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   - The Paid Time Off You Receive
   - Paid Time Off Hourly Accrual Schedule
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   - How PTO Works
   - Scheduled vs. Unscheduled Absences
   - PTO Sick Time
   - Extended Illness Bank (EIB)
   - Unauthorized/Unapproved PTO
   - Mandatory Use of PTO
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Overview
An Introduction to Your Health and Welfare Benefits

As part of your total compensation package, UPMC offers a variety of health and welfare benefit options for you and your eligible dependents through the UPMC Welfare Benefits Plan. These valuable programs are designed to attract and retain qualified staff members, as well as, provide a certain level of personal security, convenience, and assistance.

Because of the plan’s flexibility, you can select the coverage you need each year, or you can select a higher level of a specific coverage depending on your own personal situation. In addition, the Plan is designed to support our overall mission and business objectives.

The Components of Your Health and Welfare Benefits
The chart below shows the different coverages available under the health and welfare benefit options. It also shows which coverages you pay for on your own, which coverages you and UPMC pay for together, and how you pay for your share of costs (pre- or after-tax). Because your coverage costs may change each plan year, you will receive the most up-to-date cost of each benefit option with your annual enrollment materials.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>UPMC Pays</th>
<th>You Pay</th>
<th>You and UPMC Pay</th>
<th>You Pay Pre- or After-Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (includes prescription drug and vision care benefits)</td>
<td></td>
<td>X</td>
<td></td>
<td>Pretax</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Life and Accidental Death and Dismemberment (AD&amp;D) Insurance</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Life Insurance for You</td>
<td>X</td>
<td></td>
<td>After-tax</td>
<td></td>
</tr>
<tr>
<td>Supplemental Life Insurance for Your Spouse</td>
<td>X</td>
<td></td>
<td>After-tax</td>
<td></td>
</tr>
<tr>
<td>Supplemental Life Insurance for Your Dependents</td>
<td>X</td>
<td></td>
<td>After-tax</td>
<td></td>
</tr>
<tr>
<td>Supplemental Accidental Death and Dismemberment (AD&amp;D) Insurance</td>
<td>X</td>
<td></td>
<td>Pretax</td>
<td></td>
</tr>
<tr>
<td>Short-Term Disability (STD)</td>
<td>X</td>
<td></td>
<td></td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Long-Term Disability (LTD)</td>
<td>X</td>
<td></td>
<td></td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Flexible Spending Accounts (includes health care and dependent care flexible spending accounts)</td>
<td>X</td>
<td></td>
<td></td>
<td>Pretax</td>
</tr>
<tr>
<td>Pretax Transportation</td>
<td>X</td>
<td></td>
<td></td>
<td>Pretax</td>
</tr>
<tr>
<td>Voluntary AFLAC Personal STD</td>
<td>X</td>
<td></td>
<td>After-tax</td>
<td></td>
</tr>
<tr>
<td>Voluntary AFLAC Personal Accident Expense Plan</td>
<td>X</td>
<td></td>
<td>Pretax</td>
<td></td>
</tr>
<tr>
<td>Voluntary AFLAC Personal Recovery Plus Plan</td>
<td>X</td>
<td></td>
<td></td>
<td>Pretax</td>
</tr>
<tr>
<td>Voluntary AFLAC Cancer Policy</td>
<td>X</td>
<td></td>
<td>Pretax</td>
<td></td>
</tr>
<tr>
<td>Voluntary Pre-Paid Legal Services</td>
<td>X</td>
<td></td>
<td>After-tax</td>
<td></td>
</tr>
</tbody>
</table>
Overview

In addition, UPMC provides access to adoption assistance, an Employee Assistance Program (EAP), Paid Time Off (PTO), Tuition Assistance and severance benefits.

If you decide to decline any of the above coverages (except for your UPMC-paid: basic life, AD&D, STD, and LTD coverages), you will not have coverage through the plan. In addition, you will not be able to elect or change coverage until the next annual enrollment period, unless you experience a qualified change in status, or you qualify for an additional enrollment opportunity during the year. See the Changing Your Coverage section for details regarding qualified status changes and changing your coverages.

Please note: If you are a regular part-time staff member, you are not eligible for STD or LTD. If you are a limited part-time staff member, you are only eligible for PTO and retirement benefits. See the Who Is Eligible section for details regarding who is eligible for benefits.

Pretax vs. After-tax
You pay for certain coverages with pretax (tax-favored) dollars deducted from your paycheck each pay period. Using pretax dollars reduces your taxable income for federal, Social Security, and (in most cases) state income taxes. Additionally, your income is not affected when determining your benefit levels for coverages under other UPMC plans.

You pay for other coverages on an after-tax basis. This means that you pay for the coverages with your already-taxed dollars (your take-home pay). In other words, the coverage costs are included as income on your W-2 for tax purposes. IRS rules determine how each pre- and after-tax benefit you receive is taxed.

Please note: Using pretax dollars can affect any Social Security benefits you may eventually receive. This is because you do not pay Social Security (FICA) taxes on pretax dollars. For most people, the Social Security benefit reduction is just a few dollars a month. In addition, the reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any concerns, or if you need additional information, contact your local Social Security Administration office.
### Self-Insured and Fully Insured
The following chart shows which benefits are self-insured by UPMC and which are fully insured.

<table>
<thead>
<tr>
<th>Benefits</th>
<th><strong>Self-Insured</strong></th>
<th><strong>Fully Insured</strong></th>
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<tbody>
<tr>
<td></td>
<td>● Medical</td>
<td>● Dental-CIGNA Dental Care</td>
</tr>
<tr>
<td></td>
<td>● Dental -CIGNA Dental PPO</td>
<td>● Life and AD&amp;D, including:</td>
</tr>
<tr>
<td></td>
<td>● Prescription drug</td>
<td>— Basic life and AD&amp;D insurance</td>
</tr>
<tr>
<td></td>
<td>● Vision</td>
<td>— Supplemental life insurance for you</td>
</tr>
<tr>
<td></td>
<td>● STD</td>
<td>— Supplemental life insurance for your spouse</td>
</tr>
<tr>
<td></td>
<td>● All other benefits described in this handbook, including:</td>
<td>— Supplemental life insurance for your dependents</td>
</tr>
<tr>
<td></td>
<td>— Adoption assistance</td>
<td>— Supplemental AD&amp;D insurance for you</td>
</tr>
<tr>
<td></td>
<td>— The Employee Assistance Program (EAP)</td>
<td>● LTD</td>
</tr>
<tr>
<td></td>
<td>— Paid Time Off (PTO)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Pretax transportation benefits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Tuition Assistance; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— The Severance Plan</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Voluntary Benefit Programs</th>
<th><strong>AFLAC Personal Short-Term Disability Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>AFLAC Personal Accident Expense Plan</strong></td>
</tr>
<tr>
<td></td>
<td><strong>AFLAC Personal Recovery Plus Plan</strong></td>
</tr>
<tr>
<td></td>
<td><strong>AFLAC Cancer Policy</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Pre-Paid Legal Services</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definition</th>
<th>As expenses are incurred, benefits are paid from UPMC’s general assets. In addition, UPMC has an administrative service contract with the administrator or insurance carrier to process claims.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An administrator or insurance carrier provides administrative services and makes decisions regarding benefits. The administrator or insurance carrier insures coverages and makes benefit payments from the plans. UPMC pays premiums to the administrator or insurance carrier for coverages, and remits payroll deductions for any elected coverages.</td>
</tr>
</tbody>
</table>
### How This Handbook Is Organized

The chart below shows what you will find in each section of this handbook.

<table>
<thead>
<tr>
<th>Section</th>
<th>What You Will Find</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>This section highlights the features that pertain to all or most of your health and welfare benefit options.</td>
</tr>
<tr>
<td>Medical</td>
<td>Here is where you will find details about the coverage options under the UPMC Health Plan, as well as your prescription drug and vision care benefits. Even though this handbook contains detailed information regarding your coverage, be sure to refer to any additional UPMC Health Plan materials you receive.</td>
</tr>
<tr>
<td>Dental</td>
<td>This section describes your dental care options.</td>
</tr>
<tr>
<td>Life and Accidental Death and Dismemberment (AD&amp;D) Insurance</td>
<td>Here you will learn about the: • Basic life and AD&amp;D insurance protection provided for you; • Supplemental life insurance available for you, your spouse, and your dependents — if you want to purchase this additional coverage; and • Supplemental AD&amp;D insurance available for you — if you want to purchase this additional coverage.</td>
</tr>
<tr>
<td>Disability</td>
<td>This section focuses on income protection during periods of short- and long-term disability.</td>
</tr>
<tr>
<td>Flexible Spending Accounts (FSAs)</td>
<td>This section explains how you can participate in the flexible spending accounts. It also explains how you can use your contributions to help pay many of your health and dependent care expenses with tax-free dollars.</td>
</tr>
<tr>
<td>Other Benefits</td>
<td>Here you will learn about the following programs: • Adoption assistance; • Employee Assistance Program (EAP); • Paid Time Off (PTO); • Pretax Transportation • Tuition Assistance • Severance; and • Voluntary Benefit Programs</td>
</tr>
<tr>
<td>Administering the Plan</td>
<td>If you want to know how the UPMC Welfare Benefits Plan is administered, or more about your legal rights as a Plan participant, be sure to read this section.</td>
</tr>
</tbody>
</table>

Throughout this handbook, you will notice call-out boxes in the side margin. These boxes include definitions or important concepts related to your benefits.
Who This Handbook Pertains To
This handbook applies to all “eligible” staff members of the following entities. The Who Is Eligible section, describes the eligibility requirements. See that section for more details.

Canterbury Place;
Community Care Behavioral Health Organization;
Community Medicine, Inc.;
Magee-Womens Hospital of UPMC;
Medical Archival Systems, Inc.;
University Health Center of Pittsburgh
University of Pittsburgh Physicians (Staff and Physicians);
UPMC Bedford Memorial;
UPMC Behavioral Health;
UPMC Braddock;
UPMC Cancer Centers;
UPMC Diversified Services and Affiliates, Inc.;
UPMC Health Plan;
UPMC Home Care Services, Inc.;
UPMC Horizon;
UPMC Lee Regional;
UPMC McKeesport;
UPMC Passavant and UPMC Passavant Cranberry;
UPMC Presbyterian - Shadyside (includes Western Psychiatric Institute and Clinic);
UPMC Rehabilitation Hospital;
UPMC St. Margaret;
UPMC Senior Living
UPMC/South Hills Health System Joint Venture;
UPMC South Side;
UPMC Specialty Service, Inc.

This handbook also applies to staff covered by collective bargaining agreements that have adopted the UPMC Welfare Benefits Plan.

If you are a CMI, SMA, or UPP physician, certain sections of this handbook may not apply (e.g., STD, LTD, and basic life).
Overview

This summary is based on the official insurance contracts in effect. Every effort has been made to give you correct and complete information about your benefits in this handbook. However, if this handbook inadvertently states anything that disagrees with the official agreements of insurance in effect, the official agreements prevail in interpretation and administration. You may obtain a copy of the official agreements of insurance from the plan administrator. See the Administering The Plans section for the full name and address of the plan administrator.

UPMC intends to continue the UPMC Welfare Benefits Plan as described in this handbook, but reserves the right to suspend, amend, or terminate the plan — or any of the benefit options or features provided under the plan — at any time and in any manner to the extent permitted by law. As a result, this handbook is not a contract nor is it a guarantee of your benefits. Participation in the plan is not a guarantee of continued employment with the company.

If You Have Questions

If you have questions about your benefits, please contact the UPMC Employee Service Center at 1-800-994-2752, option 3. Or, you can contact the appropriate administrator. The toll-free number for each administrator is listed in the Administrative Information section.
Who Is Eligible

You and your dependents may be eligible for certain health and welfare benefits.

You

You are eligible to participate in the UPMC Welfare Benefits Plan if you are classified by UPMC as a:

- Full-time staff member;
- Flexible full-time staff member;*
- Job-share staff member;*
- Regular part-time staff member (except for the short-term and long-term disability plans);
- Limited part-time staff member (eligible for PTO and retirement benefits only); or
- Staff member covered by a collective bargaining agreement that provides for such participation.

If you are classified by UPMC as a casual or temporary staff member, you are not eligible for any benefits under the Plan.

Your Eligible Dependents

Certain health and welfare benefits also are available to your eligible dependents. Your eligible dependents (proof of dependency is required) include your:

- Spouse, according to Pennsylvania state law
- Unmarried dependent child, stepchild, legally adopted child, child placed with you for adoption, or child for whom you are a legal guardian, provided he or she:
  — Resides in your household;
  — Is under age 19; or
  — Is between age 19 and 25 (enrolled as a full-time student in an accredited school, college, or university) and is primarily dependent on you for support. If an otherwise eligible full-time student becomes disabled due to a physical or medical condition, such that full-time student status can no longer be maintained, coverage may be extended on a limited basis until such time that the student is able to return to full-time student status, provided that no less than nine (9) credits are maintained per semester during this extension and a physician attests that full-time student status can not be maintained due to the physical or medical condition. In no circumstances will this extension of coverage be continued beyond the attainment of age 25.

* You must be working a minimum of 20 hours per week to be eligible for disability coverage.
• Unmarried dependent child who becomes totally disabled, provided the disability occurred before he or she turned age 19.

Dependent coverage continues as long as your own coverage continues. In addition, your dependent child’s coverage ends on the last day of the month in which the earliest of the following events occur:

• Attains age 19 (or 25 if covered as a full-time student)
• Full-time student status is not maintained (except as indicated above due to total disability).
• Dependent child marries.
• Disabled dependent ceases to be disabled and no longer qualifies as an eligible dependent.

If you get divorced or separated, a special court order may require you as a parent to provide for your child’s health coverage. This is called a Qualified Medical Child Support Order (QMCSO). If this is the case and the court order satisfies all of the applicable legal requirements, UPMC will offer coverage to the extent provided by law.

**Dual Coverages**

If you and your spouse are both employed by UPMC, only one of you may cover your children as dependents under any one health or welfare plan. Also, if you are covered under a plan as a staff member, you may not be covered under that same plan as a dependent.

The supplemental life insurance coverage for dependents does not cover dependents who are also eligible staff members of UPMC or one of its affiliates.

**Overview**

**Spouse**
The individual to whom you are legally married through a governmental or religious ceremony. The plan also recognizes a common-law spouse as a dependent, as long as you provide proof of your common-law marriage. Contact the UPMC Employee Service Center to complete the Common Law application.

**Totally Disabled Dependent**
A dependent is considered totally disabled if his or her disability is severe enough to render the individual incapable of self-support.
How to Enroll

After you are first hired, and each year during annual enrollment, you have the opportunity to select the benefit options you want for the current (if you are a new hire) or upcoming plan year. You will be provided with benefit and employee premium contribution information at this time.

Initial Enrollment
Once you are hired, you will receive an enrollment packet. Your packet includes a brief description of the health and welfare benefits, the benefit options for which you are eligible, the cost of each option, and an enrollment worksheet.

Complete and submit your enrollment worksheet to the UPMC Employee Service Center within 30 days after you are first eligible. If you do not submit your completed worksheet within this time period, you automatically receive the UPMC provided coverages. See next page for details regarding what happens if you do not enroll. Within two weeks of the day your elections are received, you will receive a confirmation statement at your home address. The statement shows your benefit elections for the remainder of the plan year, unless you have a qualified change in status. See section titled When Coverages Begin for details regarding qualified status changes.

Annual Enrollment
Each fall, you may choose or make changes to your benefits for the upcoming plan year. You will receive a packet of information designed to help you with your annual enrollment decisions.

The packet you receive contains important tips on how to enroll. It describes the enrollment procedures, the benefit options for which you are eligible, and any changes that may have taken place since the last annual enrollment. Be sure to read the information carefully. Any benefit election you make during the annual enrollment takes effect on January 1, the start of the new plan year and remain in effect for the year (unless you have a qualifying event, see Changing Your Coverage section for mid year election changes).

If you want to upgrade certain coverages during the annual enrollment, certain restrictions may apply. For example, if you want to increase supplemental life insurance coverage for yourself, you may upgrade only one level from your current level during annual enrollment without providing evidence of insurability. See the section titled How Your Life and AD&D Coverages Work for more information on evidence of insurability.

| Plan Year | The year starting January 1 and ending December 31. |
| Benefits Express | Your automated telephone enrollment system (used only during the open enrollment period). |
| Special Enrollment | You may decide to decline medical coverage under the UPMC Health Plan because you have medical coverage under an outside plan. If this is the case and your other coverage subsequently ends, you can elect medical coverage under this plan provided you do so within 30 days after your other coverage ends. See the Special Enrollments During the Year section for details regarding special enrollments. |

| Special Enrollments During the Year | |
If You Do Not Enroll
If you do not enroll when you are first hired or within the annual enrollment period, the following applies.

Initial Enrollment
If you do not enroll within thirty (30) days after you are first eligible, but you enroll within sixty (60) days, your coverage takes effect on the first day of the month following the day your elections are received. If you do not enroll within sixty (60) days after you are first eligible, you decline the following coverages until the next annual enrollment period:

- Medical;
- Prescription drugs;
- Vision;
- Dental;
- Flexible Spending;
- Supplemental life insurance (you);
- Supplemental life insurance (spouse and/or dependents);
- Supplemental AD&D insurance; and
- Voluntary Benefit Programs (Pretax plans).

Annual Enrollment
If you do not enroll within the annual enrollment period but you enrolled in the past, most of your current coverages remain in effect for the next plan year. One exception is the flexible spending accounts. If you want to participate in the flexible spending accounts, you must reenroll during each annual enrollment period and decide how much you want to contribute to each account for the upcoming plan year. The other exception applies if UPMC changes carriers or modifies the plan significantly. If this is the case, you will need to reelect coverage.

ID Cards
Medical and prescription drug: A few weeks after you enroll, you will receive a medical insurance identification card at your home address from UPMC Health Plan.

Dental: Participants of the CIGNA Dental Care (DHMO) plan will receive an identification card with their selected primary dentist listed. The card is not required to obtain service. CIGNA Dental PPO participants should use the CIGNA Dental Claim form for services. See the Applying for Benefits section in the Dental chapter.
The chart below shows when each coverage begins, provided you meet the eligibility and enrollment requirements within 30 days after your hire date. Remember, you must enroll before medical, dental, flexible spending, supplemental life insurance (for you, your spouse, or your dependents) and supplemental AD&D coverages begin.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>When Coverage Begins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (Includes prescription drugs and vision)</td>
<td>First of the month on or after your hire date*</td>
</tr>
<tr>
<td>Dental</td>
<td>First of the month on or after your hire date*</td>
</tr>
<tr>
<td>Basic life and AD&amp;D</td>
<td>First of the month on or after your hire date</td>
</tr>
<tr>
<td>Supplemental life insurance (you)</td>
<td>First of the month on or after your hire date</td>
</tr>
<tr>
<td>Supplemental life insurance (spouse and/or dependents)</td>
<td>First of the month on or after your hire date*</td>
</tr>
<tr>
<td>Supplemental AD&amp;D</td>
<td>First of the month on or after your hire date</td>
</tr>
<tr>
<td>STD</td>
<td>First of the month on or after your hire date</td>
</tr>
<tr>
<td>LTD</td>
<td>First of the month on or after your hire date</td>
</tr>
<tr>
<td>Flexible spending accounts</td>
<td>First of the month on or after your hire date</td>
</tr>
<tr>
<td>Other Benefits:</td>
<td>First day of work</td>
</tr>
<tr>
<td>• Adoption Assistance</td>
<td></td>
</tr>
<tr>
<td>• EAP</td>
<td></td>
</tr>
<tr>
<td>• PTO</td>
<td></td>
</tr>
<tr>
<td>• Tuition Assistance*</td>
<td></td>
</tr>
<tr>
<td>• PTO</td>
<td></td>
</tr>
<tr>
<td>• Severance</td>
<td></td>
</tr>
<tr>
<td>Voluntary Benefits:</td>
<td>First of the month on or after your hire date</td>
</tr>
<tr>
<td>• AFLAC Personal STD Plan</td>
<td></td>
</tr>
<tr>
<td>• AFLAC Personal Accident Expense Plan</td>
<td></td>
</tr>
<tr>
<td>• AFLAC Personal Recovery Plus Plan</td>
<td></td>
</tr>
<tr>
<td>• AFLAC Cancer Policy</td>
<td></td>
</tr>
<tr>
<td>• Pre-Paid Legal Services</td>
<td></td>
</tr>
</tbody>
</table>

* Coverage for your dependents begins on the same day as your coverage begins, or the day your dependent first becomes eligible (whichever is later). See ‘Changing Your Coverage’ section for details regarding adding a dependent to coverage due to a qualified change in status.

** Spouse and Dependent Tuition Assistance eligibility begins after one year of service.
Changing Your Coverages

Because of the plan’s tax advantages, the Internal Revenue Service (IRS) restricts certain coverage changes you may make after enrollment. And, the IRS has rules as to the types of changes you may make during the plan year.

In general, once you enroll for (or decline) coverage, your benefit elections stay in effect for that plan year. However, under certain circumstances, you may enroll for or change certain coverages during the year. These circumstances include:

- You experience a “change in status” — as described in this section — that affects your, your spouse’s, or your dependents’ eligibility.
- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described in the Special Enrollments During the Year section.
- The plan receives a qualified medical child support order (QMCSO).
- You, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You take a leave of absence under the Family and Medical Leave Act (FMLA) (however, you cannot change coverage while you are on FMLA).

Changes in Status

You may change certain benefit elections during the plan year if you experience a qualified change in status. Changes may be made to your medical (includes prescription drug and vision), dental, life, AD&D, and flexible spending accounts. You also may make changes to the amounts you contribute to the flexible spending accounts. A qualified change in status is any of the following circumstances that may affect coverage:

- You get divorced or you have your marriage annulled.
- Your spouse or dependent dies.
- Your unmarried dependent becomes ineligible or eligible for coverage (e.g., he or she reaches the plan’s eligibility age limit, becomes or ceases to be a full time student or gets married).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- Your spouse or dependent experience a change in coverage under another employer’s plan, corresponding with an open enrollment period change made by the spouse or dependent where the other employer’s plan has a different plan year.
- Your spouse’s or dependent’s employer coverage ceases or is materially changed.
- You, your spouse, or your dependent(s) experience a change in employment status (e.g., start or end employment, strike or lockout, begin or return from an unpaid leave of absence, change work sites, or experience a change in employment that leads to a loss or gain in eligibility for coverage).
Overview

- You, your spouse, or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., a change from part-time to full-time or vice versa).
- Your, your spouse’s, or your dependent’s home address changes and the change affects the medical or dental plan network service area.
- You, your spouse, or your dependent experiences a significant change in cost or coverage (this does not apply to your Health Care Flexible Spending Account).

Regardless of the change in status, any election change you make under the UPMC Welfare Benefits Plan or an outside accident or health plan must be because of the change in status. In addition, the election change you make must be consistent with the change in status.

If you experience a qualified change in status and need to change your coverage during the plan year, notify the UPMC Employee Service Center at 1-800-994-2752, option 3 within 30 days after the event that necessitates the change. If you do not, you cannot make a coverage change until the next annual enrollment, unless you once again meet one of the conditions for a mid-year change. In addition, you must provide proof of your change in status.

Please note: If you are rehired within 30 days from your separation date you cannot make new elections. You are permitted to reinstate your previous elections or wait until the next open enrollment period to make changes.

A Note About Life Insurance Election Changes
Special rules apply for election changes to supplemental life insurance (for you, your spouse, or your dependents) and/or disability insurance:

- In the case of birth, adoption, or placement for adoption, the only change you may make to your coverage is to increase coverage.
- In the case of your spouse or dependent’s death, you may decrease coverage.
- In the case of your marital status change, or a change in your, your spouse’s or your dependent’s employment status, you may increase or decrease coverage.
- Keep in mind you can only increase Supplemental Life (you) by one coverage level without evidence of insurability. Elections for Supplemental Life (spouse) over $30,000 requires evidence of insurability.

See A Snapshot of the Types of Coverage Changes You May Make later in this section for details.
A Snapshot of the Types of Coverage Changes You May Make

If you experience a qualified change in status, you may want to revoke or change your benefit elections. Here is a snapshot of the types of coverage changes you may make if you experience a change.

