Health Coaching • *My*Health Advice Line For detailed descriptions, see below.
***My*Health OnLine**	*My*Health OnLine is where you can go every day for practical tips, tools, and strategies for better health. You can also find a doctor, view your medical history, and get information on your health plan benefits. The site keeps all your health information, all in one place. At *My*Health OnLine, you can: *Earn and track your reward dollars*, so you know exactly how much you have in your account to spend on health care. (Remember, with *HealthyU,* you earn reward dollars when you do healthy activities throughout the year.) *Enjoy discounts and savings*: Through *My*Health Community, you'll receive discounts at health-related businesses such as gyms, spas, salons, health food stores, sporting goods stores, and more. *Manage your health care information*: Access your doctor's contact information, plan benefits, research prescription and treatment options, savings information, and view your spending summary and claims. You can even order a new member ID card if you lose it. You can also chat online with a Health Care Concierge or Health Coach, read blogs from health experts, get advice on medical screenings and healthy activities, and set personal goals for managing your health.

	To get the most out of your benefits, log in to MyHealth OnLine at www.upmchealthplan.com/FEHB. To create an account click on Sign Up and use the number on your member ID card to register.
***My*Health Questionnaire**	Once you log in to *My*Health OnLine, complete your *My*Health Questionnaire. Not only will you earn reward dollars in your Health Incentive Account, but your answers generate a simple summary of your current health status and customize *My*Health OnLine with activities that benefit you the most.
***My*Health Community**	You and your family can receive discounts through *My*Health Community. For participating facilities throughout western Pennsylvania, visit www.upmchealthplan.com/FEHB, log in to *My*Health OnLine, and select *My*Health Community. Use the online tool to enter your ZIP code and view discounts close to your home or work. To take advantage of the discounts, show your UPMC Health Plan member ID card at the time of purchase and save at participating businesses that encourage a healthy lifestyle: gyms, spas, health food stores, sporting goods stores and more.
Health Coaching	A UPMC Health Plan health coach can get you started on a healthy living plan today. Enroll in one of our proven six-week or eight-week lifestyle or chronic condition coaching programs and earn reward dollars in your Health Incentive Account. A health coach can help you manage a variety of conditions, including asthma, diabetes, hypertension and low back pain. They can also help you lose weight, quit smoking, eat healthier, reduce stress, and make other lifestyle changes to improve your health. You can also choose to do a one-time visit by phone or connect via live chat. Participating in these programs also give you the opportunity to earn reward dollars in your Health Incentive Account. To get started, call a health coach at 1-800-807-0751.
***My*Health Advice Line**	For immediate access to free health care advice 24 hours a day, seven days a week call the *My*Health 24/7 Nurse Line at 1-866-918-1591. From general health information to help with a specific sickness or injury, an experienced registered nurse will provide you with prompt and efficient service.
UPMC Anywhere Care	With UPMC Health Plan coverage, provider access becomes almost instantaneous. If you can't see your regular provider right away for such things as flu or cold symptoms, a sore throat, even pink eye or a bad sunburn, now you can e-visit a UPMC provider straight from your computer. Anytime, day or night. It's convenient, affordable, and you don't have to wait. Any prescriptions will be sent to your directly to your local pharmacy. To access UPMC Anywhere Care: 1. Log in to UPMC AnywhereCare through upmcanywherecare.com.