**Please note:** These snapshots are intended to be informative and helpful illustrations. Please check your status change situation with the UPMC Employee Service Center.

<table>
<thead>
<tr>
<th>Qualified Change in Status</th>
<th>Types of Changes You May Make*</th>
<th>Impact on Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Divorce, Annulment, or Legal Separation</strong></td>
<td><img src="#" alt="List of changes here" /></td>
<td>Change in pay takes effect the first of the month following the change in status</td>
</tr>
<tr>
<td><strong>Death (Spouse or Dependent)</strong></td>
<td><img src="#" alt="List of changes here" /></td>
<td>Change in pay takes effect the first of the month following the change in status</td>
</tr>
<tr>
<td>Qualified Change in Status</td>
<td>Types of Changes You May Make*</td>
<td>Impact on Pay</td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Dependent Becomes Ineligible or Eligible for Coverage (Loss or Gain)</strong></td>
<td>• Medical: Increase or elect coverage level to add dependent or decrease coverage level to drop dependent (cannot change coverage option)&lt;br&gt;• Dental: Increase or elect coverage level to add dependent or decrease coverage level to drop dependent (cannot change coverage option)&lt;br&gt;• Supplemental Life (You): No change&lt;br&gt;• Supplemental Life (Spouse): Elect or drop coverage for the spouse, if spouse is the dependent gaining or losing eligibility&lt;br&gt;• Supplemental Life (Dependents): Elect or drop coverage for the dependent gaining or losing eligibility&lt;br&gt;• Supplemental AD&amp;D: No change&lt;br&gt;• Health Care Flexible Spending Account: Increase or decrease contributions, depending on the need for coverage resulting from the status change&lt;br&gt;• Dependent Care Flexible Spending Account: Increase or decrease contributions, depending on the need for coverage resulting from the status change&lt;br&gt;• Voluntary Benefits: Increase or decrease coverage (to the extent permitted under the policy)</td>
<td>Change in pay takes effect the first of the month following the change in status</td>
</tr>
<tr>
<td><strong>Marriage</strong></td>
<td>• Medical: Increase coverage level to add spouse (and spouse’s dependents, if plan permits) or decrease or drop coverage if you and/or your dependents will be covered under a medical plan of your spouse’s employer (cannot change coverage option)&lt;br&gt;• Dental: Increase coverage level to add spouse (and spouse’s dependents, if plan permits) or decrease or drop coverage if you and/or your dependents will be covered under a medical plan of your spouse’s employer (cannot change coverage option)&lt;br&gt;• Supplemental Life (You): Increase coverage or change from “No Coverage” to one of the coverage options&lt;br&gt;• Supplemental Life (Spouse): Elect coverage to one of the coverage options&lt;br&gt;• Supplemental Life (Dependents): Increase coverage or change from “No Coverage” to one of the coverage options&lt;br&gt;• Supplemental AD&amp;D: Elect or increase coverage&lt;br&gt;• Health Care Flexible Spending Account: Start or increase contributions&lt;br&gt;• Dependent Care Flexible Spending Account: Start contributions (cannot increase or decrease contributions)&lt;br&gt;• Voluntary Benefits: Increase or decrease coverage (to the extent permitted under the policy)</td>
<td>Change in pay takes effect the first of the month following the change in status</td>
</tr>
<tr>
<td><strong>Birth or Adoption</strong></td>
<td>• Medical: Increase coverage level (cannot change coverage option)&lt;br&gt;• Dental: Increase coverage level (can not change coverage option)&lt;br&gt;• Supplemental Life (You): Increase coverage or change from “No Coverage” to one of the coverage options (provided the change is only one coverage level)&lt;br&gt;• Supplemental Life (Spouse): Increase coverage&lt;br&gt;• Supplemental Life (Dependents): Increase coverage or change from “No Coverage” to “Coverage” (for new child only)&lt;br&gt;• Supplemental AD&amp;D: Elect or increase coverage&lt;br&gt;• Health Care Flexible Spending Account: Start or increase contributions&lt;br&gt;• Dependent Care Flexible Spending Account: Start, stop, increase, or decrease contributions&lt;br&gt;• Voluntary Benefits: Increase or decrease coverage (to the extent permitted under the policy)</td>
<td>Change in pay takes effect the first of the month following the change in status</td>
</tr>
<tr>
<td>Qualified Change in Status</td>
<td>Types of Changes You May Make*</td>
<td>Impact on Pay</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Employment Status Change</td>
<td>• Medical: Increase coverage level, drop coverage, or change from “No Coverage” to one of the coverage options if spouse loses employment and/or coverage (cannot change coverage option)</td>
<td>Change in pay takes effect the first of the month following the change in status</td>
</tr>
<tr>
<td></td>
<td>• Dental: Increase coverage level, drop coverage, or change from “No Coverage” to one of the coverage options if spouse loses employment and/or coverage (cannot change coverage option)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental Life (You): Increase or decrease coverage, or change from “No Coverage” to one of the coverage options, or drop coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental Life (Spouse): Increase or decrease coverage, or change from “No Coverage” to one of the coverage options, or drop coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental Life (Dependents): Increase or decrease coverage, or change from “No Coverage” to one of the coverage options, or drop coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental AD&amp;D: Increase coverage (cannot change coverage option)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health Care Flexible Spending Account: Elect, drop or increase contributions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dependent Care Flexible Spending Account: Stop contributions (if spouse loses employment, please advise so that contributions stop)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Voluntary Benefits: Increase or decrease coverage (to the extent permitted under the policy)</td>
<td></td>
</tr>
<tr>
<td>Employment Status Change</td>
<td>• Medical: Increase or decrease coverage level, change coverage options, or change from “No Coverage” to one of the coverage options</td>
<td>Change in pay takes effect the first of the month following the change in status</td>
</tr>
<tr>
<td>(Includes change from part time to full time and vice versa)</td>
<td>• Dental: Increase or decrease coverage level, change coverage options, or change from “No Coverage” to one of the coverage options</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental Life (You): Increase or decrease coverage, or change from “No Coverage” to one of the coverage options</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental Life (Spouse): Increase or decrease coverage, or change from “No Coverage” to one of the coverage options, or drop coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental Life (Dependents): Increase or decrease coverage, or change from “No Coverage” to one of the coverage options, or drop coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental AD&amp;D: Elect or drop coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health Care Flexible Spending Account: Cannot change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dependent Care Flexible Spending Account: Cannot change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Voluntary Benefits: Increase or decrease coverage (to the extent permitted under the policy)</td>
<td></td>
</tr>
<tr>
<td>Home Address Change</td>
<td>• Medical: Increase or decrease coverage level, change coverage options, or change from “No Coverage” to one of the coverage options (if you are moving into or outside of the Network service area)</td>
<td>Change in pay takes effect the first of the month following the change in status</td>
</tr>
<tr>
<td></td>
<td>• Dental: Increase or decrease coverage level, change coverage options, or change from “No Coverage” to one of the coverage options (if you are moving into or outside of the Network service area)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental Life (You): Cannot change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental Life (Spouse): Cannot change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental Life (Dependents): Cannot change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplemental AD&amp;D: Cannot change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health Care Flexible Spending Account: Cannot change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dependent Care Flexible Spending Account: Cannot change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Voluntary Benefits: Cannot change</td>
<td></td>
</tr>
</tbody>
</table>
Overview

<table>
<thead>
<tr>
<th>Qualified Change in Status</th>
<th>Types of Changes You May Make*</th>
<th>Impact on Pay</th>
</tr>
</thead>
</table>
| Significant Change in Cost, Coverage or Coverage Availability | • Medical: Increase or decrease coverage level, change coverage options, or change from “No Coverage” to one of the coverage options  
• Dental: Increase or decrease coverage level, change coverage options, or change from “No Coverage” to one of the coverage options  
• Supplemental Life (You): Cannot change  
• Supplemental Life (Spouse): Cannot change  
• Supplemental Life (Dependents): Cannot change  
• Supplemental AD&D: Cannot change  
• Health Care Flexible Spending Account: Cannot change  
• Dependent Care Flexible Spending Account: Increase or decrease contributions, depending on the need for coverage resulting from the status change  
• Voluntary Benefits: Increase or decrease coverage (to the extent permitted under the policy) | Change in pay takes effect the first of the month following the change in status |

*Regardless of your change in status, the change must cause you, your spouse, or your dependent to lose or gain eligibility for coverage under the UPMC Welfare Benefits Plan or an outside accident or health plan. In addition, the type of coverage change you make must be consistent with your change in status.

Special Enrollments During the Year

If you decline enrollment under the UPMC Welfare Benefits Plan for yourself and/or your dependents (including your spouse) because you have other coverage, you may in the future be able to enroll yourself and your dependents in the Plan if the other coverage ends. However, you must call the UPMC Employee Service Center to enroll within 30 days after your other coverage ends. As long as you call within the 30-day period, coverage takes effect the first of the month following the change in status. If you call between 31 and 60 days, coverage takes effect on the first of the month after your notification. If you call after the 60-day period, you must wait until the next annual enrollment to elect coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents (including your spouse). You must call the UPMC Employee Service Center within 30 days after the marriage, birth, adoption, or placement for adoption. As long as you call within the 30-day period, coverage takes effect the first of the month following the change in status (if you are already enrolled and requesting coverage for a new dependent due to birth, adoption or placement for adoption – coverage for the new dependent is effective the date of birth or date received or placed for adoption). If you call between 31 and 60 days, coverage takes effect on the first of the month after your notification. If you call after the 60-day period, you must wait until the next annual enrollment to elect coverage.
Coordination of Benefits

Your health and dental plans coordinate benefits with other group plans that may cover you and/or your dependents. This feature helps eliminate duplicate payments for the same services.

Coordinating Plans
Certain types of plans normally coordinate benefits, including the following.

- Plans provided by an employer, union, trust, or other similar sponsor.
- Other group health care plans by which you or your dependents are covered, including student coverage provided through a school above the high school level.
- Government benefit programs provided or required by law, including Medicare and Medicaid.
- Automobile insurance plans.

These coordination provisions normally do not apply to individual or private insurance plans.

Your health and dental plans consider any benefits to which you may be entitled from other group plans (even if you do not request payment from them).

How Coordination Works With Other Group Plans
If you are covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then — based on what the primary plan pays — the other plans pay reduced benefits (if any).

If the UPMC medical plan or dental plan is your primary plan, the plan pays benefits up to the limits described in this handbook. When the UPMC plan is the secondary plan, it figures its regular benefits as if it were primary, subtracts from that amount the primary plan’s benefits, and then pays the difference.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Benefit. Examples of such provisions are those related to the managed health care provisions of a plan, such as, penalties for not using a PCP when participating in an HMO type medical plan.
Determining the Order of Payment
When benefits coordinate, the plans determine which plan pays benefits first (the primary plan), second (the secondary plan), etc. Here are guidelines for determining which plan is primary:

- If one plan has no Coordination-of-Benefits provision, it automatically is the primary plan.
- The plan covering the patient, as an employee rather than as a dependent, laid-off employee, terminated employee, or retired employee is the primary plan and pays benefits first.
- In the case of a divorce or separation, the plan of the parent (who has not remarried) with custody of the dependent child usually pays benefits first. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent’s plan always is primary.
- If the parent with custody remarries, his or her plan pays benefits first, the stepparent’s plan pays second, and the plan of the parent without custody pays third. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent’s plan always is primary.
- If none of the situations above apply and if both parents’ plans cover a dependent, the plans use the birthday rule to determine which parent’s plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent’s plan is secondary. If the other plan does not follow the birthday rule, then the rules of that plan determine the order of benefits.

If a determination cannot be made as to the order of payment, the plan that has covered the patient longer is usually the primary plan.

How Coordination Works With Medicare
Under current law, you and your dependents become eligible for Medicare at age 65. (If you become disabled, you may become eligible for Medicare before age 65.)

Please notify the administrator once you start Medicare benefits. Coordination with Medicare depends on your age and whether you are an active or inactive employee.
If You are an Active Employee
If you are an active employee and you or your spouse reaches age 65, you or your spouse either have:

- Coverage under both the UPMC Health Plan and Medicare (the Health Plan is primary, it pays benefits as described in this handbook, and Medicare is secondary); or

- Coverage under Medicare only because you were not already covered under the UPMC Health Plan.

Your spouse, if age 65 or older, may make a Medicare election separate from yours. He or she, however, may not elect coverage under the UPMC Health Plan if you do not elect coverage.

If you file a medical claim with the Health Plan, be sure to submit the Explanation of Benefits (EOB) you receive from Medicare. The combination of what Medicare pays and what the Health Plan pays may not exceed what the Health Plan alone would have paid.

**Please note:** If you or your covered dependent has end-stage renal disease, UPMC’s primary status applies during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

Medicare as Secondary Payer
Under the Medicare as Secondary Payer Statute, UPMC is required to identify those staff members in the group health plan, including eligible Dependents, who are eligible for Medicare. It is the Member’s responsibility to notify UPMC, if they or any eligible Dependent have or are eligible for Medicare coverage. Member are to provide to UPMC the following information: the Member’s Medicare status including their Health Insurance Claim (HIC) number, reason for Medicare eligibility (age, end stage renal disease, or disability), effective date of Medicare Part A and Part B eligibility and any other information required by the employer for the correct coordination of claims payment.

If You Are an Inactive Employee
If you are an inactive employee (you are retired or on a disability leave) and you or your spouse is Medicare-eligible, Medicare is the primary payor regardless of your or your covered spouse’s age. You are responsible for notifying UPMC if you or your spouse becomes Medicare-eligible.
How Long Coverage Continues

Generally, your coverages continue while you are still employed by UPMC.

When Coverage Ends
The following chart shows when your coverages end.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>When Coverage Ends</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Medical</td>
<td>Coverages end on the last day of the month in which (whichever of the following occurs first):</td>
</tr>
<tr>
<td>● Dental</td>
<td>● Your employment ends (e.g., you retire or terminate);</td>
</tr>
<tr>
<td>● Flexible Spending Accounts</td>
<td>● The policy is terminated;</td>
</tr>
<tr>
<td>● Basic Life and (AD&amp;D)</td>
<td>● You stop making the necessary contributions; or</td>
</tr>
<tr>
<td>● Supplemental Life (You)</td>
<td>● You are no longer eligible to participate.</td>
</tr>
<tr>
<td>● Supplemental Life (Spouse)</td>
<td></td>
</tr>
<tr>
<td>● Supplemental Life (Dependents)</td>
<td></td>
</tr>
<tr>
<td>● Supplemental AD&amp;D</td>
<td></td>
</tr>
<tr>
<td>● STD</td>
<td>Coverages end on the day (whichever of the following occurs first):</td>
</tr>
<tr>
<td>● LTD</td>
<td>● Your employment ends (e.g., you retire or terminate);</td>
</tr>
<tr>
<td></td>
<td>● The policy is terminated;</td>
</tr>
<tr>
<td></td>
<td>● You stop making the necessary contributions; or</td>
</tr>
<tr>
<td></td>
<td>● You are no longer eligible to participate.</td>
</tr>
<tr>
<td>● AFLAC STD Plan</td>
<td>You may be able to continue Voluntary Benefits after you leave UPMC through a direct billing program.</td>
</tr>
<tr>
<td>● AFLAC Personal Accident Expense Plan</td>
<td></td>
</tr>
<tr>
<td>● AFLAC Personal Recovery Plus Plan</td>
<td></td>
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<tr>
<td>● AFLAC Cancer Policy</td>
<td></td>
</tr>
<tr>
<td>● Pre-Paid Legal Services</td>
<td></td>
</tr>
</tbody>
</table>

Your dependent’s coverage ends on the day your coverage ends, the last day of the month in which your dependent no longer meets the eligibility requirements, or the day you stop making contributions (whichever occurs first).
### Instances When Coverage May Continue
Coverage may continue under certain circumstances as shown in the chart below.

<table>
<thead>
<tr>
<th>Under This Circumstance</th>
<th>These Coverages Continue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You Become Disabled</strong></td>
<td><img src="#" alt="List of covered benefits" /></td>
</tr>
<tr>
<td><strong>You Die While You Are Employed</strong></td>
<td><img src="#" alt="List of covered benefits" /></td>
</tr>
</tbody>
</table>

- **Medical:** Coverage continues at the active rate for up to six months from your last day worked while you are on disability leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave). Coverage may continue further under COBRA, see the *Continuation of Benefits* section for additional information.

- **Dental:** Coverage continues at the active rate for up to six months from your last day worked while you are on disability leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave). Coverage may continue further under COBRA, see the *Continuation of Benefits* section for additional information.

- **Basic Life and AD&D:** Coverage continues for up to six months from your last day worked while you are on disability leave.

- **Supplemental Life (You):** Coverage continues for up to six months from your last day worked while you are on disability leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).

- **Supplemental Life (Spouse):** Coverage continues for up to six months from your last day worked while you are on disability leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).

- **Supplemental Life (Dependents):** Coverage continues for up to six months from your last day worked while you are on disability leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).

- **Supplemental AD&D:** Coverage continues for up to six months from your last day worked while you are on disability leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).

- **LTD:** Coverage continues for up to six months from your last day worked while you are on disability leave.

- **Health Care Flexible Spending Account:** You do not make any contributions while you are on a disability leave. You may use the existing balance in your account to pay for any eligible expense incurred prior to your disability date.

- **Dependent Care Flexible Spending Account:** You do not make any contributions while you are on a disability leave. You may use the existing balance in your account to pay for any eligible expense you incur prior to your disability date.

- **Voluntary Benefits:** Coverage may continue while you are on disability leave. You are responsible for making the necessary premium payments; you will be taken off payroll deduction and billed directly by the voluntary benefits carrier.

- **Medical:** Coverage for your dependents end on the last day of the month in which you die. Coverage may continue under COBRA for the 36-month COBRA continuation period, dependents pay for coverage at the COBRA rate. See *Continuation of Benefits* section for details regarding COBRA coverage.

- **Dental:** Coverage for your dependents continues under COBRA at the COBRA rate.

- **Supplemental Life (Spouse):** Coverage ends on the last day of the month in which you die.

- **Supplemental Life (Dependents):** Coverage ends on the last day of the month in which you die.

- **Health Care Flexible Spending Account:** The existing balance in your account can be used to pay for any eligible expense incurred before your death. Participation in this account can be continued by your dependents under COBRA.

- **Dependent Care Flexible Spending Account:** The existing balance in your account can be used to pay for any eligible expense incurred before your death.

- **Voluntary Benefits:** Coverage for participating covered members may continue through a direct billing arrangement with the specific voluntary benefits carriers.
<table>
<thead>
<tr>
<th>Under This Circumstance …</th>
<th>These Coverages Continue …</th>
</tr>
</thead>
</table>
| **You Take a Leave of Absence (Family Medical Leave of Absence-FMLA and Military Leave)** | ● Medical: Coverage in effect on the day your FMLA leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).  
● Dental: Coverage in effect on the day your FMLA leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).  
● Basic Life and AD&D: Coverage in effect on the day your FMLA leave begins continues during your leave.  
● Supplemental Life (You): Coverage in effect on the day your FMLA leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).  
● Supplemental Life (Spouse): Coverage in effect on the day your FMLA leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).  
● Supplemental Life (Dependents): Coverage in effect on the day your FMLA leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).  
● Supplemental AD&D: Coverage in effect on the day your FMLA leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting your portion of the premiums separately (unpaid leave).  
● STD: Coverage in effect on the day your FMLA leave begins continues during your leave.  
● LTD: Coverage in effect on the day your FMLA leave begins continues during your leave.  
● Health Care Flexible Spending Account: You continue to make contributions to your account while you are on an FMLA leave. You may use the balance in your account to pay for any claims you incur before, during, or after your FMLA leave.  
● Dependent Care Flexible Spending Account: You do not make any contributions while you are on an FMLA leave. You may use the existing balance in your account to pay for any claim you incur before your leave.  
● Voluntary Benefits: Coverage may continue while you are on leave. You are responsible for making the necessary premium payments; you will be taken off payroll deduction and billed directly by the voluntary benefits carrier. |
### You Take a Leave of Absence (Personal Leave of Absence)

<table>
<thead>
<tr>
<th>Under This Circumstance ...</th>
<th>These Coverages Continue ...</th>
</tr>
</thead>
</table>
| You Take a Leave of Absence (Personal Leave of Absence) | • Medical: Coverage in effect on the day your leave begins continues during your leave as long as you pay for coverage. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting the full premium cost (unpaid leave).  
• Dental: Coverage in effect on the day your leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting the full premium cost (unpaid leave).  
• Basic Life and AD&D: Coverage in effect on the day your leave begins continues during your leave.  
• Supplemental Life (You): Coverage in effect on the day your leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting the full premium cost (unpaid leave).  
• Supplemental Life (Spouse): Coverage in effect on the day your leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting the full premium cost (unpaid leave).  
• Supplemental Life (Dependents): Coverage in effect on the day your leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting the full premium cost (unpaid leave).  
• Supplemental AD&D: Coverage in effect on the day your leave begins continues during your leave. You continue to make the necessary premium payments through accrued paid time off (paid leave), or by submitting the full premium cost (unpaid leave).  
• STD: Coverage in effect on the day your leave begins continues during your leave.  
• LTD: Coverage in effect on the day your leave begins continues during your leave.  
• Health Care Flexible Spending Account: You continue to make contributions to your account while you are on a leave. You may use the existing balance in your account for any claims you incur before, during, or after your leave.  
• Dependent Care Flexible Spending Account: You do not make any contributions while you are on a leave of absence. You may use the existing balance in your account for any claim you incur before your leave.  
• Voluntary Benefits: Coverage may continue while you are on leave. You are responsible for making the necessary premium payments; you will be taken off payroll deduction and billed directly by the voluntary benefits carrier. |
Under This Circumstance… | These Coverages Continue…
---|---
You Are Laid Off | ● Medical: Coverage continues through the end of the month in which you receive severance payments (or would have received severance in the case of a lump-sum payout). This period is counted toward the 18-month COBRA continuation period. See Continuation of Benefits section for details.
● Dental: Coverage continues through the end of the month in which you receive severance payments (or would have received severance in the case of a lump-sum payout). This period is counted toward the 18-month COBRA continuation period.
● Basic Life and AD&D: Coverage continues through the end of the month in which you are laid off. You may elect conversion coverage.
● Supplemental Life (You): Coverage continues through the end of the month in which you are laid off. If collecting severance, you continue to make the necessary premium payments through payroll deduction. You may elect to continue this coverage on a direct pay basis, refer to the Situations Affecting Your Life and AD&D Benefits section for information.
● Supplemental Life (Spouse): Coverage continues through the end of the month in which you are laid off. If collecting severance, you continue to make the necessary premium payments through payroll deduction. You may elect to continue this coverage on a direct pay basis, refer to the Situations Affecting Your Life and AD&D Benefits section for information.
● Supplemental Life (Dependents): Coverage continues through the end of the month in which you are laid off. If collecting severance, you continue to make the necessary premium payments through payroll deduction. You may elect to continue this coverage on a direct pay basis, refer to the Situations Affecting Your Life and AD&D Benefits section for information.
● Supplemental AD&D: Coverage continues through the end of the month in which you are laid off. You continue to make the necessary premium payments through payroll deduction.
● STD: Coverage continues through your last day worked.
● LTD: Coverage continues through your last day worked.
● Health Care Flexible Spending Account: You continue to make contributions to your account through the end of the month in which you are laid off. You may use the existing balance in your account for any claims you incur before the end of the month in which you are laid off. You may continue your participation on an after-tax basis through COBRA. See the Continuation of Benefits section for details regarding COBRA.
● Dependent Care Flexible Spending Account: Your contributions stop at the end of the pay period during which you are laid off. You may use the existing balance in your account for any claim you incur before you are laid off.
● Voluntary Benefits: Coverage may continue. You are responsible for making the necessary premium payments; you will be taken off payroll deduction and billed directly by the voluntary benefits carrier.

* A waiver of premium applies while you are receiving LTD benefits. See the Life Insurance section for details regarding the waiver of premium provision. You must apply for a Waiver of Premium.
+ If you fail to return to work from an FMLA or a Personal Leave of Absence, you are still responsible for your portion of the premiums that have been paid. If you do not repay the amount, the balance of the premium owed may be turned over to a collection agency.
Taking Coverages With You
You can take the following coverages with you by purchasing the coverage through the administrator:

- Supplemental life insurance (you);
- Supplemental life insurance (your spouse);
- Supplemental life insurance (your dependents); and
- Voluntary Benefits:
  - AFLAC Personal Short-Term Disability Plan
  - AFLAC Personal Accident Expense Plan
  - AFLAC Personal Recovery Plus Plan
  - AFLAC Cancer Policy
  - Pre-Paid Legal Services

This means that you (or your dependents) can take this coverage with you should group coverage end. See the respective Life Insurance and Voluntary Benefits sections for details regarding buying coverage after group coverage ends.

Please Note: You must elect to continue coverage for yourself to be eligible to continue coverage for your spouse and/or dependents.

Converting Coverages
When certain group coverages end, you may obtain individual insurance coverage with the same insurance company without undergoing a medical examination. This is called a “conversion right” and applies to your basic life, supplemental AD&D and medical coverage.

To convert to an individual policy, you must apply and pay for the conversion coverage at the conversion rate within 30 days after the group coverage ends. Responsibility for requesting conversion rests with the individual.

Please Note: Staff members whose employment or eligibility ends prior to May 1, 2003 may continue term life coverage on a temporary basis for up to twelve (12) months. Staff members whose employment or eligibility ends after May 1, 2003 may continue or convert term life coverage.

If your term life insurance coverage ends and you die during the 31-day conversion period, your beneficiary receives the benefit that would have been payable had you converted to the individual policy. This is true regardless of whether or not you actually applied for conversion.

For medical coverage, the effective date of individual coverage shall be the day after termination of coverage under the UPMC plan. If Group coverage becomes available at any time to the individual, eligibility for a conversion policy will end.

For more information regarding conversion rights, contact the UPMC Employee Service Center at 1-800-994-2752, option 3. See the Life and Accidental Death & Dismemberment (AD&D) Insurance section for details regarding life and AD&D insurance.
Continuation of Benefits (COBRA)

You and your covered dependents can continue medical, dental, employee assistance and the Health Care Flexible Spending Account coverage for a specified time period, depending on the reason coverages end. Continued coverage is available as required by law under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

To continue coverage, you or your affected dependents are required to pay the entire cost, plus an administrative fee, as allowed by law.

Snapshot of COBRA Continuation Coverage
Here is a snapshot of who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues.

<table>
<thead>
<tr>
<th>If:</th>
<th>Qualifying Event</th>
<th>Who Is Eligible for COBRA Coverage</th>
<th>Duration of COBRA Coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>• Become laid off</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
<tr>
<td></td>
<td>• Have a reduction in hours</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
<tr>
<td></td>
<td>• Terminate employment (for reasons other than gross misconduct)</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
<tr>
<td></td>
<td>• Do not return from an FMLA leave of absence</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
<tr>
<td></td>
<td>• Become disabled within the first 60 days of COBRA continuation coverage</td>
<td>You and your dependents</td>
<td>29 months</td>
</tr>
<tr>
<td></td>
<td>• Die</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>• Become divorced</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>• Become entitled to Medicare while on COBRA</td>
<td>Your dependent</td>
<td>Up to 36 months**</td>
</tr>
<tr>
<td>Your Dependent</td>
<td>• Is no longer an eligible dependent (due to age limit or marriage)</td>
<td>Your dependent</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>• Is no longer an eligible dependent because of your death</td>
<td>Your dependent</td>
<td>36 months</td>
</tr>
<tr>
<td></td>
<td>• Becomes disabled within the first 60 days of COBRA continuation coverage</td>
<td>Your dependent</td>
<td>29 months</td>
</tr>
</tbody>
</table>

*Duration of coverage is from the date of the qualifying event.

**The 36-month coverage begins on the day you become eligible for Medicare.
Employee Loses Coverage
If you lose coverage because of a layoff, reduction in hours, termination of employment (for reasons other than gross misconduct), or if you do not return to work after an FMLA leave of absence, COBRA continuation coverage is available to you and your dependents for up to 18 months from the date of the qualifying event. The UPMC Employee Service Center notifies you and your dependents when such an event makes continuation of coverages available. You must then notify the UPMC Employee Service Center (within 60 days of the date the notice is sent or coverages are lost, whichever is later) of the decision to continue coverage.

If you are receiving severance benefits, your continued medical and dental coverages under the severance plan offset the 18-month COBRA continuation period. For example, if your severance benefits entitle you to six months of continued coverage, you are eligible for 12 months of continuation coverage under COBRA.

If you or your covered dependent becomes disabled during the first 60 days of COBRA continuation coverage, you or your covered dependent may extend the 18-month continuation period to 29 months. For the 29-month continuation coverage period to apply, you must notify the UPMC Employee Service Center within 60 days of your disability and within the initial 18-month continuation coverage period.

Dependent Continuation Coverage
Your dependent has the right to continue his or her COBRA continuation coverage for up to 36 months from the date of the qualifying event if he or she loses coverage because:

- You die;
- You and your spouse get divorced;
- He or she is no longer eligible for coverage under the plan (due to age limit or marriage); or
- You become entitled to benefits under Medicare (the 36-month coverage begins on the day you become eligible for Medicare).

If your dependents lose coverages because of your death or your entitlement to Medicare, they will be notified by the UPMC Employee Service Center of their right to continue coverage within 14 days after notification is provided to UPMC Employee Service Center. They must then decide whether or not to continue coverages within sixty (60) days of the later of this notification or the date benefits terminate.

If you get divorced, you or your dependent dies or becomes eligible for Medicare, or if your child no longer meets the eligibility requirements, you or your dependent must notify the UPMC Employee Service Center (within 60 days of the event). Failure to give notice within the time limits noted can result in COBRA coverage being forfeited. The UPMC Employee Service Center, in turn, notifies your dependent of his or her right to continue coverages. Within 60 days of the later of this notification or the date benefits terminate, your dependent must elect whether or not to continue coverages.
When You and/or Your Dependents Elect COBRA

If you and/or your dependents choose continuation coverage through COBRA, you and your dependents are offered coverage on the same basis as other participants. In addition, you may add a newborn or an adopted child during the COBRA continuation period. Your newborn or adopted child’s coverages begin immediately.

COBRA coverage takes effect on the date of the qualifying event. It is your responsibility to notify the UPMC Employee Service Center of any qualifying event (e.g., divorce, loss of student status) that happens while on COBRA continuation coverage.

When COBRA Coverage Ends

COBRA continuation coverage takes effect on the date of your qualifying event and continues until the earliest of the following:

- The end of the 18-month, 29-month, or 36-month continuation period as applicable.
- The date UPMC no longer provides health care coverage to any of its employees.
- When premiums for continuation of group coverages are not paid within the required time.
- The date you or your dependents become covered under another group health care plan (provided preexisting condition exclusions or limitations under the new group health care plan do not apply).
- The date you or your dependents become entitled to Medicare you or your dependents are no longer eligible to continue COBRA coverage. Note: If your employment ends and you are already on Medicare you may choose to elect COBRA coverage and continue with Medicare.
- The employee, spouse or dependent notifies UPMC to cancel continuation coverage.

Remember: If you are receiving severance benefits, your continued medical and dental coverages under the severance plan offset the 18-month COBRA continuation period. For example, if your severance benefits entitle you to six months of continued coverage, you are eligible for 12 months of continuation coverage under COBRA.

If your COBRA coverage terminates, and you are not eligible for coverage under any other Group health plan, you may apply within (30) days of such termination to continue coverage under a Conversion policy for which you are then eligible. The Conversion policy is not available to individuals who have been terminated for cause by UPMC.

Conversion privilege is also available to the following dependents:

- Eligible Dependents in the event of a Subscriber’s death,
- A spouse when divorced from the Subscriber and no longer eligible for coverage, and
- A child who ceases to be an eligible Dependent due to attaining the limiting age of Eligibility.

The terms of the Conversion policy may be different than the terms in this SPD. Application for the Conversion policy must be made and payment for the first premium must be received within thirty (30) days after the termination of the UPMC Group coverage. The Effective Date of coverage shall be the day after termination of coverage under the UPMC Group Agreement. To be eligible for Conversion, you must provide proof that other Group or Conversion coverage is not available.
Responsibility for requesting Conversion rests with the Member. UPMC is not responsible for further notification concerning Conversion privilege. If you do not exercise the Conversion privilege within the prescribed time, you shall be liable for the cost of any services provided after the date of termination. Forms for Conversion are available from the Member Services Department at UPMC Health Plan.

If Group coverage becomes available at any time, your eligibility for a Conversion policy will cease.

**How to Apply for COBRA Coverage**

UPMC administers COBRA. If you have any questions about the law or your COBRA coverage, contact the UPMC Employee Service Center at 1-800-994-2752, option 3; or in writing at:

UPMC
c/o Employee Service Center-COBRA
Forbes Tower, Suite 8033
200 Lothrop Street
Pittsburgh, PA 15213-2582

Please notify the UPMC Employee Services Center if you have a change in your marital status, you or your spouse changes addresses, or your dependent no longer meets the eligibility requirements for coverage.
Dear Employee, Spouse and All Covered Dependents:

This notice is intended to summarize your rights and obligations under the group health continuation coverage provision of the federal COBRA law. Employees of UPMC have the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end. UPMC Welfare Benefits Plan programs that are offered for continuation as directed by COBRA are medical/vision coverage and dental coverage. You and your spouse should take the time to read this notice carefully. Should your coverage end in the future, the following information will apply as it relates to COBRA.

TO QUALIFY FOR COBRA COVERAGE

Employees of UPMC have the right to elect continuation coverage when group health coverage is lost from UPMC Welfare Benefits Plan due to reduction in hours of employment, layoff, or employment termination (for reasons other than gross misconduct).

Spouses of UPMC employees have the right to choose continuation coverage when group health coverage is lost from UPMC Welfare Benefits Plan for any of the following reasons:
- Death of the spouse
- Termination of spouse’s employment (for reasons other than gross misconduct)
- Reduction in spouse’s hours of employment
- Divorce from spouse
- Spouse becomes entitled to Medicare.

Dependent children of UPMC employees have the right to elect continuation coverage when group health is lost from UPMC Welfare Benefits Plan for any of the following reasons:
- Death of a parent
- Termination of parent’s employment (for reasons other than gross misconduct) or reduction in parent’s hours of employment
- Parent’s divorce
- Parent becomes entitled to Medicare
- Dependent ceases to be a “dependent child” under UPMC Welfare Benefits Plan.

EMPLOYER RESPONSIBILITY UNDER COBRA

UPMC has the responsibility to notify the Plan Administrator of the employee’s death, employment termination, reduction in hours, or Medicare entitlement and to then notify the employee or employee’s family of the ability to purchase continuation coverage.

EMPLOYEE RESPONSIBILITY UNDER COBRA

An employee or family member has the later of 60 days from (1) the date of the event or (2) the date of coverage loss to inform the Plan in writing of the employee’s divorce or child losing dependent status. Failure to give notice within the time limits can result in COBRA coverage being forfeited. See summary plan description for eligibility rules regarding the loss of dependent status.

TO ELECT COVERAGE

The employee, spouse, and dependents each have independent election rights. The employee, spouse and dependents have the later of 60 days from either (1) the date coverage is lost or (2) the date of the notice to respond that they want to elect continuation coverage. There is no extension of the election period. If continuation coverage is not elected within this timeframe, then COBRA rights will end. When continuation coverage is elected the employee or their dependents will be required to pay the entire cost of the coverage plus a 2% administration fee.

COVERAGE ELIGIBILITY

Continuation coverage is identical to the coverage provided under the plan to similarly situated active employees or family members as of the time coverage is being provided. Any change to group health coverage or premium rates for active employees is reflected in COBRA continuation coverage.

An employee, spouse or dependent does not have to show that they are insurable in order to choose continuation coverage, but they must have been actually covered by the group health plan the day before the qualifying event in order to elect COBRA coverage. An exception to this rule is if while on continuation coverage a baby is born to or adopted by a covered employee. The newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The child has the same COBRA continuation period as the covered employee and is entitled to an additional period of coverage should a secondary qualifying event occur. Notification to the plan must occur within 30 days of the birth or adoption for COBRA rights to exist.
DURATION OF COBRA COVERAGE

Termination (other than for reasons of gross misconduct) or reduction in hours resulting in lost group health coverage entitles a continuation coverage period of 18 months from the date of the qualifying event, if elected. Severance benefits received do not extend the duration of COBRA coverage.

Employees, spouses or dependents with disabilities are entitled to an extension to 29 months if the Social Security Administration determines that the employee, spouse or dependent child was disabled on, or within 60 days of, the qualifying event. Proof must be provided within 60 days of the date of disability determination and before the close of the initial 18-month period. In the case of a newborn or adopted child added to a covered employee’s COBRA coverage, then the first 60 days of continuation coverage for the new born or adopted child is measured from the date of the birth or adoption.

The employee, spouse or dependent has 30 days to notify the Plan Administrator from the date of a final determination that he or she is no longer disabled.

Multiple events entitle an extension of the 18 or 29-month continuation period if, during the 18 or 29 months of continuation coverage, a second event takes place (divorce, death, Medicare entitlement, or a dependent child ceasing to be a dependent). The extension will be to 36 months from the date of the original qualifying event. Upon the occurrence of a second event, it is the employee’s, spouse’s, or dependent’s responsibility to notify the Plan Administrator in writing within 60 days of the event and within the original 18 or 29-month COBRA period. COBRA coverage does not last beyond 36 months from the original qualifying event, no matter how many events occur. A reduction in hours followed by a termination of employment is not considered a second event for COBRA purposes.

Other qualifying events entitle a continuation coverage period of 36 months from the date of the qualifying event, if elected. Other events include the death of the employee, divorce, Medicare entitlement, or a dependent child losing dependent status.

PREMIUMS

An employee, spouse or dependent pays the entire applicable premium, which generally cannot exceed 102% of the plan costs for a 12-month period. The group health plan may increase the cost that must be paid for COBRA coverage if the applicable premium cost increases.

The period for paying the initial COBRA premium following the election of coverage is 45 days. The first payment made is to be applied retroactively toward coverage for the period beginning after the date on which coverage would have been lost as a result of the qualifying event and ending at the time period of the election. Thereafter, premiums can be paid on a monthly basis. There is a 30-day grace period following the date regularly scheduled monthly premiums are due.

Only in the case of mental incapacity is any further extension permitted. To apply, the incapacitation must occur during or prior to a period of time in which an action must be taken by the qualified beneficiary.

COBRA CANCELLATION

The law provides that continuation coverage may be cut short for any of the following reasons:

- UPMC no longer provides group health coverage to any of its employees
- Continuation coverage premium is not paid in a timely manner
- Employee, spouse or dependent becomes covered under another group health plan, after the date of the COBRA election, that does not contain any exclusion or limitation with respect to any preexisting condition
- Employee, spouse, or dependent becomes entitled to Medicare
- Employee, spouse, or dependent extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that he or she is no longer disabled
- Employee, spouse or dependent notifies the Plan Administrator to cancel continuation coverage
- For cause, such as fraudulent claim submission, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

The plan administrator reserves the right to verify COBRA eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

CONVERSION PRIVILEGES

At the end of the continuation coverage period, the employee, spouse, or dependent is allowed the option to enroll in an individual conversion medical plan.

NOTIFICATION OF ADDRESS CHANGE

Notify the UPMC Payroll Department of any address change as soon as possible. Failure on your part to do so will result in delayed COBRA notifications or a loss of continuation coverage options, as COBRA notices will be sent to the last known address on file.

FURTHER INFORMATION

If you have any questions about the law or your obligations contact the Plan Administrator at: UPMC, Employee Service Center, 8033 Forbes Tower, 200 Lothrop Street, Pittsburgh, PA 15213 or at 1-800-994-2752, option 3.
Your Rights Under The Health Insurance Portability & Accountability Act of 1996 (HIPAA)

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the UPMC Welfare Benefits Plan Notice of Privacy Practices for Protected Health Information, which was distributed to all staff members in April 2003 and upon enrollment to subsequent hired staff. The notice is available from the UPMC Employee Service Center.

The UPMC Welfare Benefits Plan, will not use or further disclose information to the Plan Sponsor, UPMC, that is protected by HIPAA (Protected Health Information - PHI) except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of UPMC.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA’s privacy rules. For a copy of the notice, please contact the Employee Service Center at 1-800-994-2752, option 3. If you have questions about the privacy of your health information please contact the UPMC Privacy Officer: UPMC, Forbes Tower, Pittsburgh, PA 15213-2582, 412-647-5757. If you wish to file a complaint under HIPAA, please contact the UPMC Compliance Helpline 1-877-983-8442.

The ERISA Review Committee, acting as an agent of UPMC with respect to the Plan has certified on behalf of UPMC that:

1. UPMC will not use or further disclose PHI other than as permitted or required by the plan documents or as required by law.
2. UPMC’s agents, including subcontractors, to whom the Plan provides PHI have agreed to the same restrictions and conditions that apply to part (1) above.
3. UPMC will not use or disclose the PHI received from the Health Plan for any employment-related actions or decisions or in connection with any other benefit or employee benefit of UPMC.
4. UPMC will report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for which it becomes aware.
Your Cost for Coverage

The Introduction to *Your Health and Welfare Benefits* section identifies the coverage options provided by UPMC at no cost, those available where you and UPMC share the cost of the coverage and the options available where you pay the full cost of the coverage. Coverage costs are provided on your enrollment form when initially hired and when an opportunity to change coverage options is made available to you, such as, during the annual open enrollment period.

Your individual pay stub shows the deductions taken for the coverages where you pay all or part of the benefit. Because your coverage costs may change each plan year, you will be provided the most up to date cost for each benefit option with your annual enrollment material. Staff member contributions and full premium costs are also available from the UPMC Employee Service Center, 1-800-994-2752, option 3.

Although UPMC intends to limit changes to coverage and costs to only once per year, certain circumstances may require that the coverage and/or costs provided for under the UPMC Welfare Benefits Plan change during the year. If this is the case, you will receive materials in advance, which describes the changes and the effective date of such changes.
How the UPMC Medical Plans Work

This section provides an overview about your medical coverage options, as well as how the features of the UPMC Health Plan work. Four different options are available. Two are associated with the UPMC Advantage network while the other two provide access to a broader network of facilities and physician providers. One plan, the UPMC Out-of-Area PPO plan, is limited to those staff residing in areas with limited access to a UPMC Advantage network facility.

UPMC Health Plan’s Advantage health care products limit your out-of-pocket expenses to make it easy for you to use UPMC resources. The UPMC Advantage HMO and UPMC Advantage PPO plans provide the highest level of benefits when you use UPMC facilities, the UPMC Advantage network. Refer to the UPMC Health Plan Advantage Network Directory for a complete listing of hospitals and facilities.

The UPMC Advantage HMO and Advantage PPO plans offer incentives for using UPMC facilities; all other facilities and services in the UPMC Health Plan network are available, but at a lower benefit level.

The UPMC Open Access PPO plan and the Out-of Area PPO plans offer expanded access to facilities in addition to the UPMC Advantage network while providing the highest level of benefit. The Out-of-Area PPO plan is limited to those staff members who qualify based on limited access to UPMC Advantage Network facilities.

Each of the plans generally has two levels of benefit available, depending upon the provider network you choose to use.

Regardless of which plan you choose, you have full access to any physician in the UPMC Health Plan’s network. There are no incentives related to which Health Plan network physician you select. In all cases, visits to in-network physicians require a low co-payment.
About Your Coverage Options
The following summaries provide a brief description of how the UPMC Advantage HMO, UPMC Advantage PPO, UPMC Open Access PPO and UMPC Out-of-Area PPO plan options work.

UPMC Advantage HMO Option:
You are encouraged to use a PCP for medical care. Your PCP performs routine and preventive care and provides referrals for specialist care.

You can self-refer to a specialist within the UPMC Health Plan Network for nonroutine or nonpreventive care services.

Women may select an obstetrician/gynecologist (OB/GYN) to provide or coordinate all covered obstetric/gynecologic care. If you do not select an OB/GYN, routine and preventive care must be provided by your PCP to receive benefits.

This option covers most medical expenses (including preventive services) in full when your PCP coordinates the care.

For most services you must meet a copay requirement before the plan pays its portion of eligible expenses. See the How Your Coverage Option Pays Benefits section for the services that require a copayment under your coverage option.

If you receive routine or non-emergency care from a provider outside the UPMC Health Plan Network, the Health Plan does not pay benefits unless your care has been authorized by your PCP and UPMC Health Plan.

If you go to a UPMC Advantage network facility you will not pay a deductible or coinsurance charge. If you use a UPMC Health Plan network facility that is not part of the UPMC Advantage network, you will be responsible for an annual deductible and coinsurance. Refer to the Benefit Summary: UPMC Advantage HMO section for specific amounts. There are annual out-of-pocket maximums or caps on the amount you may have to pay during the year. If your physician refers you to a specialist, be aware of their ability to treat you at a UPMC facility. Physicians with admitting privileges at a UPMC facility can limit your out-of-pocket costs.

If you select this option, be sure to refer to any UPMC Health Plan materials you may receive in addition to this SPD.

UPMC Advantage HMO Terms:
PCP
A physician designated by a Member in accordance with provisions established by UPMC Health Plan who has specifically contracted with UPMC Health Plan or its designated agent to supervise, coordinate and provide initial care and basic medical services to Members, initiate referral for specialist care, and maintain continuity of patient care. A PCP may be a family practitioner, internist, pediatrician, or general practitioner who works within the UPMC Health Plan Network. A PCP is required only if enrolled in the UPMC Advantage HMO plan.

Coordinated Care
Care that your PCP or UPMC Health Plan Network provider delivers, authorizes, or approves. You receive the highest level of benefit if you receive coordinated care and if necessary, the care is provided at a UPMC Advantage Network facility.

Self-Referred Care
Care or services that you receive without obtaining your PCP’s or Network provider’s approval beforehand. In other words, your PCP or Network provider does not provide, authorize, or approve your care. This also is called non-coordinated care.

If you are an HMO participant, you receive self-referred care, and you go outside the UPMC Health Plan Network for nonemergency services, the Health Plan does not pay benefits.
UPMC Advantage PPO option:
You have the freedom to choose any doctor or hospital and there is no requirement to coordinate with a PCP. However, you are encouraged to use UPMC facilities. The incentives to use a UPMC Advantage network facility or Health Plan network physician include lower annual deductibles, lower copayment requirements and lower out-of-pocket maximums.

See the *How Your Coverage Option Pays Benefits* section for the deductible and coinsurance that apply under your coverage option.

- Women may select an obstetrician/gynecologist (OB/GYN) to provide all covered obstetric/gynecologic care. Care provided through a UPMC Health Plan network physician is provided at a higher level of benefit.

- Under this option, the Health Plan pays benefits based on the physician services provided in or out of the UPMC Health Plan network and facility services provided in or out of the UPMC Advantage network. See the *How Your Coverage Option Pays Benefits* section for details regarding the deductible and coinsurance that apply.

- For certain services you must meet a copay requirement before the plan pays benefits for eligible expenses. See the *How Your Coverage Option Pays Benefits* section for the services that require a copayment under your coverage option.

- You must meet the annual deductible amount before the Health Plan pays benefits for certain services. Services received from a provider outside the network also are covered, but at a lower benefit level. In addition, you may have to pay the difference between the provider’s charge and the UPMC Health Plan payment (which is based on the reasonable and customary amount). See the *How Your Coverage Option Pays Benefits* section for details regarding the deductible and coinsurance that apply.

- If you select this option, be sure to refer to any UPMC Health Plan materials you may receive in addition to this handbook.

Regardless of whether you are an HMO or PPO participant, be sure to see if your provider participates in the UPMC Health Plan Network. A network directory lists the participating hospitals and physicians. The directory is available on line at [www.upmchealthplan.com](http://www.upmchealthplan.com) or you can verify a physician’s participation in the network by contacting the Health Plan via UPMC DirectLink at 1-800-994-2753, option 2, option 1.
UPMC Open Access PPO option:
The Open Access PPO plan is similar to the Advantage PPO plan except that the highest level of benefits are provided when using a UPMC Health Plan network provider for covered services. Facilities are not limited to the UPMC Advantage network.