	2. Describe your symptoms in a brief questionnaire. 3. Receive a personalized care plan, and a prescription, if needed, from a UPMC provider — *usually within 30 minutes.*
Mobile Health Plan Mobile App	When you download this free app to your smartphone, you can: • Access your UPMC Health Plan member ID card. • Contact your providers from a personalized list. • Check the status of your claims. • And much more.
Tobacco Cessation	UPMC Health Plan offers the *My*Health Ready to Quit™ health coaching program. The program will help you to quit using tobacco with a personal action plan that includes behavior modification strategies and tools based on the latest research. You will also receive reward dollars in your HIA by participating in the program.
Beating the Blues *Us*	UPMC Health Plan offers Beating the Blues, US™, a free, eight session online program for members who are dealing with stress, mild depression, or anxiety. Making use of cognitive behavior therapy (CBT), Beating the Blues, US is based on the concept that changing your thoughts can change your feelings and behaviors as well. Beating the Blues will show you how to: • Better understand your feelings. • Identify negative thoughts, and replace them with more helpful, positive thoughts. • Focus on what is happening right now, rather than on the past. Beating the Blues *US* is completely confidential and available 24/7, so you can complete the program at your own pace. You will also receive reward dollars in your HIA by participating in the program.
Assist America	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. Support is accessible 24 hours a day, 365 days a year. For a complete list of Assist America services visit www.assistamerica.com. To receive services, 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.
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.

Feature	Description
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).

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

Special features	Description
Health education resources	*HealthyU* makes it easy to get information, knowledge, and resources to help you guide your health care needs and health care costs. You can earn reward dollars and save more money by picking the best health care options for you. Educate yourself on your health by: • Asking your doctor for generic drugs • Reviewing treatment options for your condition on *My*Health OnLine, and possibly avoid costly procedures • Working with a health coach to assist with your health decisions • Calling the Nurse Advice Line if you have questions on any health issue Our secure member portal, *My*Health OnLine, gives you instant access to tools and support. You can earn and track reward dollars, search for a doctor, review claims and spending account balances, chat with a Member Services Health Care Concierge, and more. Once you log in to *My*Health OnLine, complete your *My*Health Questionnaire and earn reward dollars in your health incentive account. Your answers generate a simple summary of your current health status and customize *My*Health OnLine with activities that benefit you the most. UPMC Health Plan provides health education, decision-making, and price and quality comparison tools. You are able to access more than 200 health topics covering many common conditions, procedures, and alternative treatments. You'll also find online health coaching, helpful videos, and downloadable educational materials. Join our health discussion online. Visit the UPMC MyHealth Facebook page or follow @UPMCMyHealth on Twitter for health and wellness information. Or read the UPMC *My*Health Matters blog from our health and nutrition experts that cover a variety of topics that will inspire you to take an active role in your health. To get the most out of your benefits, log in to *My*Health OnLine at www.upmchealthplan.com/FEHB. To create an account click on Sign Up and use the number on your member ID card to register.
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, • You HRA balance will be available through *My*Health OnLine. Visit www.upmchealthplan.com/FEHB and login to *My*Health OnLine using the member identification number on your member ID card. • 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/FEHB. 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.

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 Avesis 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 Avesis 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 and a description of the benefits is included in your UPMC Health Plan enrollment packet. You can also visit the Avesis website at http://www.avesis.com/ or contact UPMC Health Plan by telephone at 1-877-648-9641 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.

UPMC Vision *Advantage*: Members are eligible for a 20% discount on frames and lenses for glasses when received from a participating provider. 20% discount does not apply to contact lenses. UPMC Vision *Advantage* participants are eligible for discounts on LASIK surgery when received by one of the following preferred providers: UPMC Eye Center, TLC Vision, or QualSight.

UPMC *Advantage*: If you or a family member is without coverage, UPMC Health Plan offers UPMC *Advantage* for direct purchase. This product is also available to non-FEHB members, such as domestic partners of FEHB members. All prospective purchasers of UPMC *Advantage* can shop for plans during Healthcare Exchange Open Enrollment or may qualify for a Special Enrollment Period, depending on circumstances, outside of this period. UPMC *Advantage* includes coverage for:

- Preventive care
- Physical exams and office visits
- Hospital and emergency services
- Other medical services, including diagnostic, behavioral health and women's care
- Prescriptions drugs

You may learn more about UPMC *Advantage* by visiting www.upmchealthplan.com or healthcare.gov, calling our offices at 1-877-563-0292 or contacting an insurance broker.