- You have the freedom to choose any doctor or hospital and there is no requirement to coordinate with a PCP. You are encouraged to use UPMC Health Plan network facilities. The incentives to use a Health Plan network facility or physician include lower annual deductibles, lower copayment requirements and lower out-of-pocket maximums.
- With the Open Access PPO option a PCP is not required.
- A lower annual deductible and copayments are charged when a UPMC Health Plan network provider is used.
- For most services you must meet a deductible and copay requirement before the plan pays its portion of the costs.

Out-of-Area PPO Option (option limited to eligible staff residing outside the Advantage Network service area):
If you live outside the UPMC Advantage Network service area, as defined by UPMC, you are eligible for Out-of-Area PPO coverage. The Out-of-Area plan has the same benefits as the Open Access PPO plan, but offers different networks through the Health Plan to obtain the highest level of benefits.

- With this option, you do not have to select a PCP. Network providers coordinate services. However, if you select a non-Network hospital facility or professional provider, in most cases, the Health Plan pays benefits based on a percentage of reasonable and customary charges rather than the higher coinsurance level. Refer to the Benefit Summary: UPMC Out-of-Area PPO section for specific amounts.
- Two levels of benefits are available. The highest level of benefits are obtained when a UPMC Health Plan participating provider or facility are used. The Health Plan network consists of facilities owned by UPMC and facilities and network providers who have agreed to participate with the Health Plan to provide service to its members. Different provider networks are used in different geographical areas. Refer to the Network Resource section following the Benefit Summary for the UPMC Out-of-Area PPO Plan for additional details.

Choosing Whom to Cover
In addition to selecting a coverage option, you need to decide whom to cover by selecting a coverage level. You can select from the following coverage levels:

- Employee Only coverage;
- Employee and Spouse coverage;
- Employee and Child(ren) coverage; or
- Family coverage.

Please see Who Is Eligible in the Overview section for a complete description of which family members are eligible.
How the Health Plan Pays Benefits

Depending on the coverage option you select, a deductible, copayment, coinsurance, or annual out-of-pocket maximum may apply. Here is a brief description of each feature.

Deductibles

The deductible is the specified dollar amount that you pay out of your pocket each year before the Health Plan pays benefits. See the How Your Coverage Option Pays Benefits section for the deductible (if any) that applies for your coverage.

The individual deductible applies separately to each covered individual, and the family deductible applies collectively to all covered persons in the same family. Once you meet the family deductible, your remaining covered family members do not have to meet their individual deductible amounts for the rest of that year.

Copayments

A copayment is a specified dollar amount that you pay for certain services before the Health Plan pays benefits. See your coverage option under the How Your Coverage Option Pays Benefits section for the copay that applies for certain services.

Copays generally apply to office visits, emergency room visits, therapy visits, prescription drugs, and vision care services. Copayments do not apply toward any deductible requirement you may have, coinsurance, or any annual out-of-pocket maximum that may apply.

Coinsurance

Coinsurance is the percentage of eligible expenses you and the Health Plan are responsible for paying. Percentages apply after any applicable deductible or copayment amounts. The amount you pay depends on the coverage option you select, and if you receive care inside or outside the UPMC Advantage or UPMC Health Plan Networks. See your coverage option under the How Your Coverage Option Pays Benefits section for the percentage the Health Plan pays for each type of eligible expense.

Eligible Expenses

All references to eligible expenses throughout this section assume that charges are for reasonable and customary charges for covered services. In most cases, the Health Plan pays benefits directly to the provider. If necessary, benefits are paid to you once you incur the expense. The Health Plan determines the reasonable and customary charge for a particular treatment or service.

Medically Necessary and Appropriate

Services and supplies provided by a hospital, facility, professional provider, or other professional provider that the UPMC Health Plan determines are:

- Appropriate for the symptoms and diagnosis or treatment of a condition, illness, disease, or injury;
- Provided for the diagnosis or the direct care and treatment of a condition, illness, disease, or injury;
- Can reasonably be expected to improve an individual’s condition or level of functioning;
- Conform, at the time of treatment, with medical management criteria/guidelines adopted by UPMC Health Plan;
- Provided according to good medical practice standards and consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies accepted by the UPMC Health Plan; and
- Not provided only as a convenience or comfort measure or to improve physical appearance
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

The UPMC Health Plan reserves the right to determine in its sole judgment whether a service is medically necessary and appropriate. Benefits are not provided unless the UPMC Health Plan determines that the service or supply is medically necessary and appropriate.

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.

Reasonable and Customary

A reasonable and customary charge is the:

- Amount UPMC Health Plan determines is reasonable for covered services provided to a member.
- Fee that’s most frequently charged to the majority of a physician’s patients for a similar service or procedure; and
- Prevailing range of fees charged by most physicians of similar training and experience within a geographic area for similar services or procedures.
Please note: As long as you receive care from a UPMC Health Plan Network provider (including Advantage Network providers), the reasonable and customary charge is accepted as payment-in-full for the particular service (even if the provider’s normal charge for the service is more expensive). Therefore, if you receive care outside the Network, you are responsible for any amount in excess of the reasonable and customary charge. Remember, if you are an HMO participant, the Health Plan does not pay benefits for out-of-network services (except for emergency or urgent care you may need while you are outside the service area).

**Annual Out-of-Pocket Maximums**
The annual out-of-pocket maximum is the specific dollar amount at which your payment responsibility ceases under the plan during the calendar year. Generally your deductible and coinsurance costs count toward the annual out-of-pocket maximum. See your coverage option under the *How Your Coverage Option Pays Benefits* section for the individual and family out-of-pocket maximums that apply.

Once you reach your individual out-of-pocket maximum, the Health Plan pays 100% of your additional eligible expenses for the remainder of that plan year. The family out-of-pocket maximum applies collectively to all covered family members. Once you meet the family out-of-pocket maximum, the Health Plan pays 100% of eligible expenses for any covered family member for the remainder of that plan year.

Please Note: If you reach the in-network out-of-pocket maximum, but choose to receive services from non-UPMC or non-network providers, you will be responsible for additional costs relating to the higher non-network deductible and coinsurance limits, as applicable.

Certain charges do not apply toward the out-of-pocket maximum. As a result, the Health Plan does not pay these expenses at 100%. These expenses include:

- Copayments (where applicable);
- Any additional expense you may be required to pay for not following the managed care program’s requirements; and
- Any expense that is not considered an eligible reasonable and customary charge, or that exceeds other Health Plan limits.

**Lifetime Maximums**
The individual lifetime maximum is the maximum amount the Health Plan pays for eligible expenses during the life of a covered individual. See the *How Your Coverage Option Pays Benefits* section for the lifetime maximum that applies under your coverage option.

The lifetime maximum applies whether the Health Plan pays benefits under one coverage option or more than one coverage option over the years.
The UPMC Health Plan Network
This integrated Network of regional hospitals, physicians, and community surgical centers is built on the excellence of UPMC hospitals and affiliated or aligned hospitals. The Network, which also includes hospitals not part of UPMC, services a geographic region centered on Allegheny County and the counties around it. As a result, Network providers are distributed throughout southwestern Pennsylvania so that most staff members have reasonable access to the Network’s services.

The UPMC Advantage Network
UPMC has developed a national reputation for quality, and its hospitals and facilities are offered as a distinct network, called the UPMC Advantage network. The network consists of facilities owned by UPMC. In addition to hospitals, UPMC facilities include rehabilitation centers, home health care, durable medical equipment and a range of other services. The Advantage network also includes providers who have received credentials from UPMC Health Plan. Refer to the UPMC Advantage Network Directory for a listing of participating hospitals and providers. The Advantage network also includes all physicians participating in the UPMC Health Plan network.

Contact the Health Plan at 1-888-876-2756 or visit the Health Plan Web site at www.upmc.edu/upmchealthplan for the most up-to-date list of the UPMC Advantage and the UPMC Health Plan network.

Emergency Care
Emergency care is covered at the highest benefit level possible, after a copayment. You are expected to call your PCP or Network provider in advance of seeking treatment, unless the situation is so critical that you need to be treated immediately. If this is the case, go directly to the nearest emergency facility.

- **If you are an Advantage HMO participant:** Contact your PCP within 24 hours (or as soon as reasonably possible) of receiving the care. If you receive routine or nonemergency services in the emergency room, the Health Plan does not pay benefits if a PCP has not approved them.

- **If you are a PPO participant:** Contact UPMC Health Plan Member Services if admitted to a non-UPMC Advantage Network facility within 24 hours (or as soon as reasonably possible) of receiving care. If you use the services of the emergency room for a nonemergency condition, the Health Plan pays benefits for eligible expenses at the lower benefit payment level.

Urgent Care Out of the Service Area
If you are outside the service area and you need urgent care, the Health Plan pays benefits at your coverage option’s highest benefit level, after the member’s copayment and deductible are paid. Be sure to contact your PCP (for HMO members) or UPMC Health Plan Member Services (for PPO members), within 24 hours or as soon as reasonably possible of receiving the care. The Health Plan does not pay benefits for routine care received outside of the coverage area unless the care has been approved by your PCP and UPMC Health Plan (for HMO members) or UPMC Health Plan (for PPO members).
How Your HMO Coverage Option Works

UPMC Advantage Health Maintenance Organization (HMO) Option
The following benefit summary gives a brief overview of how the Health Plan pays benefits under the Advantage HMO option. If your PCP does not coordinate or a UPMC Health Plan Network specialist does not provide your care, the Health Plan does not pay benefits. Please be sure to see your separate HMO materials provided by the Health Plan for more details regarding your covered services.

The UPMC Advantage HMO product offers you the choice of two levels of health care benefits for eligible medical care or service received at UPMC Advantage Network Facilities and UPMC Health Plan Facilities. The highest level of benefit reimbursement is generally provided for care received at UPMC Advantage Network Facilities or received from UPMC Health Plan Network Professional Providers. There are generally no deductible or coinsurance responsibilities if you receive care at a UPMC Advantage Network Facility or from a UPMC Health Plan Network Professional Provider. Deductible and Coinsurance amounts may apply if you receive care at a UPMC Health Plan Facility.

Care is considered coordinated when it is performed, referred, or authorized by a your Primary Care Physician (PCP) or selected OB/Gyn (Women’s Care only) prior to services being delivered. You will not be covered for services received from Non-Participating Providers unless prior authorization is obtained from your PCP and UPMC Health Plan, except in the event of an emergency.

Primary Care Physicians (PCPs)
If you select the Advantage HMO coverage option, you are encouraged to select a PCP for yourself and each of your covered family members. As a result, each covered family member may have a different PCP.

The PCP is responsible for: (a) providing medical services; (b) coordinating Member access to Hospitals and Facility/Other Providers; (c) referring services for specialist care; and (d) referring to other Providers. In the case where there may not be a Network Provider available in a particular specialty, the PCP will make a referral outside the Network, with the approval of UPMC Health Plan or its designated agent.

Hundreds of physicians (over 1,000 in primary care) participate in the UPMC Health Plan Network, and are listed in a provider index. To request an index, contact the UPMC Health Plan at 1-888-876-2756. The Health Plan is available Monday through Friday, 8:00 a.m. to 5:30 p.m., Eastern Time, and Saturday, 8:00 a.m. to 12:00 p.m., Eastern Time. The UPMC Health Plan directory is also available online at www.upmchealthplan.com.

Change in PCP
When you enroll, you are encouraged to select a Primary Care Physician (PCP) from whom you will receive basic health care on an ongoing basis and coordination of all needed health services. If you want to change your or your covered family member’s PCP, you must contact the UPMC Health
Plan. Request for changes received by Member Services will become effective immediately and a new Identification Card will then be issued, reflecting the change. If for any reason, UPMC Health Plan were to terminate the contract of a PCP, Members who had chosen that PCP would be notified and Member Services would assist them in selecting new PCPs.

Your UPMC Health Plan materials contain additional information regarding how the PCP process works, as well as, how to go about seeing a specialist. Please refer to those materials for details.

All services must meet UPMC Health Plan’s definition of “Medically Necessary and Appropriate” in order to be Covered Services. Some services may require Precertification from UPMC Health Plan. This managed care plan may not cover all your health care expenses.

Selection of an OB/GYN
The OB/GYN is responsible for providing/coordinating Women’s Care including: (a) performing routine gynecological examinations and Pap tests; (b) referring to Network Providers for mammograms and other diagnostic tests; (c) providing Maternity Care; and (d) providing/referring to Network Providers for related surgical services. Although Members are encouraged to consult their selected OB/GYN to coordinate their care, Members may self-refer to any Participating or Non-Participating OB/GYN; however, benefits will only be paid for a Participating OB/GYN, and at a lower level of reimbursement. If a Member does not select an OB/GYN, the Network OB/GYN who performs the initial Women’s Care provided to the Member will be identified as the Member’s selected OB/GYN.

Change in OB/GYN
Any change in OB/GYN should be coordinated through Member Services. Request for changes received by Member Services will become effective immediately and the system will reflect the change. If for any reason, UPMC Health Plan were to terminate the contract of an OB/GYN, Members who had chosen that OB/GYN would be notified and Member Services would assist the Members in selecting a new OB/GYN.

Specialist as PCP/Standing Referral to a Specialist
A Member with a life-threatening, degenerative, or disabling disease or condition, upon request, shall receive an evaluation. If UPMC Health Plan’s established standards are met, the Member will be permitted to receive either a standing referral to a specialist with clinical expertise in the treatment of the Member’s disease or condition, or alternatively, the Member will be permitted to have a Specialist designated to provide and coordinate the Member’s primary and specialty care, according to a Treatment Plan approved by UPMC Health Plan, in consultation with the PCP, the Member, and, as appropriate, the specialist. When possible, the specialist must be a UPMC Health Plan Participating Provider.

A Member with such a disease or condition should contact Member Services in order to set up the above-described evaluation.

Specialty Care Physicians
Members are encouraged to consult their PCPs for all specialty care. The PCP will either provide the treatment or coordinate the referral. If Members self-refer and use a UPMC Health Plan Network specialist, benefits will be paid but a higher Copayment will apply.
**Hospital or Facility/Other Providers**
A Member covered under the UPMC Advantage HMO plan has the option of choosing from UPMC Advantage Network facilities, UPMC Health Plan Network facilities and Participating Professional Providers to receive benefits for covered services. Members must go to a Participating Facility/Provider in order to receive benefit payment.

Members choosing from the list of UPMC Advantage Network facilities will receive the highest-level benefit reimbursement. If a UPMC Health Plan Network facility, other than an Advantage network provider is utilized, eligible benefits will be paid at the lower level.

Use of Non-Participating Providers for non-Emergency Services without prior approval of UPMC Health Plan, or its designated agent, and/or the Member’s PCP, will not be covered.

**Participating and Non-Participating Professional Providers**
A Member covered under the UPMC Advantage HMO plan has the option of choosing where and to whom to go for Covered Services between Participating and Non-Participating Professional Provider.

Use of Non-Participating Providers without prior approval of UPMC Health Plan or its designated agent and/or the Member’s PCP will not be covered.

**Contracting and Non-Contracting Suppliers**
A Member covered under the UPMC Advantage HMO plan has the option of choosing among suppliers where and to whom to go for Covered Services among UPMC Health Plan’s network of participating Suppliers.

Use of Non-Contracting Suppliers without prior approval of UPMC Health Plan, or its designated agent and/or the Member’s PCP will not be covered. Refer to the Benefit Summary: UPMC Advantage HMO section for more details on covered services.

**Coordinated Care Requirement for Emergency Services**
Emergency Services are not subject to prior approval although Members are expected to call their PCP in advance of seeking treatment unless the situation is so critical that care needs must be treated immediately. In this case, Members should proceed to call “911” or go to the nearest Hospital emergency room. Members are then required to call their PCP within 24 hours or as soon as reasonably possible. If the Member is out of the Network Service Area at the time of the emergency, the same procedures should be followed. Emergency medical care is available 24 hours a day, seven days a week. Routine or non-emergency services provided in the emergency room will not be covered, unless specifically authorized by the Member’s PCP.
Medical Treatment In Progress (Continuity of Care/Transitional Care)

Newly Enrolled Member
If a newly enrolled Member is currently receiving Medical Care from a Primary Care Physician, the course of treatment may be continued at the Coordinated Care/highest benefit level. However, if a newly enrolled Member is currently undergoing medical treatment by a Participating Provider who is not a Primary Care Physician, the Member must select a Primary Care Physician and receive the appropriate referral to continue treatment with such Provider, unless the newly enrolled Member is evaluated as having a life threatening, degenerative, or disabling disease or condition. In this case, the newly enrolled Member would follow the procedure set out in the prior section: Specialist as a PCP/Standing Referral to a Specialist.

If a newly enrolled Member is undergoing an ongoing course of treatment with a non-Participating Provider, he or she may apply to continue this treatment for a transition of care period for up to sixty (60) days effective from the date of enrollment. UPMC Health Plan will consult with the newly enrolled Member and the health care Provider, and may extend this transitional period, if this is determined to be clinically appropriate.

In the case of a newly enrolled Member who is in the second or third trimester of Pregnancy as of the Effective Date of enrollment, the transitional period shall extend through postpartum care related to the delivery.

If a Member wishes to apply for transitional care, he or she will need to complete a Transition of Care form that can be obtained by calling UPMC Health Plan Member Services at 1-888-876-2756. Requests for Transition of Care must be received at the Health Plan no later than fifteen (15) days after the effective date of coverage.

A Member receiving transitional care benefits will still need to have his or her care coordinated through the PCP.

It should be noted that provisions of Pennsylvania Act 1998-68 stipulate that in transition of care situations, UPMC Health Plan may require a non-participating health care Provider whose health care services are covered under transition of care requirements to meet the same terms and conditions as a UPMC Health Plan participating health care Provider. Furthermore, UPMC Health Plan is not required to provide health care services that are not otherwise covered under the terms and conditions of the UPMC Health Plan’s plan.

Existing Members
Additionally, in some cases, existing UPMC Health Plan Members may also be eligible to apply for transitional care in the event that UPMC Health Plan were to terminate a network Provider’s contract during a Member’s course of treatment for conditions as described above. In this case, transitional care will be for a period of 90 days from the date the Member is notified of the termination or the pending termination of the Provider. The process to apply transition of care is the same as described in the above section: Medical Treatment in Progress.
Medical Management/Prior Authorizations
Certain non-Emergency Services and surgical procedures or services require a prior authorization for payment from UPMC Health Plan’s Medical Management Department. A Member’s Participating PCP or Participating Provider, or designee, will obtain all the prior authorizations from UPMC Health Plan. All UPMC Health Plan Providers are aware of these responsibilities.

The Medical Management Department performs the Medical Management function for UPMC Health Plan. The circumstances that require management by the Medical Management Department are:

- A request by the Member or the Member’s Physician for out-of-network care and service,
- A request for approval of a procedure, service or level of care that UPMC Health Plan has determined requires a prior authorization, and
- Transition of Care requests.

If the Member or their Participating Physician requests any out-of-network services that are non-Emergency Services, the request needs to be reviewed by the Medical Management Department to determine if the service can be provided by a UPMC Health Plan Participating Provider. In all cases, a denial can only be rendered after a UPMC Health Plan Medical Director, or an appropriate Physician specialist, reviews the information and makes a decision.

UPMC Health Plan’s Participating doctors represent nearly every medical specialty. However, if the service a Member needs is not available from a Participating Provider, the Member’s PCP or selected OB/GYN (Women’s Care Only) can request a referral to the appropriate specialist outside the UPMC Health Plan Network. If approved by the UPMC Health Plan Medical Director, the service will be covered.

Claims Payment
For services, which are determined to be Covered Services, payment will be made in accordance with UPMC Health Plan’s applicable claims payment/adjudication policies and procedures. This may result in non-payment of services provided, resulting in Member responsibility for services delivered by Non-Participating Providers.
**Benefit Summary: UPMC Advantage HMO**
Here’s how the Health Plan pays benefits for medically necessary eligible expenses under the UPMC Advantage HMO coverage option:

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<tr>
<th>BENEFIT PERIOD</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ANNUAL DEDUCTIBLE</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>None</td>
<td>$300</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>$600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COINSURANCE</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td></td>
<td>80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANNUAL OUT-OF-POCKET MAXIMUM</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>None</td>
<td>$1,500 (Includes Individual Deductible)</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>$3,000 (Includes Family Deductible)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIFETIME MAXIMUM</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlimited</td>
<td></td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRE-EXISTING CONDITION LIMITATIONS</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRIMARY CARE PHYSICIAN (PCP) REQUIRED</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRECERTIFICATION REQUIREMENTS</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Responsibility</td>
<td>Provider Responsibility</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITAL SERVICES</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Private Room</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Private Room if Medically Necessary and Appropriate</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Surgery</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Pre-Admission Testing</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>
**UPMC HEALTH PLAN NETWORK**

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>EMERGENCY ROOM SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% after $30 copayment per visit (copayment waived and inpatient stay paid at the highest benefit level if admitted). Must contact PCP within 24 hours or as soon as reasonably possible. Call UPMC Health Plan Member Services if admitted to a non-UPMC Advantage Network facility.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIAGNOSTIC SERVICES - X-rays, labs and other tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient &amp; outpatient hospital services</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Hospital Outpatient mammogram (based on age guidelines)</td>
<td>100%</td>
<td>80% (deductible does not apply)</td>
</tr>
<tr>
<td>Non-hospital Outpatient Facility</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Non-hospital Outpatient Facility mammogram (based on age guidelines)</td>
<td>100%</td>
<td>80% (deductible does not apply)</td>
</tr>
<tr>
<td>Diagnostics billed by Physician Office</td>
<td>100%</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>UPMC HEALTH PLAN NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSICIAN SERVICES</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
</tr>
<tr>
<td>Adult Routine Physical Examinations</td>
<td>100% after $5 Copayment</td>
</tr>
<tr>
<td>Adult Immunizations when medically necessary</td>
<td>100%</td>
</tr>
<tr>
<td>Pediatric Care and Immunizations</td>
<td></td>
</tr>
<tr>
<td>Routine Physical Exam</td>
<td>100% after $5 Copayment</td>
</tr>
<tr>
<td>Pediatric Immunizations</td>
<td>100%</td>
</tr>
<tr>
<td>Well-Baby Visits</td>
<td>100% after $5 Copayment</td>
</tr>
<tr>
<td>PCP Office Visit: for treatment of medical disease or injury</td>
<td>100% after $10 Copayment per visit</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td></td>
</tr>
<tr>
<td>With Referral from PCP</td>
<td>100% after $15 Copayment/visit</td>
</tr>
<tr>
<td>Without Referral from PCP</td>
<td>100% after $30 Copayment/visit</td>
</tr>
<tr>
<td>Physician Surgical Services</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>100%</td>
</tr>
<tr>
<td>Special Surgery—Vasectomy, Tubal Ligation, Mastectomy/Reconstructive Surgery</td>
<td>100%</td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td>100%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>100%</td>
</tr>
<tr>
<td>Second Surgical Opinion Services</td>
<td>100%</td>
</tr>
</tbody>
</table>
### COVERED SERVICES

| Service Description                                                                 | UPMC HEALTH PLAN NETWORK
|------------------------------------------------------------------------------------|------------------------
| **Physician Medical Services**                                                       |                        |
| Inpatient Medical Care Visits and Intensive Medical Care                            | 100%                   |
| Consultation (Inpatient)                                                            | 100%                   |
| Newborn Care                                                                       | 100%                   |
| Women’s Care: Annual Gynecologic Exam, Breast Exam, and Pap Test, Mammogram (based on age guidelines), Maternity Care, Diagnostic Tests and Surgical Services. |                        |
| Care Delivered by PCP or selected OB/GYN                                            | 100% after $5 Copayment for annual Gynecologic exam only. 100% after $10 copayment for illness/accidental injury. 100% after $10 for first Obstetrical visit; 100% thereafter for obstetrical office visits |
| Allergy Services                                                                    |                        |
| Diagnostic Testing                                                                 | 100%                   |
| Treatment Including Injections and Serum                                            | 100%                   |

### COVERED SERVICES

| Service Description                                                                 | UPMC ADVANTAGE NETWORK | OTHER UPMC HEALTH PLAN FACILITIES
|------------------------------------------------------------------------------------|------------------------|--------------------------
<p>| <strong>REHABILITATION THERAPY SERVICES</strong>                                                |                        |                          |
| Physical, Speech, And Occupational Therapy: Covered up to the greater of: 60 consecutive days OR 25 visits per condition, per Benefit Period, for all three therapies combined subject to ongoing Substantial Improvement. |                        |                          |
| Hospital Outpatient                                                                | 100% after $10 Copayment/visit | 80% after deductible |
| Non-hospital Outpatient                                                            | 100% after $10 copayment/visit UPMC Health Plan Network Providers |
| Cardiac Rehabilitation: Covered up to 12 weeks per Benefit Period                   |                        |                          |
| Hospital Outpatient                                                                | 100%                   | 80% after deductible    |
| Pulmonary Rehabilitation: Covered up to 24 visits per Benefit Period                |                        |                          |
| Hospital Outpatient                                                                | 100% after $10 Copayment/visit | 80% after deductible |
| <strong>MEDICAL THERAPY SERVICES</strong>: Chemotherapy, Radiation therapy, Infusion Therapy, Dialysis Treatment |                        |                          |
| Inpatient &amp; Outpatient Hospital Services                                           | 100%                   | 80% after deductible    |
| Non-Hospital Outpatient Services                                                   | UPMC Health Plan Network Providers |
| <strong>PAIN MANAGEMENT PROGRAMS</strong>                                                       |                        |                          |
| Hospital Outpatient: With Referral from PCP                                        | 100% after $15 Copayment/visit | 80% after deductible |
| Without Referral from PCP                                                           | 100% after $30 Copayment/visit |
| Professional Services: With Referral from PCP                                       | 100% after $15 Copayment/visit |
| Without Referral from PCP                                                           | 100% after $30 Copayment/visit UPMC Health Plan Network Providers |</p>
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility: Limited to a maximum of 90 days per Benefit Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital based facility</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Non-hospital based facility</td>
<td></td>
<td>100% UPMC Health Plan Network Providers</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility &amp; Ancillary Services</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Physician Office Services</td>
<td>100%</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>100%--Provided service is not Experimental/Investigative or covered under a grant for the clinical trial.</td>
<td></td>
</tr>
<tr>
<td>Dental Services: Related to Accidental Injury to sound and natural teeth. Services must be provided within 30 days after date of accidental injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>100%</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
<tr>
<td>Hospital related services</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Oral Surgical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>100%</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
<tr>
<td>Hospital related services</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>See Prescription Drug Program Section</td>
<td></td>
</tr>
<tr>
<td>Corrective Appliances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital related services</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Physician &amp; Ancillary Services</td>
<td>100%</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
<tr>
<td>Therapeutic Manipulation</td>
<td>100% after $30 Copayment for first visit; then 100% after $15 Copayment/visit thereafter Covered up to 25 Visits/Benefit Period</td>
<td></td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>100% After $25 Copayment/visit No referral required form PCP</td>
<td></td>
</tr>
<tr>
<td>Fertility Testing</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Nutritional Supplements: Limited to the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.</td>
<td>100%</td>
<td>80% (deductible does not apply)</td>
</tr>
<tr>
<td>Diabetic Equipment, Supplies and Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucometer, Test Strips, Lancets, Insulin And Syringes</td>
<td>Must be obtained at a Participating Pharmacy. 100% after Copayment, if applicable.</td>
<td></td>
</tr>
<tr>
<td>COVERED SERVICE</td>
<td>UPMC ADVANTAGE NETWORK (HOME HOST)</td>
<td>OTHER UPMC HEALTH PLAN FACILITIES</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Diabetic Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital services</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Physician &amp; Ancillary Services</td>
<td>100%</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30 days Maximum per Benefit Period. Lifetime maximum of 90 days. Thirty (30) inpatient days may be exchanged on a 1:2 basis to secure up to 60 transitional partial hospitalization days.</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after $20 Copayment/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limit 20 visits per Benefit Period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group visits and 15-minute medication visits count as ½ visit.</td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency: Contact Western Behavioral Health Care Network 1-888-251-0083</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Detoxification</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 days Maximum per admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lifetime Maximum of four admissions</td>
<td></td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30 days Maximum per Benefit Period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lifetime Maximum 90 days.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60 full-session visits or equivalent partial visits per Benefit Period and 120 full-session visits or equivalent partial visits per lifetime.</td>
<td></td>
</tr>
<tr>
<td>Non-hospital Residential Alcohol or Other Drug Services</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thirty (30) days per Benefit Period for residential care. Additional days are available in exchange for sessions of outpatient or partial hospitalization on a 2:1 basis to secure up to 15 additional non-hospital, residential alcohol treatment days.</td>
<td></td>
</tr>
</tbody>
</table>
How Your PPO Coverage Options Work

The Health Plan administers three PPO options for UPMC staff members. The UPMC Advantage PPO and UPMC Open Access PPO are coverage options available in addition to the UPMC Advantage HMO plan. One additional PPO option is made available to staff members residing outside of the UPMC Advantage Network service areas – UPMC Out-of-Area PPO plan. The PPO coverage operations are described below, followed by a Benefit Summary for each option.

Selection of PPO Providers

The three UPMC PPO products offer Members the choice between two levels of health care benefits for eligible medical care or services. The Networks are different between the three PPO options. The UPMC Advantage PPO offers the Advantage Network for the highest level of benefit. The Open Access PPO option offers the full UPMC Health Plan Network for the highest level of benefit. The Out-of-Area PPO option supplements the Health Plan Network with additional contracted networks to provide coverage in areas outside of western Pennsylvania.

The Member enrolled in a PPO coverage option also has the choice of going in-network to a participating professional provider or going out-of-network to a non-participating professional provider. A higher level of benefit reimbursement is generally provided when network providers, also known as participating providers, deliver services. Benefit reimbursement is also provided, at a lower level, for services delivered by out-of–network providers, also known as non-participating providers.

Hospital or Facility/Other Providers

A Member covered under a UPMC PPO plan has the option of choosing Providers for Covered Services. Participating Members of the Advantage PPO must go to a UPMC Advantage Network Facility in order to receive the highest benefit payment. Participating members in the UPMC Open Access PPO must go to a UPMC Health Plan network facility in order to receive the highest benefit payment. The UPMC Out-of-Area PPO plan provides the highest level of benefit whenever providers in the expanded UPMC Health Plan network are chosen for necessary care. See your provider options under the UPMC Out-of-Area PPO section.

Use of a UPMC Hospital or Facility not owned or affiliated with UPMC as well as any non-participating hospital or facility for non-emergency services, without prior approval of UPMC Health Plan or its designated agent, will be reimbursed at a lower benefit level and in some instances may not be covered. Moreover, some inpatient and outpatient services and procedures require pre-notification or pre-certification for payment. Failure to notify UPMC Health Plan prior to receipt of certain non-emergency services at a non-participating facility, will result in the Member being assessed a significant financial penalty.
Participating and Non-Participating Professional Providers
A Member covered under a UPMC PPO plan has the option of choosing where and to whom to go for Covered Services among Providers. Members must go to a Participating Provider to receive the highest benefit payment.

Hundreds of physicians (over 1,000 in primary care) participate in the UPMC Health Plan Network, and are listed in a provider index. To request an index, contact the UPMC Health Plan at 1-888-876-2756. The Health Plan is available Monday through Friday, 8:00 a.m. to 5:30 p.m., Eastern Time, and Saturday, 8:00 a.m. to 12:00 p.m., Eastern Time. The UPMC Health Plan directory is also available online at www.upmchealthplan.com.

Use of non-participating providers for non-emergency services without prior approval of UPMC Health Plan or its designated agent, will be reimbursed at a lower benefit level and in some instances may not be covered.

Contracting and Non-Contracting Suppliers
A Member covered under one of the UPMC PPO plans has the option of choosing among suppliers where and to whom to go for Covered Services. Members must utilize Contracting Suppliers to receive the highest benefit payment.

Use of Non-Contracting Suppliers without prior approval of UPMC Health Plan or its designated agent, will be reimbursed at a lower benefit level and in some instances may not be covered.

Requirement For Emergency Services
Emergency Services provided at Participating Provider facilities are covered at the highest level of benefit. In the event that the Member requires and receives Emergency Services by a Non-Participating Provider, all charges for such Covered Services will be paid at the Participating benefit level if it is not reasonably possible to be attended to by a Participating Provider or Physician. Members or a family Member should contact Member Services within 24 hours of the Emergency Services, or as soon as reasonably possible.

Medical Treatment In Progress (Continuity Of Care/Transitional Care)
Newly Enrolled Member
If a newly enrolled Member is currently receiving Medical Care from a Participating Physician, the course of treatment may be continued at the Participating Provider benefit level.

If a newly enrolled Member is undergoing an ongoing course of treatment with a non Participating Provider, he or she can continue this treatment for a transition of care period for up to sixty (60) days effective from the date of enrollment. UPMC Health Plan will consult with the newly enrolled Member and the health care Provider, and may extend this transitional period, if this is determined to be clinically appropriate.

In the case of a newly enrolled Member who is in the second or third trimester of Pregnancy as of the effective date of enrollment, the transitional period shall extend through postpartum care related to the delivery.
If a Member wishes to apply for transitional care, he or she will need to complete a Transition of Care form that can be obtained by calling UPMC Health Plan Member Services at 1-888-876-2756. Requests for Transition of Care must be received at the UPMC Health Plan no later than fifteen (15) days after the effective date of coverage.

It should be noted that provisions of Pennsylvania Act 1998-68 stipulate that in transition of care situations, UPMC Health Plan, may require a non-participating provider whose health care services are covered under transition of care requirements to meet the same terms and conditions as a UPMC Health Plan participating provider. Furthermore, UPMC Health Plan is not required to provide health care services that are not otherwise covered under this document.

**Existing Members**

Additionally, in some cases, existing UPMC Health Plan Members may also be eligible to apply for transitional care in the event that UPMC Health Plan were to terminate a participating provider’s contract during a Member’s course of treatment for conditions as described above. In this case, transitional care will be for a period of ninety (90) days from the date the Member is notified of the termination or the pending termination of the Provider. The process to apply transition of care is the same as described above in the *Medical Treatment in Progress* section for newly enrolled Members.

**Medical Management/Prior Authorization**

Certain non-Emergency Services and procedures require a prior authorization for payment from UPMC Health Plan’s Medical Management Department. A Member’s participating physician will obtain all the necessary approvals or prior authorizations from UPMC Health Plan. All UPMC Health Plan participating providers are aware of these responsibilities. If a Member seeks non-emergency services from a non-participating provider without prior approval from UPMC Health Plan, the Member is required to pre-notify the Medical Management department for all inpatient admissions and select outpatient services and to pre-certify payment of certain services. Failure to comply with these requirements will result in a significant financial penalty to the Member, per incident. Refer to the Benefit Summary section for the respective PPO plan or contact Member Services at 1-888-876-2756 for additional information.

The Medical Management Department performs the medical management function for UPMC Health Plan. Medical Management of the care and services a Member receives are required in these circumstances:

- A request by a Member or a Member’s Physician for out-of-network care, procedures or services to be covered at the Participating Provider level;
- A request for approval of a procedure, service or level of care that UPMC Health Plan has determined requires pre-certification for payment;
- Transition of Care requests.

If a Member or a Member’s Physician requests Participating payment levels for non-Emergency Services to be delivered by a Non-Participating Provider, the Medical Management Department must review the request to determine if the service can be provided by a UPMC Health Plan participating provider. In all cases, a denial can only be rendered after a UPMC Health Plan Medical Director, or appropriate Professional Provider/Other Provider reviews the information and makes a decision.
Claims Payment

For services, which are determined to be Covered Services, payment will be made in accordance with UPMC Health Plan’s applicable claims payment/adjudication policies and procedures. This may result in non-payment of services provided, resulting in Member responsibility for Covered Services delivered by non-participating providers.

All services must meet UPMC Health Plan’s definition of “Medically Necessary and Appropriate” in order to be Covered Services. Some services may require pre-certification from UPMC Health Plan. This medical plan may not cover all your health care expenses.
UPMC Advantage PPO Option and Benefit Summary
The following benefit summary shows how the Health Plan pays benefits under the UPMC Advantage PPO option.

The UPMC Advantage PPO Network product offers Members the choice of two levels of health care benefits for eligible medical care or services. Eligible care or services received at UPMC Advantage Network facilities or eligible care received at either UPMC Health Plan facilities or all out-of-network facilities. The highest level of benefit reimbursement is generally provided for care received at UPMC Advantage Network Facilities.

The Member also has the option of going In-Network to a UPMC Health Plan Participating Professional Provider or going Out-of-Network to a Non-Participating Professional Provider. A higher level of benefit reimbursement is generally provided when services are delivered by Network Providers, also known as Participating Providers. Benefit reimbursement is also provided, at a lower level, for services delivered by Out-of-Network Providers, also known as Non-Participating Providers.

Benefits Summary: UPMC Advantage PPO

<table>
<thead>
<tr>
<th>BENEFIT PERIOD</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANNUAL DEDUCTIBLE</strong></td>
<td>Individual $150</td>
<td>$400</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family $300</td>
<td>$800</td>
<td></td>
</tr>
<tr>
<td><strong>COINSURANCE</strong></td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td><strong>ANNUAL OUT-OF-POCKET MAXIMUM</strong>—All amounts are based on reasonable &amp; customary charges</td>
<td>UPMC ADVANTAGE NETWORK (Home Host)</td>
<td>OTHER UPMC HEALTH PLAN FACILITIES</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000</td>
<td>$3,000 (Includes Individual Deductible)</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$2,000</td>
<td>$6,000 (Includes Family Deductible)</td>
<td></td>
</tr>
<tr>
<td><strong>LIFETIME MAXIMUM</strong></td>
<td>UPMC ADVANTAGE NETWORK (Home Host)</td>
<td>OTHER UPMC HEALTH PLAN FACILITIES</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td></td>
<td>$2,000,000</td>
<td>$300,000</td>
<td></td>
</tr>
<tr>
<td><strong>PRE-EXISTING CONDITION LIMITATIONS</strong></td>
<td>UPMC ADVANTAGE NETWORK (Home Host)</td>
<td>OTHER UPMC HEALTH PLAN FACILITIES</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>PRIMARY CARE PHYSICIAN (PCP) REQUIRED</td>
<td>UPMC ADVANTAGE NETWORK (Home Host)</td>
<td>OTHER UPMC HEALTH PLAN FACILITIES</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>---------------------------------------</td>
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</tr>
<tr>
<td>No</td>
<td>No</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>PRECERTIFICATION REQUIREMENTS</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Responsibility</td>
<td>Provider Responsibility</td>
<td>Member Responsibility —</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Precertification is required for</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>select services at Out-of-Netwo</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>rk Providers. $500 financial</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>penalty for failure to comply</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>UPMC ADVANTAGE NETWORK (Home Host)</th>
<th>OTHER UPMC HEALTH PLAN FACILITIES</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITAL SERVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-Private Room</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td>Private Room if Medically Necessary and Appropriate</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td>Pre-Admission Testing</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td>EMERGENCY ROOM SERVICES</td>
<td>100% after $30 Copayment per visit (Copayment waived and inpatient stay paid at highest level if admitted) Call UPMC Health Plan Member Services if admitted to an Out-of-Network facility.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIAGNOSTIC SERVICES: X-rays, labs, and other tests</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient &amp; outpatient hospital services</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Hospital Outpatient mammogram (based on age guidelines)</td>
<td>80% (deductible does not apply)</td>
</tr>
<tr>
<td>Non-hospital Outpatient Facility</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Non-hospital Outpatient Facility mammogram (based on age guidelines)</td>
<td>80% (deductible does not apply)</td>
</tr>
<tr>
<td>Diagnostic billed by Physician Office</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>UPMC HEALTH PLAN NETWORK</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSICIAN SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Routine Physical Examinations</td>
<td>100% after $5 Copayment/visit</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Adult Immunizations</td>
<td>80% after deductible if medically necessary.</td>
<td>60% after deductible if medically necessary</td>
</tr>
<tr>
<td>Pediatric Care and Immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Physical Exam</td>
<td>100% after $5 Copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>UPMC HEALTH PLAN NETWORK</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Pediatric Immunizations</td>
<td>100% (deductible does not apply)</td>
<td>60% (deductible does not apply)</td>
</tr>
<tr>
<td>Well-Baby Visits</td>
<td>100% after $5 copayment/visit</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>PCP Office Visit: for treatment of medical disease or injury</td>
<td>100% after $15 Copayment per visit</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>100% after $20 Copayment per visit</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Physician Surgical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Special Surgery—Vasectomy, Tubal Ligation, Mastectomy/Reconstructive Surgery</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Second Surgical Opinion Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Physician Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Medical Care Visits and Intensive Medical Care</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Consultation (Inpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Women’s Care: Annual Gynecologic Exam, Breast Exam, and Pap Test, Mammogram (based on age guidelines), Maternity Care, Diagnostic Tests and Surgical Services</td>
<td>100% after $5 Copayment for gynecologic exam; 100% after $15 copayment for illness visit; 80% for Pap test and mammogram (not subject to deductible)</td>
<td>60% after deductible. Routine gynecologic exam, Pap test and mammogram not subject to deductible.</td>
</tr>
<tr>
<td><strong>Allergy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Treatment Including Injections and Serum</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>UPMC ADVANTAGE NETWORK (Home Host)</td>
<td>OTHER UPMC HEALTH PLAN FACILITIES</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>REHABILITATION THERAPY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Speech, And Occupational Therapy: Covered up to the greater of: 60 consecutive days OR 25 visits per condition, per Benefit Period, for all three therapies combined subject to ongoing Substantial Improvement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>100% after $15 Copayment/visit</td>
<td></td>
</tr>
<tr>
<td>Non-hospital Outpatient</td>
<td>100% after $15 Copayment/visit</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
<tr>
<td>Cardiac Rehabilitation: Covered up to 12 weeks per Benefit Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehabilitation: Covered up to 24 visits per Benefit Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>100% after $15 Copayment/visit</td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAL THERAPY SERVICES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy, Radiation Therapy, Infusion Therapy, Dialysis Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient &amp; Outpatient Hospital Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Non-Hospital Services</td>
<td>80% after deductible</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
<tr>
<td><strong>PAIN MANAGEMENT PROGRAMS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Services</td>
<td>100% after $20 Copayment/visit</td>
<td></td>
</tr>
<tr>
<td>Professional Services</td>
<td>100% after $20 Copayment/visit</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
<tr>
<td><strong>OTHER MEDICAL SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility: Limited to a maximum of 90 days per Benefit Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital based facility</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Non-hospital based facility</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Facility &amp; Ancillary Services</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>80% after deductible</td>
<td>UPMC Health Network Providers</td>
</tr>
<tr>
<td>Blood And Blood Products</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Clinical Trials: Provided service is not Experimental/ Investigative or covered under a grant for the clinical trial.</td>
<td>80% after deductible</td>
<td>UPMC Health Plan Network Providers</td>
</tr>
</tbody>
</table>
### Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>UPMC Advantage Network (Home Host)</th>
<th>Other UPMC Health Plan Facilities</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services: Related to Accidental Injury to sound and natural teeth. Services must be provided within 30 days after date of accidental injury.</td>
<td>80% after deductible UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Physician Services</td>
<td>80% after deductible UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Hospital related services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Oral Surgical Services</td>
<td>80% after deductible UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Physician Services</td>
<td>80% after deductible UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Hospital related services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>80% after deductible UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>80% after deductible UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>80% after deductible UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Refer to the Prescription Drug Program section</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Corrective Appliances</td>
<td>80% after deductible UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Hospital related services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Therapeutic Manipulation: covered up to 25-visits/benefit period.</td>
<td>100% after $30 Copayment for first visit; then 100% after $20 Copayment/visit thereafter UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>100% after $25 Copayment/visit UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Fertility Testing</td>
<td>80% after deductible UPMC Health Plan Network Providers</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Nutritional Supplements: Limited to the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.</td>
<td>80% (deductible does not apply)</td>
<td>60% (deductible does not apply)</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diabetic Equipment, Supplies, and Education</td>
<td>Must be obtained at a Participating Pharmacy. 100% after Copayment, if applicable.</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

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**UPMC**

**61** Summary Plan Description Handbook – Welfare Benefits Plan – 04/03
### General Mental Illness

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>UPMC Health Plan Network</th>
<th>Out-Of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Services:</strong> Contact Western Behavioral Health Care Network 1-888-251-0083</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>30 days maximum per benefit period, ninety (90) days lifetime maximum. 30 (30) inpatient days may be exchanged on a 1:2 basis to secure up to 60 transitional partial hospitalization days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>100% after $20 Copayment/visit</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Limit 20 visits per Benefit Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group visits and 15 minute medication visits count as ½ visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Chemical Dependency: Contact Western Behavioral Health Care Network 1-888-251-0083

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>UPMC Health Plan Network</th>
<th>Out-Of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Detoxification</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>7 days Maximum per admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum of four admissions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>30 days Maximum per Benefit Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum 90 days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitation</strong></td>
<td>100% after $20 Copayment/visit</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>60 full-session visits or equivalent partial visits per Benefit Period and 120 full-session visits or equivalent partial visits per lifetime.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-hospital Residential Alcohol or Other Drug Services</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Thirty (30) days per Benefit Period for residential care. Additional days are available in exchange for sessions of outpatient or partial hospitalization on a 2:1 basis to secure up to 15 additional non-hospital, residential alcohol treatment days.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please Note:** For Out-of-Network Providers – the percent of benefit noted is based on UPMC Health Plan reasonable and customary amount. If you go to an out-of-network provider, you may have to pay the difference between the provider’s charge and the UPMC Health Plan payment.
UPMC Open Access PPO Option and Benefit Summary
The UPMC Open Access PPO product offers Members the choice of two levels of health care benefits for most eligible medical services. A higher level of benefit reimbursement is generally provided when services are delivered by UPMC Health Plan Network Providers, also known as Participating Providers, for facility and professional services. Benefit reimbursement is also provided for services delivered by Out-of–Network Providers, also known as Non-Participating Providers.

The following benefit summary shows how the Health Plan pays benefits under the UPMC Open Access PPO option.