Section 6. General exclusions – services, drugs and supplies we do not 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 in the High Option and Standard Option (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 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-participating 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, contact us at 1-877-648-9641 or at our website at 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 2999
Pittsburgh, PA 15230-2939

Prescription drugs

Submit your claims to:

UPMC Health Plan
Claims Department
P.O. Box 2999
Pittsburgh, PA 15230-2939

Other supplies or services

Submit your claims to:

UPMC Health Plan
Claims Department
P.O. Box 2999
Pittsburgh, PA 15230-2939

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.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English version of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and the procedure codes.

Section 8. The disputed claims process

You may 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. To make your request, please contact our Member Services Department by writing to UPMC Health Plan,
Claims Department, P.O. Box 2939, Pittsburgh, PA 15230-2939 or 1-877-648-9641.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or part) on medical judgment (i.e. medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of the benefits.

Disagreements between you and the 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 within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 1, 1900 E Street, NW, Washington, DC 20415-3610.

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 file a lawsuit, 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 file a lawsuit 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 expedite 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. You may call OPM's Health Insurance 1 at (202) 606-0737 between 8 a.m. and 5 p. m. Eastern Standard Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You may raise eligibility issues with your Agency personal/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and 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' (NAIC) guidelines. For more information on NAIC rules regarding the coordination of benefits, visit the NAIC website at http://www.NAIC.org.

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.

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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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 or by phone 1-877-888-3337 (TTY 1-877-889-5680), 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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Adminstration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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.

When You have Medicare

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. 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. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY: 1-800-325-0778).

- **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 payor, 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 website at www.upmchealthplan.com/FEHB.

Under the Standard Option HMO: If you are enrolled in Original Medicare Parts A and B, member coinsurance is waived and the deductible is reduced to that of the High Option HMO if Medicare is your primary payor.

Under the High Option HMO, if Original Medicare is your primary payor then no costs are waived.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$800	$650 Self Only/$500 Self Plus One or Self and Family
Out of Pocket Maximum	$5,000 Self Only/$10,000 Self Plus One or Self and Family	$5,000 Self Only/$10,000 Self Plus One or Self and Family
Primary Care Physician	20%	0%
Specialist	20%	0%
Inpatient Hospital	20% per admission	0% per admission
Outpatient Hospital	20% per visit	0%
Rx	Tier 1 -$10 Tier 2 -$40 Tier 3 - $100 Tier 4 – $100 Specialty (30 day supply)	Tier 1 -$10 Tier 2 -$40 Tier 3 - $100 Tier 4 – $100 Specialty (30 day supply)
Rx – Mail Order (90 day supply)	2x retail copay	2x retail copay

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). However, 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.

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.

Calendar year deductible

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.

Catastrophic Limits

When you use participating 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%.

For all plans, the annual catastrophic limit for out-of-pocket expenses can be either embedded or aggregate. Embedded means the out-of-pocket maximum has an individual out-of-pocket maximum within the family maximum. It is met by either an individual reaching the maximum or a combination of family members reaching the maximum out-of-pocket limit. Individual plans have individual out-of-pocket maximums.

The aggregate out-of-pocket maximum means the plan has a single out-of-pocket maximum that the entire family must meet either by a combination of family members' claims or by one person's claims. Individual plans have an individual out-of-pocket maximum.

Clinical Trial Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

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
- 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. These costs are generally covered by the clinical trials. This plan does not cover these costs.

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 25.

Copayment

A copayment is a fixed amount of money you pay to the participating pharmacy when you receive covered medications after your deductible is met.

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 each year for certain covered services and supplies before we start paying benefits for those services. See pages 153, 155, and 157.

For all plans, the annual deductible can be either embedded or aggregate. Embedded means the deductible has an individual deductible within the family deductible. It is met by either an individual reaching the deductible or a combination of family members reaching the deductible limit. Individual plans have individual deductibles.