**Benefit Summary:  UPMC Open Access PPO**

<table>
<thead>
<tr>
<th>BENEFIT PERIOD</th>
<th>UPMC HEALTH PLAN NETWORK</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANNUAL DEDUCTIBLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$200</td>
<td>$500</td>
</tr>
<tr>
<td>Family</td>
<td>$400</td>
<td>$1,000</td>
</tr>
<tr>
<td>COINSURANCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>ANNUAL OUT-OF-POCKET MAXIMUM—All amounts are based on reasonable &amp; customary charges</td>
<td>UPMC HEALTH PLAN NETWORK</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>$8,000</td>
</tr>
<tr>
<td>LIFETIME MAXIMUM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$2,000,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>PRE-EXISTING CONDITION LIMITATIONS</td>
<td>UPMC HEALTH PLAN NETWORK</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>PRIMARY CARE PHYSICIAN (PCP) REQUIRED</td>
<td>UPMC HEALTH PLAN NETWORK</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>PRECERTIFICATION REQUIREMENTS</td>
<td>UPMC HEALTH PLAN NETWORK</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td></td>
<td>Provider Responsibility</td>
<td>Member Responsibility—Required for select services at Out-of-Network Providers. $500 financial penalty for failure to comply.</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>UPMC HEALTH PLAN NETWORK</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
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<td>--------------------------</td>
</tr>
<tr>
<td><strong>HOSPITAL SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-Private Room</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Private Room if Medically Necessary and Appropriate</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Surgery</td>
<td>100% after deductible</td>
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<tr>
<td>Pre-Admission Testing</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
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<tr>
<td><strong>EMERGENCY ROOM SERVICES</strong></td>
<td>100% after $30 Copayment per visit (Copayment waived and inpatient stay paid at highest level if admitted) Call UPMC Health Plan Member Services if admitted to a non-participating facility.</td>
<td></td>
</tr>
<tr>
<td>Mammogram (based on age guidelines)</td>
<td>100% (deductible does not apply)</td>
<td>70% (deductible does not apply)</td>
</tr>
<tr>
<td>X-ray, Lab and Other Tests</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC SERVICES:</strong> Inpatient &amp; Outpatient Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
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<td>Adult Routine Physical Examinations</td>
<td>100% after $5 Copayment/visit</td>
<td>70% after deductible</td>
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<td>Adult Immunizations</td>
<td>100% when medically necessary</td>
<td>70% after deductible when medically necessary</td>
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<tr>
<td><strong>PHYSICIAN SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Care and Immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Physical Exam</td>
<td>100% after $5 Copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Pediatric Immunizations</td>
<td>100% (deductible does not apply)</td>
<td>70% (deductible does not apply)</td>
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<tr>
<td>Well-Baby Visits</td>
<td>100% after $5 copayment/visit</td>
<td>70% after deductible</td>
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<td>Specialist Office Visit</td>
<td>100% after $15 Copayment per visit</td>
<td>70% after deductible</td>
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<td>Physician Surgical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Surgery: Vasectomy, Tubal Ligation, Mastectomy/Reconstructive Surgery</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Second Surgical Opinion Services</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>UPMC HEALTH PLAN NETWORK</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td><strong>Physician Medical Care Services</strong></td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Inpatient Medical Care Visits and Intensive Medical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation (Inpatient)</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Women’s Care: Annual Gynecologic Exam, Breast Exam, and Pap Test, Mammogram (based on age guidelines), Maternity Care, Diagnostic Tests and Surgical Services.</td>
<td>100% after $5 Copayment/gynecologic exam; 100% after $10 copayment/illness visit; 100% pap test &amp; mammogram (deductible does not apply)</td>
<td>70% after deductible. Routine gynecologic exam, Pap test and mammogram not subject to deductible.</td>
</tr>
<tr>
<td><strong>Allergy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Treatment Including Injections and Serum</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>REHABILITATION THERAPY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Speech, And Occupational Therapy</td>
<td>100% after $10 Copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered up to the greater of: 60 consecutive days OR 25 visits per condition, per Benefit Period, for all three therapies combined subject to ongoing Substantial Improvement.</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>100% after $10 Copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Covered up to 12 weeks per Benefit Period</td>
<td>70% after deductible</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
<td>100% after $10 Copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Covered up to 24 Visits per Benefit Period</td>
<td>70% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAL THERAPY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Dialysis Treatment</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>PAIN MANAGEMENT PROGRAMS</strong></td>
<td>100% after $15 Copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>OTHER MEDICAL SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Covered up to 90 days Maximum per Benefit Period</td>
<td>70% after deductible</td>
<td></td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>UPMC HEALTH PLAN NETWORK</td>
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</tr>
<tr>
<td>Podiatry Services</td>
<td>100% after $25 copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Fertility Testing</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Nutritional Supplements: Limited to the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria</td>
<td>100% (deductible does not apply)</td>
<td>70% (deductible does not apply)</td>
</tr>
<tr>
<td>Diabetic Equipment, Supplies, And Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucometer, Test Strips, Lancets, Insulin And Syringes</td>
<td>Must be obtained at a Participating Pharmacy. 100% after Copayment, if applicable.</td>
<td></td>
</tr>
<tr>
<td>Diabetic Education</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Blood And Blood Products</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Clinical Trials: Provided service is not experimental/investigative or covered under a grant for the clinical trial.</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Dental Services: Related to accidental injury to sound and natural teeth. Services must be provided within 30 days after date of accidental injury.</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Oral Surgical Services</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Refer to the Prescription Drug Program section</td>
<td></td>
</tr>
<tr>
<td>Corrective Appliances</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Therapeutic Manipulations: Covered up to 25-visits/benefit period.</td>
<td>100% after $30 copayment for first visit; then 100% after $15 copayment/visit thereafter</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Mental Health Services: Contact Western Behavioral Health Care Network 1-888-251-0083</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>30 days maximum per benefit period, ninety (90) day lifetime maximum. Thirty (30) inpatient days may be exchanged on a 1:2 basis secure up to 60 transitional partial hospitalization days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after $25 Copayment/visit</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Limit 20 visits per Benefit Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group visits and 15-minute medication visits count as ½ visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>UPMC Health Plan Network</th>
<th>Out-Of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Detoxification</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>7 days Maximum per admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lifetime Maximum of four admissions</td>
<td></td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>30 days Maximum per Benefit Period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lifetime Maximum 90 days.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>100% after $25 copayment/visit</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>60 full-session visits or equivalent partial visits per Benefit Period and 120 full-session visits or equivalent partial visits per lifetime.</td>
<td></td>
</tr>
<tr>
<td>Non-hospital Residential Alcohol or Other Drug Services</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>Thirty (30) days per Benefit Period for residential care. Additional days are available in exchange for sessions of outpatient or partial hospitalization on a 2:1 basis to secure up to 15 additional non-hospital, residential alcohol treatment days.</td>
<td></td>
</tr>
</tbody>
</table>

**Please Note:** For Out-of-Network Providers – the percent of benefit noted is based on UPMC Health Plan reasonable and customary amount. If you go to an out-of-network provider, you may have to pay the difference between the provider’s charge and the UPMC Health Plan payment.
UPMC Out-of-Area PPO Option and Benefit Summary
The following describes the networks associated with the UPMC Out-of-Area PPO plan. The benefit summary shows how the Health Plan pays benefits under this PPO option.

The UPMC Out-of-Area PPO product offers Members the choice of two levels of health care benefits for most eligible medical services. A higher level of benefit reimbursement is generally provided when services are delivered by contracted Network Providers, also known as Participating Providers. Benefit reimbursement is also provided for services delivered by Out-of-Network Providers, also known as Non-Participating Providers, however at a lower benefit level.

Selection Of Providers for the Out-of-Area PPO Plan
Hospital or Facility/Other Providers
A Member covered under the UPMC Out-of-Area PPO plan has the option of choosing Providers for Covered Services. Members must go to a Participating Hospital or Facility/Other Provider in order to receive the highest benefit payment.

Use of a Non-Participating Hospital or Facility for non-Emergency Services, without prior approval of UPMC Health Plan, or its designated agent, will be reimbursed at a lower benefit level and in some instances may not be covered. Moreover, some Inpatient and Outpatient services and procedures require pre-notification or pre-certification for payment. Failure to notify UPMC Health Plan, prior to receipt of certain non-Emergency Services at a Non-Participating Facility, will result in the Member being assessed a significant financial penalty.

Participating and Non-Participating Professional Providers
A Member covered under the UPMC Out-of-Area PPO plan has the option of choosing where and to whom to go for Covered Services among Providers. Members must go to a Participating Provider to receive the highest benefit payment.

Use of Non-Participating Providers for non-Emergency Services without prior approval of UPMC Health Plan or its designated agent, will be reimbursed at a lower benefit level and in some instances may not be covered.

UPMC Out-of-Area PPO Network Resources
If you live outside the Advantage Network area and are enrolled in the UPMC Out-of-Area PPO plan, two levels of benefits are available in the UPMC Out-of-Area PPO plan.

For members living in western Pennsylvania: the higher level of benefits is obtained when a UPMC Health Plan participating provider or facility is used. The UPMC Health Plan network encompasses other facilities in addition to those owned by UPMC (UPMC Advantage network). Benefits also are available, although at a reduced level, when a non-UPMC Health Plan participating provider is used.
For members who live outside western Pennsylvania (Health Plan network area) you have access to an expanded network of providers. Several networks are available to receive the highest level of benefits:

- Western Pennsylvania - UPMC Health Plan network
- Ohio - SuperMed Plus
- West Virginia - SelectNet
- Eastern Pennsylvania and the rest of the United States - NPPN network

UPMC Health Plan providers are identified on the Health Plan’s website, www.upmchealthplan.com. Click on the online Provider Directory link to locate a facility or provider near you. If one is not available, access the Out-of-Area link on the website. This will connect you with additional networks that have been contracted by UPMC Health Plan to provide additional network coverage to out-of-area Health Plan members. If you do not have access to the Internet, contact UPMC DirectLink at 1-800-994-2752 (select option 2; followed by option 1) to locate a participating provider. Health Plan Member ID cards contain the logos for participating networks. Providers participating in the identified networks should accept the UPMC Health Plan ID cards. If there are any questions, you or the provider can call the Health Plan’s Member Service number listed on the ID card.

Please Note: Staff living in an area where both UPMC Health Plan providers or facilities and contracted network providers are available will need to use UPMC Health Plan Network providers or facilities in order to receive the highest level of benefit.
Benefit Summary: UPMC Out-of-Area PPO Plan

Benefits for the UPMC Out-of-Area PPO are consistent with the UPMC Open Access PPO Plan. Refer to the Benefit Summary below for a summary of covered services.

The Out-of-Area PPO plan is distinct from the Open Access Plan in identifying Participating Providers. The Out-of-Area PPO plan uses the additional contracted networks to supplement UPMC Health Plan’s Provider Network in areas outside of western Pennsylvania.

**BENEFIT PERIOD**

<table>
<thead>
<tr>
<th></th>
<th>UPMC HEALTH PLAN NETWORK or Contracted Network Outside of western Pennsylvania</th>
<th>OUT-OF-Network PROVIDERS</th>
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<tbody>
<tr>
<td><strong>ANNUAL DEDUCTIBLE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$200</td>
<td>$500</td>
</tr>
<tr>
<td>Family</td>
<td>$400</td>
<td>$1,000</td>
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</table>

**COINSURANCE**

<table>
<thead>
<tr>
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<th>UPMC HEALTH PLAN NETWORK or Contracted Network Outside of western Pennsylvania</th>
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<tbody>
<tr>
<td>100%</td>
<td></td>
<td>70%</td>
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</tbody>
</table>

**ANNUAL OUT-OF-POCKET MAXIMUM—All amounts are based on reasonable & customary charges**

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<tbody>
<tr>
<td>Individual</td>
<td>None</td>
<td>$4,000</td>
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<tr>
<td>Family</td>
<td>None</td>
<td>$8,000</td>
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**LIFETIME MAXIMUM**

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<tbody>
<tr>
<td></td>
<td>$2,000,000</td>
<td>$300,000</td>
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**PRE-EXISTING CONDITION LIMITATIONS**

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<tr>
<td></td>
<td>None</td>
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</table>

**PRIMARY CARE PHYSICIAN (PCP) REQUIRED**

<table>
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<tbody>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>PRECERTIFICATION REQUIREMENTS</td>
<td>UPMC HEALTH PLAN NETWORK or Contracted Network Outside of western Pennsylvania</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Provider Responsibility</td>
<td>Member Responsibility—Required for select services at Out-of-Network Providers. $500 financial penalty for failure to comply.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<td>70% after deductible</td>
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<tr>
<td><strong>EMERGENCY ROOM SERVICES</strong></td>
<td>100% after $30 Copayment per visit (Copayment waived and inpatient stay paid at highest level if admitted) Call UPMC Health Plan Member Services if admitted to a non-participating facility.</td>
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<td>Mammogram (based on age guidelines)</td>
<td>100% (deductible does not apply)</td>
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<td>X-ray, Lab and Other Tests</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
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<td>Preventive Care</td>
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<td>Adult Routine Physical Examinations</td>
<td>100% after $5 Copayment/visit</td>
<td>70% after deductible</td>
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<td>Adult Immunizations</td>
<td>100% when medically necessary</td>
<td>70% after deductible when medically necessary</td>
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<tr>
<td>Pediatric Care and Immunizations</td>
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<tr>
<td>Routine Physical Exam</td>
<td>100% after $5 Copayment</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Pediatric Immunizations</td>
<td>100% (deductible does not apply)</td>
<td>70% (deductible does not apply)</td>
</tr>
<tr>
<td>Well-Baby Visits</td>
<td>100% after $5 Copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Physician Office Visit: for treatment of medical disease or injury</td>
<td>100% after $10 Copayment per visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>100% after $15 Copayment per visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>UPMC HEALTH PLAN NETWORK or Contracted Network Outside of western Pennsylvania</td>
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<td>Surgery</td>
<td>100% after deductible</td>
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<td>Special Surgery—Vasectomy, Tubal Ligation, Mastectomy/Reconstructive Surgery</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Second Surgical Opinion Services</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>Physician Medical Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Medical Care Visits and Intensive Medical Care</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Consultation (Inpatient)</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Women’s Care: Annual Gynecologic Exam, Breast Exam, and Pap Test, Mammogram (based on age guidelines), Maternity Care, Diagnostic Tests and Surgical Services.</td>
<td>100% after $5 Copayment/gynecologic exam; 100% after $10 copayment/illness visit; 100% pap test &amp; mammogram (deductible does not apply)</td>
<td>70% after deductible. Routine gynecologic exam, Pap test and mammogram not subject to deductible.</td>
</tr>
<tr>
<td><strong>Allergy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Treatment Including Injections and Serum</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>REHABILITATION THERAPY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Speech, And Occupational Therapy</td>
<td>100% after $10 Copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><em>Covered up to the greater of: 60 consecutive days OR 25 visits per condition, per Benefit Period, for all three therapies combined subject to ongoing Substantial Improvement.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><em>Covered up to 12 weeks per benefit period</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
<td>100% after $10 Copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><em>Covered up to 24 Visits per Benefit Period</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>UPMC HEALTH PLAN NETWORK or Contracted Network Outside of western Pennsylvania</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>MEDICAL THERAPY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Dialysis Treatment</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>PAIN MANAGEMENT PROGRAMS</strong></td>
<td></td>
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<tr>
<td></td>
<td>100% after $15 copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>OTHER MEDICAL SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>100% after deductible, Covered up to 90 days Maximum per Benefit Period</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>100% after $25 copayment/visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Fertility Testing</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Nutritional Supplements: Limited to the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria</td>
<td>100% (deductible does not apply)</td>
<td>70% (deductible does not apply)</td>
</tr>
<tr>
<td>Diabetic Equipment, Supplies, And Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucometer, Test Strips, Lancets, Insulin And Syringes</td>
<td>Must be obtained at a Participating Pharmacy. 100% after Copayment, if applicable</td>
<td></td>
</tr>
<tr>
<td>Diabetic Education</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Blood And Blood Products</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Clinical Trials: Provided service is not experimental / investigative or covered under a grant for the clinical trial.</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Dental Services: Related to accidental injury to sound and natural teeth. Services must be provided within 30 days after date of accidental injury.</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>UPMC HEALTH PLAN NETWORK or Contracted Network Outside of western Pennsylvania</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Oral Surgical Services</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Refer to the Prescription Drug Program section</td>
<td></td>
</tr>
<tr>
<td>Corrective Appliances</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Therapeutic Manipulations - Covered up to 25 visits/benefit period</td>
<td>100% after $30 copayment for first visit; then 100% after $15 copayment/visit thereafter</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

Mental Health Services: Contact Western Behavioral Health Care Network 1-888-251-0083

**General Mental Illness**

Inpatient
100% after deductible 70% after deductible
30 days maximum per benefit period, ninety (90) day lifetime maximum.
Thirty (30) inpatient days may be exchanged on a 1:2 basis secure up to 60 transitional partial hospitalization days.

Outpatient
100% after $25 Copayment/visit
50% after deductible
Limit 20 visits per Benefit Period
Group visits and 15 minute medication visits count as ½ visit.

Chemical Dependency: Contact Western Behavioral Health Care Network 1-888-251-0083

Inpatient Detoxification
100% after deductible 70% after deductible
7 days Maximum per admission
Lifetime Maximum of four admissions

Inpatient Rehabilitation
100% after deductible 70% after deductible
30 days Maximum per Benefit Period
Lifetime Maximum 90 days.

Outpatient Rehabilitation
100% after $25 copayment/visit
50% after deductible
60 full-session visits or equivalent partial visits per Benefit Period and 120 full-session visits or equivalent partial visits per lifetime.

Non-hospital Residential Alcohol or Other Drug Services
100% after deductible 70% after deductible
Thirty (30) days per Benefit Period for residential care.
Additional days are available in exchange for sessions of outpatient or partial hospitalization on a 2:1 basis to secure up to 15 additional non-hospital, residential alcohol treatment days.

**Please Note:** For Out-of-Network Providers – the percent of benefit noted is based on UPMC Health Plan reasonable and customary amount. If you go to an out-of-network provider, you may have to pay the difference between the provider’s charge and the UPMC Health Plan payment.
Covered Services Under All Medical Options

The Health Plan pays benefits — up to the reasonable and customary charge or negotiated fee — for medically necessary eligible expenses. The benefit summary for your coverage option provides details as to how the Health Plan pays benefits for each covered service. It also includes any benefit limits or copay requirements that may apply.

Description Of Benefits
You are entitled to receive the benefits listed below, subject to the exclusions, conditions, and limitations of this document. You are entitled to benefits for Medically Necessary and Appropriate services rendered by a Hospital, Facility/Other Provider, Professional Provider or Professional/Other Provider in the amounts specified in the appropriate Benefit Summary section. Different levels of benefits will apply, depending on your selected medical plan and whether care is received at a UPMC Advantage Network facility provider, at a UPMC Health Plan facility or at a non-network facility provider. Care or services received at or by UPMC Health Plan Network non – Hospital providers, including Professional Providers will be reimbursed at the same benefit level in the amounts specified in the appropriate Benefit Summary.

Hospital Services
Coverage exists for the following hospital related services:

Inpatient
Unlimited Inpatient days in a Hospital or facility, including:
- A semi-private room and board
- A private room and board when determined to be Medically Necessary and Appropriate.
- General nursing care
- Ancillary services and supplies relating to the Inpatient stay.

Emergency Accident/ Medical Care
Hospital services and supplies for Inpatient or Outpatient treatment of an emergency. Coverage for Emergency Services will be determined under the Prudent Layperson standard. The prudent layperson standard considers the symptoms of the Member and includes the following:

Any health care service provided to a Member after sudden onset of a medical condition that manifest itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the Member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment of bodily function, or (3) serious dysfunction of any bodily organ or part.
Emergency Services are not subject to prior approval although Members are expected to coordinate care through their selected PCP (Advantage HMO members) or the Health Plan’s Member Service Department (all PPO plan members) to ensure payment at the highest level of reimbursement, unless the situation is so critical that care needs must be treated immediately. In this case, the Member should proceed to call “911” or go to the nearest hospital emergency room. Services will be reimbursed at the highest coordinated care level. They are then required to call the PCP or Member Services, depending on the medical plan enrolled in, within 24 hours or as soon as reasonably possible. If the Member is out of the Network Service Area at the time Emergency Services are needed, the Member should follow the same procedures. Emergency accident/medical care is available 24 hours a day, seven days a week.

Routine or non-Emergency Services provided in the emergency room will not be covered at the higher benefit level, unless specifically authorized by the Member’s PCP or Health Plan’s Member Service Department, depending on medical plan, and delivered by a Participating Provider. Routine care will be paid at the lower level of benefits if it could have been anticipated prior to leaving the Network Service Area.

If a Member is admitted to a Non-Participating facility for emergency services, the Member must contact their PCP (if Advantage HMO Member), and/or UPMC Health Plan (if a PPO Member) within 24 hours or as soon as reasonably possible. UPMC Health Plan will contact the treating Physician and facility. In some cases, where it is medically safe to do so, the Member may be required to transfer to a Participating Facility Provider.

**Surgery**
- Hospital services and supplies for Outpatient Surgery.
- Pre-Admission Testing
- Tests and studies required in advance of a Member's admission to the Hospital, performed on an Outpatient basis.

**Surgical/Medical Services**
Coverage exists for the following surgical/medical services:

**Surgical Services**
- Surgery required for treatment of disease or injury.
- Special Surgery
  - Vasectomy;
  - Tubal Ligation.
- Mastectomy/Reconstructive Surgery benefits include: reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.
- Surgical Assistant Services are covered for a Physician who assists the operating surgeon, only if an intern, resident or house staff member is not available.
• Anesthesia supplies, services, and administration at a Hospital or Facility/Other Provider. Anesthesia must be ordered and provided by an attending Professional Provider other than the surgeon or assisting surgeon.

• Second Surgical Opinion: Members may be covered for a second surgical opinion at their option upon the recommendation to perform Surgery in order to confirm the need for recommended elective Surgery. The Surgery cannot represent an emergency.

**Inpatient Medical Services**
Medical care by a professional provider to a Member who is a hospital inpatient for a condition not related to surgery, pregnancy, or behavioral health, except as specifically provided.

• Routine Visits by the admitting Physician to follow the Member’s care.

• Intensive Medical Care rendered to a Member whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

• Consultation services requested by the attending Physician.

• Care of a Newborn when a Member is admitted for delivery.

**Outpatient Medical Care Services**
Medical care rendered by a professional provider to a Member as an outpatient for a condition not related to surgery, pregnancy, mental health services or chemical dependency services except as specifically provided.

Medical care visits and consultation for the examination, diagnosis and treatment of an injury or illness.

**Emergency Accident/Medical Care Services**
Emergency services rendered by a professional provider to a Member. Coverage for emergency services will be determined under the prudent layperson standard. Any health care service provided to a Member after sudden onset of a medical condition that manifest itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the Member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment of bodily function, or (3) serious dysfunction of any bodily organ or part.

**Blood and Blood Products**
Administration costs of blood and blood plasma. Autologous transfusion services. Packed red blood cells, cryoprecipitate, Factor VII and platelets are covered. Other clotting factors or blood components, such as Factor VIII or Factor IX, whether naturally or artificially derived, are covered only for acute traumatic events or when Medically Necessary and Appropriate.
Clinical Trials
Medically Necessary and Appropriate services required as part of clinical trials, provided the service/drug/therapy is not considered Experimental/Investigative and/or or covered under the grant for the clinical trial.

Pediatric Care and Immunizations
- Coverage for well childcare and routine physical examinations when Medically Necessary and Appropriate.
- Coverage for newborns for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care for the first thirty-one (31) days after birth. **NOTE: Members must notify the UPMC Employee Service Center of the birth of a newborn child and desire to continue coverage under the plan within 30 days after the date of birth in order to have the coverage continue beyond the initial 31-day coverage period.**
- Coverage for Medically Necessary and Appropriate booster doses of all immunizing agents used in pediatric immunizations.
- Pediatric immunizations are exempt from Deductible and dollar limit provisions.

Adult Routine Physical Examination
- A complete adult medical history and routine physical examination.
- Adult immunizations when Medically Necessary and Appropriate.

Office Visits for Sick Care: PCP (HMO members)/Doctors (PPO members)
Evaluation, examination, diagnosis, services and necessary supplies required to treat basic medical diseases and injuries.

Specialist Office Visits
Evaluation, examination, diagnosis, services and necessary supplies required to treat medical diseases and injuries when they require the care of a specialist.

Women’s Care
Annual gynecological examinations, including pelvic examination, breast examination, and routine Pap smears (in accordance with the recommendations of the American College of Obstetricians and Gynecologists).

If Women’s Care is not provided by the Member’s PCP, a referral from the PCP is not required to receive Coordinated Care benefit levels when the gynecological exam and/or testing are performed by the Member’s selected OB/GYN. If the Member self-refers to a Participating OB/GYN, care will be reimbursed at the Self-Referred In-Network. Treatment includes all Medically Necessary and Appropriate, covered obstetrical and gynecological services, including Outpatient and Inpatient admissions.

Allergy Services
Diagnostic testing and treatment including injections and serum.
**Cancer Treatment**
Cancer Chemotherapy and cancer hormone treatments, which have been approved by the United States Food and Drug Administration for general use in treatment of cancer, whether performed in a Physician's office, in an Outpatient department of a Hospital, in a Hospital as a Hospital Inpatient or in any other Medically Necessary and Appropriate treatment setting.

**Diagnostic Services**
Benefits will be provided for Medically Necessary and Appropriate x-ray, laboratory, and pathology tests, procedures, services and materials when such services are ordered by a Participating Physician or Professional/Other Provider.

**Mammographic Screening**
Benefits will be provided for the following Covered Services in the amounts specified in the Schedule of Benefits.

Yearly mammographic screening for all female Members 40 years of age or older and for women under 40 years of age based on a Physician's recommendation.

**Rehabilitation Therapy Services**
Rehabilitative Therapy Services, including Physical Therapy, Occupational Therapy, and Speech Therapy, delivered in an acute care Hospital, Skilled Nursing Facility, Rehabilitation Hospital or Outpatient setting when the primary reason for the admission or Visit is for the purpose of receiving Physical, Speech, or Occupational Therapy. The services must be anticipated to provide Substantial Improvement in the Member's medical condition and delivered at the appropriate level of care. Services are covered up to the greater of: Maximum numbers of consecutive days of coverage, or Maximum numbers of Visits, per condition, per Benefit Period, for all three therapies combined, subject to ongoing Substantial Improvement. Specific to Physical Therapy, services are limited to four (4) therapies per day. See the Schedule of Benefits for Benefit Maximums.

Coverage is also provided for Outpatient cardiac and Pulmonary Rehabilitation services provided such services are authorized for payment in accordance with UPMC Health Plan’s applicable policies and procedures. Outpatient Cardiac Rehabilitation is limited to a maximum of twelve (12) weeks and Outpatient Pulmonary Rehabilitation is limited to twenty-four (24) visits per benefit period.

Pain Management/Rehabilitation Management Programs are covered for medical conditions provided such services are authorized in accordance with UPMC Health Plan’s applicable policies and procedures. The services must be anticipated to provide substantial improvement in the Member’s medical condition.

**Medical Therapy Services**
Medical Therapy Services, including Chemotherapy, Radiation, and Infusion Therapy and Dialysis Treatments delivered at the appropriate level of care.
Maternity Services – Newborn & Mothers Health Protection Act
Hospital Services and Surgical/Medical Services rendered by a Hospital, Facility/Other Provider, Professional Provider, or Professional/Other Provider are covered for maternity care and nursery care of the newborn child. This includes pre-and post-natal care, complications of Pregnancy, and childbirth.

Members are covered for Hospital Services associated with childbirth for the mother or newborn child for at least 48 hours following a normal vaginal delivery.

Members are covered for Hospital Services associated with childbirth for the mother or newborn child for at least 96 hours following a cesarean section.

Members are covered for one home health care Visit within 48 hours after early discharge, if the treating or attending Physician determines that the mother and newborn meet medical criteria for safe discharge. Early discharge is defined as discharge that occurs prior to 48 hours of Inpatient care following normal vaginal delivery and 96 hours of Inpatient care following Cesarean delivery.

Mental Health Services

Inpatient Facility Services
Members are covered for a Maximum number of days per benefit period, and a maximum number of days per lifetime for inpatient treatment by a hospital or facility/other provider. Refer to the Benefit Summary sections for benefit maximums.

A Maximum number of inpatient days may be exchanged on a one-for-two basis to secure up to a Maximum number of Transitional Partial Hospitalization days. Refer to the Benefit Summary sections for Benefit Maximums.

Inpatient Services
Covered Services include but are not limited to:

- Individual, Group and Family Psychotherapy/Counseling,
- Semi-private room and board,
- Drugs and medications, including electro convulsive treatment if Medically Necessary and Appropriate,
- Medical supplies and services, and
- Diagnostic and other therapeutic services.

Outpatient Services
Members are covered up to a Maximum number of individual Visits per Benefit Period. Group Visits and 15-minute medication Visits are counted as one-half Visit. Refer to the Schedule of Benefits for Benefit Maximum.

Psychological Testing/Neuropsychological Testing
Testing is covered for Medically Necessary and Appropriate purposes only, as determined by a UPMC Health Plan Participating Provider or designee.
Chemical Dependency Services

Inpatient Services
Inpatient services are covered for Chemical Dependency detoxification for a Maximum of seven (7) days per admission and a lifetime Maximum of four (4) admissions for detoxification. Inpatient detoxification is provided either in a Hospital or in an Inpatient non-hospital facility which has a written affiliation agreement with a Hospital for emergency, medical and psychiatric or psychological support services, meets minimum standards for client-to-staff ratios and staff qualifications which shall be established by the Department of Health and is licensed as an alcoholism and/or drug addiction treatment program.

Rehabilitative Services
Members are covered for rehabilitative services in a Chemical Abuse Treatment Facility for non-Hospital Inpatient therapy for thirty (30) days per Benefit Period. Additional days are available in exchange for sessions of Outpatient or partial hospitalization on a two-to-one basis to secure up to fifteen additional non-hospital, residential alcohol treatment days. Benefits are limited to ninety (90) days per lifetime. Treatment is provided in a facility which meets minimum standards for client-to-staff ratios and staff qualifications which are established by the Bureau of Drug and Alcohol Programs and is appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Before the Member may qualify to receive benefits under this section, a licensed Physician or licensed Behavioral Health professional must certify the Member as a person suffering from alcohol or other Chemical Abuse or Chemical Dependence and refer the Member for the appropriate treatment.

Inpatient and Rehabilitative Services
Inpatient and rehabilitative services in a facility include, but are not limited to:

- Lodging and dietary services,
- Physician, Psychologist, nurse, certified addictions counselor and trained staff services,
- Diagnostic x-ray,
- Psychiatric, psychological and medical laboratory testing, and
- Drugs, medicines, equipment use and supplies.

Outpatient Rehabilitation Services
Outpatient rehabilitation services for the treatment of Chemical Dependency are covered for a maximum of sixty (60) days full-session visits or equivalent partial visits per year and 120 full-session visits or equivalent partial visits per lifetime. Treatment is provided in a facility appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Before a Member may qualify to receive benefits under this section, a licensed Physician or licensed Behavioral Health professional must certify the Member as a person suffering from alcohol or other Chemical Dependence and refer Member for the appropriate treatment.
Outpatient rehabilitation services include, but are not limited to:

- Physician, Psychologist, nurse, certified addictions counselor and trained staff services,
- Rehabilitation therapy and counseling,
- Family Counseling and intervention,
- Psychiatric, psychological and medical laboratory tests, and
- Drugs, medicines, equipment use and supplies.

Ambulance Service
Ambulance Service is covered when using a specially equipped vehicle used only for transporting the sick and injured, and when rendered in accordance with UPMC Health Plan’s applicable policies and procedures. Services include transportation to the nearest Hospital able to treat the condition; transportation between Hospitals; and transportation between Hospitals and Skilled Nursing Facilities.

Private Duty Nursing Services
Private Duty Nursing Services of an actively practicing Registered Nurse (RN) or a Licensed Practical Nurse (LPN) are covered only when authorized for payment in accordance with UPMC Health Plan’s applicable policies and procedures.

Skilled Nursing Facility Services
Inpatient days in a Skilled Nursing Facility (semi-private rooms only) are covered when:

- The admission is arranged by the Member’s Primary Care Physician;
- The Member’s medical condition is such that the Member requires skilled care twenty-four (24) hours per day;
- The skilled services are provided either directly by or under the supervision of a licensed medical professional: e.g. Registered Nurse, Physical Therapist, Licensed Practical Nurse, Occupational Therapist, Speech Pathologist, or Audiologist with the treatment described and documented in the Member’s medical record; and
- The care could not be performed by a non-medical individual instructed to deliver such services.

Inpatient days in a Skilled Nursing Facility shall be limited to a Maximum number of days per Benefit Period when the primary reason for the admission is to receive skilled Medical Care. Refer to the Schedule of Benefits for Benefit Maximums. If the primary reason for the admission is to receive rehabilitative care, i.e. Physical, Occupational, and/or Speech Therapy, Inpatient days in a Skilled Nursing Facility shall be limited to a maximum number of consecutive days of coverage, per condition, per Benefit Period. Refer to the Schedule of Benefits for Benefit Maximums.
Home Health Care
Care of a skilled nature provided by a Home Health Care Agency, or a Hospital program for home health care. Covered Services include, but are not limited to:

- Skilled Nursing Services/Skilled Rehabilitation Services,
- Physical Therapy, Occupational Therapy, and Speech Therapy,
- Non-disposable medical and surgical supplies, including oxygen,
- Medical social service consultations, and
- Health aide services when the Member is receiving skilled nursing or therapy care.

Services must be arranged in accordance with UPMC Health Plan’s policies and procedures.

Hospice Care Services
Hospice Care services and supplies delivered on either an Inpatient or Outpatient basis when provided by a Hospice or a Hospital program for Hospice Care. Members are covered for the full service of a participating Hospice when there is a life expectancy of 180 days or less, as determined by the attending Physician.

Each Covered Service or supply must be furnished within six (6) months from the date the Member entered the Hospice program, and ordered and approved by the Physician directing the Hospice program.

Dental Services Related To Accidental Injury
Emergency care of accidental injury to sound, natural teeth during the first thirty (30) days after accidental injury. Injury as a result of chewing or biting is not considered an accidental injury. All other dental services are excluded.

Oral Surgical Services
Oral surgical services required for:
- Removal of impacted third molars which are partially or totally covered by bone;
- Exclusion of malignant lesions/tumors of the mandible; mouth, lip or tongue;
- Reduction or manipulation of fractures of facial bones;
- Incision of accessory sinuses, mouth, salivary glands, or ducts;
- Manipulation of dislocations of the jaw;
- Reconstruction or repair of a non-dental physiological condition which has resulted in a severe functional impairment; and
- Other services normally performed by either a Physician or an oral surgeon for conditions common to both medicine and dentistry, as determined by UPMC Health Plan.
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

All other Oral Surgery services are excluded from coverage.
Durable Medical Equipment
Purchase and/or rental of Durable Medical Equipment that meets UPMC Health Plan’s criteria for coverage. Rental or purchase is at the sole discretion of UPMC Health Plan.

Preventive maintenance is covered by UPMC Health Plan when performed by a participating vendor within eleven (11) months of the Member’s receipt of the item and at least every twelve (12) months thereafter, provided the Member remains a UPMC Health Plan Member.

Although UPMC Health Plan will cover the preventive maintenance, it is the Member’s responsibility to ensure that preventative maintenance has been performed at designated intervals. If the Member does not have the preventative maintenance performed, the cost of repairs or replacement is the responsibility of the Member.

Coverage of repairs will be provided when the cost of the repair is less than 50% of the cost of a new item. Replacement coverage will be provided when:

- the cost to repair the item exceeds 50% of the price of a new item,
- Medical Necessity and Appropriateness exists due to a change in the Member’s medical condition,
- there is documentation that preventative maintenance was performed at designated intervals, and
- if the item is lost, the Member provides appropriate documentation of the events and circumstances of the loss.

Repair or replacement coverage is at the sole discretion of UPMC Health Plan. Examples of Durable Medical Equipment include, but are not limited to, Hospital beds, wheelchairs, ventilators, oxygen tanks or concentrators, crutches, walkers, canes, commodes, and suction machines.

Examples of items which do not meet the definition of Durable Medical Equipment and may not be covered include: (1) medical equipment/supplies of an expendable nature, i.e. disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings and dressings; (2) medical equipment/supplies that are primarily used for non-medical purposes, i.e., air conditioners, humidifiers, or electric air cleaners; and (3) equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member, i.e. exercycle or other physical fitness equipment, stair glides, elevators, hoyer lifts, shower/bath bench or “barrier free” home modifications, whether or not specifically recommended by a Professional Provider or Professional/Other Provider.

Corrective Appliances
Corrective Appliances/devices, determined to be the standard to restore basic function, are covered when necessitated due to an injury or disease. Examples of prosthetic appliances include, but are not limited to: artificial limbs, artificial eyes, external breast prosthesis, hip/knee prosthetics, and penile prosthesis. Penile prosthesis must be authorized for payment in accordance with UPMC Health Plan’s policies and procedures. Examples of orthotic devices include, but are not limited to: leg braces and shoes permanently attached to a leg brace. Orthopedic shoes and shoe inserts are covered only when necessitated to prevent foot injury/disease in a Member with diabetes or peripheral vascular disease.
Coverage is provided for the purchase, fitting, and necessary adjustments. The cost of repairs will be covered when the cost is less than 50% of the cost of a replacement item. Replacement coverage will be provided when:

- the cost to repair the current item exceeds 50% of the price of a new item,
- Medical Necessity and Appropriateness exists due to a change in the Member’s medical condition,
- repair of the item is not a feasible option, and
- if the item is lost, the Member provides appropriate documentation of the events and circumstances of the loss.

Repair or replacement coverage is at the sole discretion of UPMC Health Plan.

**Transplantation Services**

Subject to the provisions of this document, benefits will be provided for Covered Services for organ transplantation services. Benefits for a covered transplant procedure include coverage for the medical expenses of a live donor to the extent that those medical expenses are not covered by another program. Transplantations are not covered if they are considered Experimental/Investigative per UPMC Health Plan’s definition of Experimental/Investigative.

If a human organ or tissue transplant is provided from a living donor to a human transplant recipient:

1. When both the recipient and the donor are Members, each is entitled to the benefits of this SPD;
2. When only the recipient is a Member, both the donor and the recipient are entitled to the benefits of this SPD subject to the following additional limitations:
   a. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or any government program, and
   b. Benefits provided to the donor will be charged against the recipient's coverage under this SPD;
3. When only the donor is a Member, the donor is entitled to benefits based on the medical option chosen, subject to the following additional limitations:
   a. The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this SPD, and
   b. No benefits will be provided to the non-Member transplant recipient.
4. If any organ or tissue is sold rather than donated to the Member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Member recipient's contractual limit as set forth in the SPD.
**Therapeutic Manipulation**
Evaluation, spinal x-rays, vertebral adjustment or manipulation, and adjunctive procedures are covered for an initial evaluation and a maximum number of visits thereafter, per benefit period, from any participating provider so licensed. No referral from the Primary Care Physician is required to receive coordinated care benefits, unless the Member is less than 13 years of age. Refer to the Benefit Summary sections for the benefit maximums.

**Podiatry Services**
Routine Podiatry Services provided by a Podiatrist are covered when the Member has a medical condition, such as diabetes or peripheral vascular disease, which warrants specialized podiatric care. Other Covered Podiatry Services include open cutting procedures and removal of nail roots.

**Fertility Testing**
Except as delineated elsewhere in this SPD and under the terms specified in the Benefit Summary sections, Members are covered up to the diagnosis of fertility/infertility. Services provided after the diagnosis of fertility/infertility is made, are the responsibility of the Member.

**Vision Services for a Medical Condition**
Prescription eyewear and the fitting and adjustment of contact lenses are covered only for: cataracts, keratoconus, and aphakic Members. Dilated retinal eye examinations are also covered for Members with Diabetes.

Refer to the *Vision Care Program* section for a summary of the vision benefits.

**Nutritional Supplements**
Nutritional Supplements are covered when administered on an Outpatient basis, either orally or through a tube, for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria. Benefits for such supplements are exempt from any applicable Deductible requirements.

Additional coverage for nutritional supplements administered on an Outpatient basis is provided when considered to be Medically Necessary and Appropriate for the Member’s medical condition and the sole source of nutrition and:

- When provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized, instead of regular shelf food or regular infant formulas; or
- When provided orally, and identified as a formulae with: hydrolyzed (pre-digested) protein or amino acids; specialized content for special metabolic needs, modular components; or standardized nutrients.

These additional benefits are subject to the program Deductible, Copayments and Maximums.

If the above criteria are met, coverage will continue as long as the formulae represents at least 50% of the Member’s daily caloric requirement.
Diabetes Equipment, Supplies and Education
Coverage for the cost of diabetic equipment, supplies and Outpatient self-management training and education including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non insulin using diabetes if prescribed by a Physician.

Equipment and supplies shall include the following:

- Blood Glucose Monitors
- Monitor Supplies
- Insulin
- Injection Aids
- Syringes
- Insulin Infusion Devices
- Pharmacological Agents for Controlling Blood Sugar
- Orthotics

Diabetic Outpatient Self Management Training and Education shall include the following:

- Visits Medically Necessary and Appropriate upon the diagnosis of diabetes,
- Visits whereby a Physician identifies or diagnoses a significant change in the patient’s symptoms or condition that necessitates changes in a patient’s self-management, and
- Visits whereby a new medication or therapeutic process relating to the Member’s treatment and/or management of diabetes has been identified as Medically Necessary and Appropriate by a Physician.
Medical Expenses Not Covered

The Health Plan does not pay benefits for all types of medical expenses.

What The Health Plan Does Not Cover
Your Health Plan covers many expenses, provided they are medically necessary and appropriate to properly treat a medical condition. However, some limits and exclusions apply. The Health Plan does not pay benefits for services or products — other than those noted under Covered Services section.

Not all services, supplies or charges are Covered Services. Remember that an exception to an exclusion means that the service is covered. Except as specifically provided in this SPD, no benefits will be provided for services, supplies, and charges including, but not limited to:

Assisted Fertilization
Artificial conception processes such as, but not limited to, GIFT, ZIFT, embryo transplants, and in-vitro fertilization, reversal of voluntary sterilization procedures, and sex transformation services and procedures.

Behavioral Health Services
Any psychotherapy or psychiatric treatment, or chemical dependency treatment which is court-ordered, unless such services are Medically Necessary and Appropriate for the treatment of a treatable Behavioral Health Disorder.

Inpatient or outpatient treatment related to: mental retardation, pervasive developmental disorder, or autism, which extends beyond traditional medical management.

Treatment for personality disorders as the primary diagnosis, learning disabilities, or behavioral problems and those conditions for which an individual is eligible for Social Security disability benefits for a mental or emotional disability.

Any services related to disorders that are not treatable DSM-IV defined mental disorders. Examples include, but are not limited to, nicotine dependence, caffeine intoxication, stuttering, tension headache, stress reactions, reading disorder, mathematics disorder, pathological gambling, disorder of written expressions, expressive/receptive language disorders, phonological disorder, developmental coordination disorder, learning disorders, sleep disorders, and V codes.

Any treatment/services, including motivational training programs, related to personal or professional growth/development, educational or professional training or certification, or for investigative purposes related to employment.

Any services related to purposes of obtaining or maintaining employment, insurance or for purposes related to judicial or administrative proceedings such as adjudication of marital, child support, or custody cases.

Treatment for organic disorders, including, but not limited to organic brain disease.
Behavioral Health Services not expected to result in demonstrable improvement in the Member’s condition and/or level of functioning, and chronic maintenance therapy.

Treatment for chronic behavioral conditions, once the individual has been restored to the pre-crisis level of function.

Treatment for stress and treatment for co-dependency.

Marriage or family counseling, except when rendered in connection with services provided for a treatable mental health disorder.

Treatment for chronic pain management programs or any related services.

Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies such as art or psychodrama and hyperbaric or other oxygen therapy.

Acupuncture and acupressure.

Aromatherapy, Ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation and yoga.

Sex therapy, without a DSM-IV diagnosis and treatment for sexual addiction.

Sedative action electrostimulation therapy.

Sensitivity training.

Twelve step model programs as sole therapy for problems such as eating disorders or addictive gambling.

Treatment or consultation provided by the Members’ parents, siblings, children, current or former spouse or domiciliary partner.

Truancy or disciplinary problems alone.

Psychoanalysis or other therapies which are not short-term or crisis-oriented.

Psychological and/or Neuro-psychological or Neuro-psychiatric Testing for: (1) learning disabilities/problems; (2) school related issues; (3) the purposes of obtaining or maintaining employment; and (4) the purpose of submitting a disability application for a mental or emotional condition.

**Comfort/Convenience Items**

Health club memberships, air conditioners, television, telephone, de-humidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a Physician.

**Corrective Appliances**

Corrective Appliances primarily intended for athletic purposes or those related to a sports medicine treatment plan, and other appliances/devices, and any related services, including but not limited to, children’s corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, and shoe inserts and orthopedic shoes unless the shoe inserts or orthopedic shoes are required specifically due to diabetes or peripheral vascular disease.
Cosmetic Surgery
Cosmetic Surgery to repair or reshape a body structure for the improvement of the person’s appearance or for psychological or emotional reasons, including, but not limited to, port wine stain, augmentation procedures, reduction procedures, and scar revisions.

Except where covered as part of the Women’s Health and Cancer Rights Act of 1998 (WHCRA) for Mastectomy/Reconstructive Surgery benefits include: reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymph edemas.

Court Ordered
Court ordered services when not Medically Necessary and Appropriate for the Member’s medical condition, as determined by a UPMC Health Plan Physician or designee.

Custodial Care
Custodial Care, domiciliary care, Respite Care and/or rest cures.

Dental Care
Services directly related to treatment of the teeth, extraction of teeth, treatment of dental abscesses or granuloma, treatment of gingival tissues (other than for tumors), dental examinations, and any other dental related product or services. Except as specifically stated as a covered service under the Covered Services, Dental Services Related to Accidental Injury section.

Durable Medical Equipment
Medical equipment/supplies that are (1) of an expendable nature, i.e. disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings and dressings; (2) Primarily used for non-medical purposes, i.e., air conditioners, humidifiers, or electric air cleaners; and (3) basically comfort or convenience items or are primarily for the convenience of a person caring for a Member, (i.e. exercise equipment, stair glides, elevators, hoyer lifts, shower/bath bench, orthopedic mattresses, or home or automobile modifications); whether or not specifically recommended by a Physician or Professional/Other Provider, unless specifically authorized by UPMC Health Plan or its designee.

Experimental/Investigative
Procedures, technologies, treatments, equipment, drugs, and devices which are Experimental/Investigative or which are used as a necessary accompaniment to an Experimental/Investigative procedure/service. Also excluded are Experimental/Investigative drugs/therapy and services that are covered under the grant for a clinical trial.

Food Supplements/Vitamins
Food, food supplements, vitamins (except prenatal vitamins), and other nutritional and over-the-counter electrolyte supplements except as required to treat phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

Genetic Counseling Studies
Genetic counseling and studies which are not Medically Necessary and Appropriate for treatment of a defined medical condition.
**Medical**

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

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

**Hearing Examinations**
All routine hearing examinations and services.

**Home Care**
Home care for chronic conditions such as permanent, irreversible disease, injuries or congenital conditions requiring long periods of care or observation. No coverage is provided for dietary services, homemaker services, maintenance therapy, Custodial Care, and food or home-delivered meals.

**Immunizations and Drugs**
Immunizations and drugs used for prevention of disease when traveling outside of the United States.

**Medically Unnecessary Services**
Services or supplies which do not meet UPMC Health Plan’s definition or criteria of Medically Necessary and Appropriate.

**Medicare**
UPMC Health Plan will act as the primary payer for Members eligible for Medicare by reason of age in compliance with TEFRA or existing regulations regarding Medicare reimbursement. However, when the cost of services is covered under the Medicare Program as the primary payer, UPMC Health Plan providers shall file the Member’s health service claim(s) directly to the Medicare Program for reimbursement. UPMC Health Plan will coordinate the liability under this document with any Medicare reimbursement. In cases where Medicare’s reimbursement is issued directly to the Member, the Member is liable for the payment to the UPMC Health Plan provider.

**Medicare Eligibility**
For payment made under Medicare when Medicare is primary or would have been made if the Member had enrolled in Medicare and claimed Medicare benefits; however, the exclusion shall not apply when the Group is obligated by law to offer the member all benefits of this SPD and the Member so elects this coverage as primary.

**Mental Retardation**
Services for treatment of mental retardation except as otherwise provided herein.

**Military Service**
Care for military service connected disabilities and conditions for which the Member is legally entitled to services, and for which facilities are reasonably accessible to the Member.
**Miscellaneous**
Any services, supplies or treatments not specifically listed in the document as covered benefits, services, supplies, or treatments, unless they are a Basic Health Service.

Services and supplies which are not provided or arranged for by a UPMC Health Plan Physician and authorized for payment in accordance with UPMC Health Plan’s medical management policies and procedures.

Any services related to or necessitated by an excluded item or non-covered service.

Services provided by a non-licensed practitioner or practitioner not recognized by UPMC Health Plan.

Services which are primarily educational in nature, vocational rehabilitation and recreational and educational therapy.

Services Incurred after the date of termination of your coverage except as provided elsewhere in this Agreement.

Services for which you would have no legal obligation to pay.

Services rendered by a provider who is a member of your Immediate Family.

Charges for failure to keep a scheduled appointment.

Services performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program.

Charges for completion of any insurance form or copying of medical records.

**Motor Vehicle Accident/Workers’ Compensation**
The cost of Hospital, medical or other health services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used—including such benefits mandated by law) of any automobile insurance policy unless otherwise prohibited by applicable law. Services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers’ compensation, no-fault automobile insurance, or similar legislation.