The aggregate deductible means the plan has a single deductible that the entire family must meet either by a combination of family members' claims or by one person's claims. Individual plans have a individual deductibles.

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.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Us/We

Us and We refer to UPMC Health Plan.

You

You refers to the enrollee and each covered family member.

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.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible

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 participating 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%.

Copayment (prescription drugs)

A copayment is a fixed amount of money you pay to the participating pharmacy when you receive covered medications after your deductible is met.

Deductible

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

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

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

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. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about 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. Participating employees save an average of about 30% on products and services they 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 $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) $2,550. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** — Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **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).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or a provider files claims with your FEHB or FEHBVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **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 out-of-pocket 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).
- **Dependent Care FSA (DCFSA)** — Reimburses you for eligible **non-medical** day care expenses for your children 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. FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

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. 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 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

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/dental and www.opm.gov/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.

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Notes

Summary of benefits for the High Option HMO of UPMC Health Plan - 2016

- **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 $650 Self Only/$1,300 Self Plus One or Self and Family calendar year deductible.

High Option Benefits	You Pay	Page
Medical services provided by physicians*:		
Diagnostic and treatment services provided in the office	15% of the Plan allowance	31
Services provided by a hospital*:		
• **Inpatient**	15% of the Plan allowance	54
• **Outpatient**	15% of the Plan allowance	55
Emergency benefits*:		
• **In-area**	15% of the Plan allowance	58
• **Out-of-area**	15% of the Plan allowance	58
Mental health and substance abuse treatment*:	Regular cost-sharing	59
Prescription drugs*:		
• Retail pharmacy — up to a 30 day supply (or up to a 90 day supply for three copayments)	$10 generic $40 preferred brand-name $100 non-prefered brand-name	63
• Special mail order — up to a 30 day supply	$100	63
• Mail-order — up to a 90 day supply	$20 generic $80 preferred brand-name $200 non-preferred brand-name	63
Dental care:	Limited Dental benefits and discounts under a non-FEHB benefit program	66
Vision care:	Nothing for routine eye exam. Once every 24 months for adults/Once every 12 months for children.	41
Special features:	• Health Care Concierge Team • Health Incentive Account • *My*Health Health and Wellness • *My*Health OnLine	67

	• *My*Health Questionnaire • *My*Health Community • Health Coaching • *My*Health Advice Line • UPMC Anywhere Care • Mobile Health Plan Mobile App • Tobacco Cessation • Beating the Blues *US* • Assist America • Services for Members who have a Hearing Impairment • Flexible Benefits Option	
Protection against catastrophic costs (out-of-pocket maximum):	$4,000 Self Only or $8,000 Self Plus One or Self and Family per year.	26

Summary of benefits for the Standard Option HMO of UPMC Health Plan - 2016

- **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 $800 Self Only/$1,600 Self Plus One or Self and Family calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians*:		
Diagnostic and treatment services provided in the office	20% of the Plan allowance	31
Services provided by a hospital*:		
• Inpatient	20% of the Plan allowance	54
• Outpatient	20% of the Plan allowance	55
Emergency benefits*:		
• In-area	20% of the Plan allowance	58
• Out-of-area	20% of the Plan allowance	58
Mental health and substance abuse treatment*:	Regular cost-sharing	59
Prescription drugs*:		
• Retail pharmacy — up to a 30 day supply (or up to a 90 day supply for three copayments)	$10 generic $40 preferred brand-name $100 non-preferred brand-name	63
• Special mail order — up to a 30 day supply	$100	63
• Mail order — up to a 90 day supply	$20 generic $80 preferred brand-name $200 non-preferred brand-name	63
Dental care:	Limited Dental benefits and discounts under a non-FEHB benefit program.	66
Vision care:	Nothing for routine eye exam. Once every 24 months for adults/Once every 12 months for children.	41
Special features:	Health Care Concierge Team Health Incentive Account *My*Health Health and Wellness *My*Health OnLine	67

	*My*Health Questionnaire *My*Health Community Health Coaching *My*Health Advice Line UPMC Anywhere Care Mobile Health Plan Mobile App Tobacco Cessation Beating the Blues *US* Assist America Services for Members who have a Hearing Impairment Flexible Benefits Option	
Protection against catastrophic costs (out-of-pocket maximum**):**	$5,000 Self Only or $10,000 Self Plus One or Self and Family per year.	26

Summary of benefits for the HDHP of UPMC Health Plan - 2016

- **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 2016 for each month you are eligible for the Health Savings Account (HSA), we will deposit $83 per month for Self Only Only enrollment or $166 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 $2,000 for Self Only and $4,000 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 $1,000 for Self Only and $2,000 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.
- Below, an asterisk (*) means the item is subject to the calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other health care professional.

HDHP Benefits	You Pay	Page
In-network medical and dental preventive care	Nothing	83
Medical services provided by physicians*:	In-Network: 10% Out-of-Network: 40%	31
Diagnostic and treatment services provided in the office*:	In-Network: 10% Out-of-Network: 40%	88
Services provided by a hospital*:		
• Inpatient	In-Network: 10% Out-of-Network: 40%	108
• Outpatient	In-Network: 10% Out-of-Network: 40%	109
Emergency benefits*:		
• In-area	In-Network: 10% Out-of-Network: 40%	112
• Out-of-area	In-Network: 10% Out-of-Network: 40%	112
Mental health and substance abuse treatment*:	In-Network: 10% Out-of-Network: 40%	113
Prescription drugs*:		
• Retail pharmacy— up to a 30 day supply (or up to a 90 day supply for three copayments)	$10 generic drugs $40 preferred brand-name drugs $100 non-preferred brand-name drugs	116
• Specialty mail-order — up to a 30 day supply	$100	116

HDHP Benefits	You Pay	Page
• Mail-order— up to a 90 day supply	$20 generic drugs $80 preferred brand-name drugs $200 non-preferred brand-name drugs	116
Dental care:	Limited Dental benefits and discounts under a non-FEHB benefit program.	121
Special Features	• Health Care Concierge Team • Health Incentive Account • *My*Health Health and Wellness • *My*Health OnLine • *My*Health Questionnaire • *My*Health Community • Health Coaching • *My*Health Advice Line • UPMC Anywhere Care • Mobile Health Plan Mobile App • Tobacco Cessation • Beating the Blues *US* • Assist America • Services for Members who have a Hearing Impairment • Flexible Benefits Option	122
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-Network: $5,000 Self Only or $10,000 Self Plus One or Self and Family Out-of-Network: $8,000 Self Only or $16,000 Self Plus One or Self and Family	26

2016 Rate Information for UPMC Health Plan

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

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees.

Postal Category 2 rates apply to career non-bargaining unit employees.

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.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

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	$213.37	$142.98	$462.30	$309.79	$131.12	$142.98
High Option Self Plus One	8W3	$461.02	$340.76	$998.88	$738.31	$315.15	$340.76
High Option Self and Family	8W2	$488.50	$348.89	$1058.42	$755.93	$321.75	$348.89
Standard Option Self Only	UW4	$200.63	$66.87	$434.69	$144.89	$55.51	$66.87
Standard Option Self Plus One	UW6	$451.39	$150.46	$978.01	$326.00	$124.88	$150.46
Standard Option Self and Family	UW5	$471.44	$157.14	$1021.44	$340.48	$130.43	$157.14
HDHP Option Self Only	8W4	$177.58	$59.19	$384.75	$128.25	$49.13	$59.19
HDHP Option Self Plus One	8W6	$393.65	$131.22	$852.92	$284.30	$108.91	$131.22
HDHP Option Self and Family	8W5	$409.36	$136.45	$886.94	$295.65	$113.26	$136.45