**Nutritional Counseling**
Nutritional counseling except for Members who are diabetic, or pregnant.
**Nutritional Supplements**
Blenderized food, baby food, or regular shelf food when used with an Enteral system;
- Milk or soy based infant formulae with intact proteins;
- Any formulae, when used for the convenience of you or your family members;
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance;
- Oral semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and
- Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

**Oral Surgery**
Oral Surgery related services including: (1) services which are part of an orthodontic treatment program; (2) services required for correction of an occlusal defect; (3) services which encompass orthognathic or prognathic surgical procedures; (4) treatment of temporomandibular joint syndrome or temporomandibular joint disorders, regardless of the nature of the problem; (5) removal of asymptomatic, non-impacted third molars; and (6) orthodontia and related services.

**Over-the-Counter Drugs and Medications**
All over-the-counter drugs and medications or nicotine patches and nicotine gum unless described in this document.

**Physical Examinations**
Physical examination or evaluation or any Mental Health or Chemical Dependency evaluation given primarily at the request of; for the protection or convenience of; or to meet a requirement of a third party, including, but not limited to, attorneys, employers, insurers, schools, camps, and driver’s license.

**Podiatry Services**
Palliative or cosmetic foot care including but not limited to: treatment of weak, strained, flat, unstable, or unbalanced feet; removal or reduction of warts; metatarsalgia or bunions (except open cutting procedures); and treatment of corns, calluses, or toenails (except Medically Necessary and Appropriate Surgery to remove nail roots.) Also excluded are supportive orthotic devices for the foot (unless Member has a medical condition, such as diabetes or peripheral vascular disease.)

**Private Duty Nursing**
Private duty nursing services unless specifically authorized for payment by UPMC Health Plan in accordance with applicable policy and procedure.

**Public Facility/Government**
Care for conditions that federal, state or local law requires to be treated in a public facility or services furnished by any level of government, unless payment is legally required.
Rehabilitative Therapy
Rehabilitative Therapy Services, including but not limited to Physical Therapy, Occupational Therapy, and Speech Therapy, for developmental delay, school-related problems, apraxic disorders (unless caused by accident or episodic illness), stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders.

Also excluded are: Physical, Occupational, and Speech Therapy services provided in excess of a Maximum number of consecutive days of coverage, or a Maximum number of Visits, per condition, per Benefit Period, for all three therapies combined as indicated in the Schedule of Benefits; Cardiac Rehabilitation services provided in excess of 12 weeks; Pulmonary Rehabilitation services provided in excess of 24 Visits per Benefit Period; rehabilitation Therapy Services not expected to result in ongoing Substantial Improvement in the Member’s medical condition; and services provided after a maintenance level has been established.

Skilled Nursing
Inpatient days in a Skilled Nursing Facility in excess of the Maximum number of days per Benefit Period when the primary reason for the admission is to receive skilled Medical Care as indicated in the Schedule of Benefits; or Inpatient days in a Skilled Nursing Facility in excess of the maximum number of consecutive days per Benefit Period when the primary reason for the admission is to receive Rehabilitative Services as indicated in the Schedule of Benefits.

Inpatient days in a Skilled Nursing Facility which do not meet UPMC Health Plan’s definition of Skilled Nursing/Rehabilitation Services. Also, Skilled Nursing Facility Care is not covered for Mental Health treatment or the treatment of Chemical Dependency.

Smoking Programs
Nicotine cessation programs, products and prescription medication when prescribed for cessation of smoking.

Surrogate Mother
All services and supplies associated with surrogate motherhood, including, but not limited to, all services and supplies relating to the conception and prenatal through post natal care of a Member acting as a surrogate mother.

Therapeutic Manipulation
Therapeutic Manipulations in excess of a Maximum number of Visits per Benefit Period as indicated in the Schedule of Benefits. Also, coverage for Adjunctive Procedures is limited to a Maximum of four (4) therapies per day for the combination of procedures performed.

Transplants/Organ Donation
Excluded coverage includes any Experimental/Investigative transplants. Services required by a Member related to organ donation where the Member serves as the organ donor for a non-Member recipient when benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or any government program. No payment will be made for human organs which are sold rather than donated.
**Transportation**
Routine or non-emergency transportation, by any means, unless authorized for payment in accordance with UPMC Health Plan’s applicable policy and procedure.

**Vision** - refer to the *Vision Care Program* section.
All vision related services including, but not limited to:

- Surgery to correct myopia, hyperopia, or astigmatism, and radial keratotomy; and
- Vision training and orthoptics.

**Weight Reduction**
Weight reduction programs, including all related diagnostic testing and other services. Anti-obesity medications, including but are not limited to appetite suppressants and lipase inhibitors, are also excluded.

In addition, if you are an active staff member over age 65, the Health Plan acts as the primary plan with regards to Medicare reimbursement and complies with TEFRA (or existing regulations). If Medicare does not pay benefits for a particular service and that service also is not an eligible expense under the UPMC Health Plan, the Health Plan does not pay benefits.
Prescription Drug Program

If you enroll in the HMO or PPO coverage option, you are eligible for the prescription drug program.

Prescription Drugs
Except as delineated elsewhere in this SPD, benefits will be provided for prescription drugs in the amounts specified in the Schedule of Benefits sections and Prescription Drug Schedule of Benefits section when filled at a UPMC Health Plan Participating Pharmacy. Coverage is provided for injectable insulin and other prescription drugs that under Federal law may only be dispensed by written prescription and which are approved for general use by the Food and Drug Administration.

Prenatal vitamins, prescription strength vitamins ‘D’ and ‘K’, and pediatric vitamins containing fluoride will be covered.

Drugs that are lost, stolen or destroyed will not be replaced under the plan within the 75% refill period. The Member will be responsible for full payment for any medication that has been lost, stolen or destroyed.

Drugs that are available in a larger strength and FDA approved for once daily dosing instead of multiple doses of the smaller strength will be limited to one unit per day for a 30-day supply.

Specific drugs will be limited to the quantity per day supply that meets FDA approved length of therapy guidelines.

Specific drugs with potential for abuse/misuse, limited indications and safety issues may require prior authorization.

The Member is responsible for the payment differential when a Generic Drug is authorized by the Physician and the Member elects to purchase a Brand Name Drug. The Member payment is the price difference between the Brand and Generic, in addition to the Copayment.

Certain prescriptions are considered controlled substances (classified as Schedule II, III and IV medications) and are available through the mail order program and are limited to a 30-day supply.

A mail order program is available to UPMC Health Plan Members. The Member can receive an extended supply of maintenance drugs for a reduced price. When filled through UPMC Health Plan pharmacy mail order program, Members will be covered for up to a 90-day supply of Prescription Drugs (after an initial retail or mail order 30-day supply) for the designated mail order Copayment charge per prescription.
Snapshot of Your Prescription Drug Benefits
To be eligible for benefits, you must purchase your outpatient prescription drugs from a participating pharmacy or through the mail-order program. The chart below shows the copays that apply before the Health Plan pays prescription drug benefits.

<table>
<thead>
<tr>
<th>Program Feature</th>
<th>All Medical Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copayments</strong>*</td>
<td></td>
</tr>
<tr>
<td>- Participating Pharmacy</td>
<td></td>
</tr>
<tr>
<td>- Generic</td>
<td>$10 per prescription</td>
</tr>
<tr>
<td>- Preferred-Brand</td>
<td>$20 per prescription</td>
</tr>
<tr>
<td>- Non-preferred-Brand</td>
<td>$40 per prescription</td>
</tr>
<tr>
<td>- Mail-Order</td>
<td></td>
</tr>
<tr>
<td>- Generic</td>
<td>$20 per prescription</td>
</tr>
<tr>
<td>- Preferred-Brand</td>
<td>$40 per prescription</td>
</tr>
<tr>
<td>- Non-Preferred-Brand</td>
<td>$80 per prescription</td>
</tr>
<tr>
<td><strong>Day Supply Limit</strong></td>
<td></td>
</tr>
<tr>
<td>- Participating Pharmacy</td>
<td>30-day supply</td>
</tr>
<tr>
<td>- Mail-Order</td>
<td>90-day supply</td>
</tr>
<tr>
<td><strong>Refill Limit</strong></td>
<td>You must use 75% of your medication before you can obtain a refill</td>
</tr>
<tr>
<td><strong>When to Use</strong></td>
<td></td>
</tr>
<tr>
<td>- Participating Pharmacy</td>
<td>Short-term medications or immediate prescription drug needs</td>
</tr>
<tr>
<td>- Mail-Order</td>
<td>Long-term and injectable medications</td>
</tr>
</tbody>
</table>

*If you choose to purchase a name-brand drug even though your PCP or Network provider authorizes a generic drug, you are responsible for the name-brand copayment and any price difference between the cost of the name-brand and generic drugs.
Pharmacy Network
The UPMC Health Plan’s participating pharmacy network includes:

- All Giant Eagle pharmacies;
- More than 450 local independent pharmacies; and
- Selected hospital pharmacies, including:
  - UPMC Presbyterian (Falk Clinic) (for staff and dependents of UPMC)*;
  - UPMC St. Margaret*;
  - UPMC Braddock (for staff of Braddock only)*;
  - Children’s Hospital of Pittsburgh (for staff of Children’s Hospital only)*; and
  - Magee-Womens Hospital of UPMC (for staff of Magee-Womens Hospital of UPMC only)*.

*These pharmacies are not licensed for retail dispensing. Therefore, they can only fill prescriptions for their respective staff members.

If you need to fill a short-term prescription, use one of the participating pharmacies. To locate a participating pharmacy near you, call the UPMC Health Plan at 1-888-876-2756. Or, you can access the most up-to-date list of participating pharmacies on the Network’s Web site at www.upmchealthplan.com.

If you use a participating retail pharmacy, you receive up to a 30-day supply of your short-term medication, and you do not have to file a claim before the Health Plan pays benefits. **The Health Plan, however, does not cover any prescription filled at a nonparticipating pharmacy.**

How to Use Participating Pharmacies
- Have your physician call in or you may take your prescription (30-day supply) to a participating pharmacy near you.
- Present your I.D. card. You receive your medical I.D. card through the mail shortly after you enroll in the Advantage HMO or one of the PPO coverage options.
- Verify that your pharmacist has accurate information about you and your covered dependents (including your date of birth and Social Security number).
- Pay the required copayment for your prescription.
- Sign for and receive your prescription.

**Short-Term Medications**
Short-term medications are generally prescribed to treat illnesses such as colds, flu, or strep throat.
Local Pharmacy Refills
You may purchase up to a 30-day supply through a participating pharmacy. If your physician authorizes a prescription refill, simply bring the prescription bottle or package to the participating pharmacy.

Mail-Order Service
For long-term prescriptions and injectable medications, you may use the mail-order service provided through CuraScript (a mail-order program of through UPMC Health Plan). UPMC staff also may get 90-day prescriptions filled at the UPMC Presbyterian (Falk Clinic) pharmacy.

With the mail-order service, you pay a copayment before receiving up to a 90-day supply of your medicine through the mail. The copayment applies to each original prescription or refill (name-brand or generic).

How to Use the Mail-Order Service
• Complete the special order envelope and fill out the patient information section for each new prescription you send. You receive a packet of information containing the envelope and patient information section from CuraScript when you enroll for medical coverage.
• Submit the following in the pre-addressed special order envelope:
  — Your completed patient information section;
  — An original prescription (you may not submit photocopies of your prescription); and
  — Your appropriate per-prescription copayment.
• You receive your prescription no later than 14 days after CuraScript receives your order.
• You receive a new special order envelope and patient information section with each shipment.

If you misplace the special order envelope or patient information section, or you need additional forms, contact CuraScript at 1-877-787-6279.

Long-Term Medications
A long-term medication is a drug that you take on a regular basis. The following conditions are examples of those that require long-term medications:
• High blood pressure;
• Arthritis;
• Allergies and asthma;
• Heart or thyroid conditions; and
• Diabetes.

Injectable Medications
Many common injectable medications are available through retail pharmacies. The most common injectable medications include:
• Imitrex;
• Lovenox;
• Fragmin;
• Glucagon;
• Depo-Provera;
• Insulin; and
• Bee-sting kits.
All other injectables are only available through CuraScript.

CuraScript mails or delivers the medication to your home or doctor’s office.
**Mail Order Refills**

If you need your long-term medication refilled, you can order your refill by phone or mail as shown in the table below.

<table>
<thead>
<tr>
<th>Refills by Phone</th>
<th>Refills by Mail</th>
<th>Refills by Web</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use a touch-tone phone to order your prescription refill or inquire about your order’s status.</td>
<td>• Attach the refill label (you receive a label with each order) to your mail order form.</td>
<td>• You can order refills via the Internet.</td>
</tr>
<tr>
<td>• The automated refill phone service is available 24 hours a day.</td>
<td>• Pay your appropriate copayment via check, money order, or credit card.</td>
<td>• To order through the Web, go to <a href="http://www.curascript.com">www.curascript.com</a> and complete the online form.</td>
</tr>
<tr>
<td>• When you call, provide the member identification code, birth date, the prescription number, your credit card number (including expiration date), and your phone number.</td>
<td>• Mail the form in the pre-addressed envelope.</td>
<td></td>
</tr>
</tbody>
</table>

Be sure to order your refill two to three weeks before the completion of your current prescription. If you have any questions regarding the mail-order service, contact the UPMC Health Plan toll-free at 1-888-876-2756 or you can contact CuraScript directly at 1-877-787-6279.

**Your Choice Pharmacy Plan**

The YOUR CHOICE pharmacy plan offers three different levels of copayment to help you manage your prescription drug costs. When you need a prescription, you and your doctor can choose your medication from a variety of different drugs, depending on which level of copayment you want.

Generic medications are the same strength and formulation as their brand name counterparts. These generic drugs are available at your lowest copayment. The preferred brand drugs do not have generic versions available, but they are the Preferred Brands of the pharmacy plan. They are available at a copayment of $20 or $40 depending on the number of days supplied. The YOUR CHOICE pharmacy plan also gives you access (at your highest copayment) to Non-Preferred name brand drugs. These medications would not otherwise be included on the drug list. Lifestyle enhancement/cosmetic medications are not covered under the pharmacy plan.

**Please Note:** If your prescription is for a name brand drug not included in the medication listing, you must accept a generic drug anytime that one is available for your medication. If a generic drug is available, and you still choose to have its name brand version, you will pay the $20 or $40 copayment, depending on the number of days supplied, plus the retail price difference between the generic drug and the name brand drug.

For a detailed listing of medications covered under the YOUR CHOICE pharmacy plan, refer to the UPMC Health Plan **Your Choice Prescription Drug Program** brochure; contact UPMC Health Plan at 1-888-876-2756 or on the Internet at [www.upmchealthplan.com](http://www.upmchealthplan.com).

The pharmacy plan has a program that allows you to receive 90-day supplies of certain types of medications. For a first time prescription or a new medication, you must use a 30-day supply of the drug before you can request the larger quantity through the 90-day supply program. This policy reduces wasted medication and copayments by giving your doctor a chance to make sure that the medication is the right dose for you and causes you no side effects. UPMC Health Plan Pharmacy &
Therapeutics Committee regularly reviews new and existing therapies to make sure the pharmacy plan provides you with high quality, cost-effective prescription drugs. Because of this constant review, changes may occasionally occur to the drug list. Your UPMC Health Plan newsletters or pharmacy mailings will inform you of these updates. Please call the Clinical Pharmacy Services Department at 1-800-396-4139 if you have any questions about whether a certain drug is covered under your pharmacy plan.

**UPMC Health Plan Quantity Limits**
UPMC Health Plan Pharmacy and Therapeutics Committee has established Quantity Limits on certain medications to comply with FDA guidelines and to encourage the appropriate use of these medications.

The Food and Drug Administration (FDA) has approved some medications to be taken once daily in a larger dose instead of several times a day in a smaller dose. For these medications, your pharmacy plan only covers one larger dose per day for 30 days at a time. For example: you have a prescription that calls for you to take two 20mg doses of medicine per day. If the 40mg strength of that same medicine exists, your pharmacist will substitute one 40mg dose per day instead of two 20mg doses per day. If a medical reason prevents you from taking the medication once daily in the larger dose, your doctor may call Pharmacy Services at 1-800-396-4139 to request a medical exception.

**Medications Requiring Prior Authorization**
There is a short list of medications that requires your doctor to consult with UPMC Health Plan’s Pharmacy Services at 1-800-396-4139 the first time he or she prescribes the medication for you. Pharmacy Services must authorize these drugs before your pharmacy plan will begin to cover them. The Summary of Benefits that comes in your Enrollment Kit will give you more specific information on any restrictions or exclusions that apply to you.

**Prior Authorization Drugs:**
- Accutane
- Celebrex
- Lamisil/Sporanox
- Welchol
- Arave/Enbrel
- Colazal
- Protopic
- Aricept/Exelon/Reminyl
- Concenta
- Starlix
- Azulfidine En-tabs
- Growth Hormones
- Testosterone

**Prescriptions Not Covered**
- Infertility and impotency medications.
- Vitamins (except for folic acid, pediatric vitamins containing fluoride, prenatal vitamins and prescription strength vitamin D, and vitamin K).
- Medications that are lost, stolen, or spilled.
- Drugs dispensed in any amount that exceeds the supply limit (based on FDA-approved length of therapy guidelines).
- Prescriptions received while you are confined in a hospital, nursing home, or similar place that dispenses its own medications.
- Prescriptions acquired through a nonparticipating pharmacy.
- Over-the-counter drugs that do not require a prescription or a refill by federal or state law before they’re dispensed.
- All medications excluded from coverage under the UPMC Health Plan (e.g., smoking deterrents, anti-obesity drugs, etc.).
Vision Care Program

The vision care program pays benefits for exams, eyeglasses, and contact lenses. You are eligible to participate in this program if you select coverage under the Advantage HMO or one of the PPO plan options. An allowance is covered toward eyeglasses or contact lenses every 24 months, as specified below in the Snapshot of Your Vision Benefits section (except for congenital cataracts where contact lenses are covered until corneal transplants).

Snapshot of Your Vision Benefits
The following is a snapshot of how the Health Plan pays benefits if you go to a vision network or non-network provider.

<table>
<thead>
<tr>
<th>Vision Benefits</th>
<th>Vision Network Provider</th>
<th>Non-Network Provider (Schedule of Benefits)*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Copay Requirement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exams</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Covered Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exams</td>
<td>100%</td>
<td>$20</td>
</tr>
<tr>
<td>Lenses (per pair)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>100%</td>
<td>$50</td>
</tr>
<tr>
<td>Bifocal</td>
<td>100%</td>
<td>$50</td>
</tr>
<tr>
<td>Trifocal</td>
<td>100%</td>
<td>$50</td>
</tr>
<tr>
<td>Lenticular</td>
<td>100%</td>
<td>$50</td>
</tr>
<tr>
<td>Progressive</td>
<td>100%</td>
<td>$50</td>
</tr>
<tr>
<td>Frames</td>
<td>100%**</td>
<td>$50</td>
</tr>
<tr>
<td>Contact Lenses (includes eye exam allowance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective contact lenses (in lieu of spectacle lenses and frames)</td>
<td>$175***</td>
<td>$120</td>
</tr>
<tr>
<td>Medically necessary contact lenses</td>
<td>UCR%***</td>
<td>$250</td>
</tr>
<tr>
<td><strong>Low-Vision Aids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>UCR****</td>
<td>$500</td>
</tr>
</tbody>
</table>

*To learn how the Health Plan defines “schedule of benefits,” see the next page.
**Within the $40 wholesale allowance (approximately $90 retail).
***This is in lieu of all benefits for the benefit period. You do not receive any additional money for contact lenses and/or contact lens exam costs that are more than the allowance. Usual, Customary and Reasonable as determined by Vision Benefits of America (VBA)
****Requires prior authorization and must be medically necessary for visual welfare.

For more details regarding what the Health Plan covers, see the Medical section. If you have any questions regarding your vision benefits, contact the administrator at the address listed in the Administrative section.
**Network and Non-Network Providers**
You can receive services from a network or non-network provider.

**Network Providers**
Network providers offer the convenience of “one-stop shopping,” and can provide everything you need (eye exams, routine eye care, eyeglasses, and contacts) on a paid-in-full basis. As long as you receive care and materials from a network provider, the Health Plan pays the full cost of your covered service. See the snapshot chart on the previous page for details.

**Non-Network Providers**
If you prefer, you can go to an optometrist, ophthalmologist, or dispensing optician who is a non-network provider. If you do, you pay the provider’s regular charges in full. Once you submit an itemized receipt, the Health Plan reimburses you for the eligible expense (up to the scheduled benefit amount). See the snapshot chart on the previous page for the scheduled amount the Health Plan pays.

See **How to File a Benefit Form** at the end of this section for details about filing claims.

**Copayments**
If you receive services from a network provider, you must meet a copay requirement before the Health Plan pays benefits. See the snapshot chart on the previous page for the copay that applies.

**Schedule of Benefits**
If you receive care from a non-network provider, the Health Plan pays benefits up to a certain dollar amount for covered services. You pay the remaining cost of your service. See the snapshot chart on the previous page for the scheduled amount the Health Plan pays for each type of covered service.

**Please Note:** There is no guarantee that the scheduled amount the Health Plan pays will cover the entire cost of your exam, glasses, or contact lenses.

**Maximum Benefits**
If you receive care from a network provider, the Health Plan limits the benefits you can receive, as shown in the chart below. Your dependents are considered children up to age 19.

<table>
<thead>
<tr>
<th>Service</th>
<th>Plan Limits Benefits to …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exams</td>
<td><strong>Adults:</strong> One exam every 24 months</td>
</tr>
<tr>
<td></td>
<td><strong>Children:</strong> One exam every 12 months</td>
</tr>
<tr>
<td>Lenses</td>
<td><strong>Adults:</strong> One pair every 24 months</td>
</tr>
<tr>
<td></td>
<td><strong>Children:</strong> One pair every 12 months</td>
</tr>
<tr>
<td>Frames</td>
<td><strong>Adults:</strong> One pair every 24 months</td>
</tr>
<tr>
<td></td>
<td><strong>Children:</strong> One pair every 24 months</td>
</tr>
<tr>
<td>Elective contact lenses (in lieu of spectacle lenses and frames)</td>
<td><strong>Adults:</strong> $175 allowance every 24 months</td>
</tr>
<tr>
<td></td>
<td><strong>Children:</strong> $175 allowance every 12 months</td>
</tr>
</tbody>
</table>
How to Use Network Providers
Here is what you need to do, and what happens when you use a network provider.

- Before you make an eye appointment, call Vision Benefits of America (VBA) customer service department through DirectLink at 1-800-994-2752, option 2, then option 4. VBA will determine your eligibility for services at that time. If eligible, VBA will send a validated benefit form directly to your home. The form is valid for 90 days and will contain a listing of participating providers.

- Call the network provider to make an appointment. Make sure you identify yourself as a VBA participant.

- Give the network provider your validated VBA benefit form on your first visit. This ensures that you receive benefits at the participating network-provider level.

- At the time of your visit, you sign the benefit form and pay the required copayment. The administrator takes care of all paperwork, and pays the provider for your services.

- If you obtain services at a participating provider without a validated benefit form and pay for the services provided up front, you will only be reimbursed according to the out-of-network reimbursement schedule of benefits.

Non-Network Provider Patients
If you do not use a network provider, your provider does not have to accept the Health Plan’s negotiated fees as full payment. As a result, you are responsible for any cost difference. See the Snapshot of Your Vision Benefits section for details on how to apply for benefits in this instance.

Vision Covered Services
The Health Plan covers the following vision care services.

- Eye exams.
- Lenses.
- Frames.
- Medically necessary contact lenses:
  — Following cataract surgery;
  — To correct extreme visual acuity problems not correctable with spectacle lenses;
  — To correct significant anisometropia; or
  — To correct keratoconus.
- Elective contact lenses.
- Low-vision aids.
Vision Expenses Not Covered
The Health Plan does not pay benefits for the following vision care services.

- Medical or surgical eye care services.
- Cosmetic materials.
- Cosmetic options, including: photochromic lenses; tinted or coated lenses; or sunglasses.
- Any frame that costs more than the allowance.
- Elective contact lenses (in excess of the allowance).
- Orthoptics or vision training, or subnormal-vision aids.
- Nonprescription lenses.
- Two pairs of eyeglasses in lieu of bifocals.
- Services or materials provided as a result of any Workers’ Compensation Law or similar legislation.
- Eye exams or corrective eyewear required by an employer as a condition of employment.
- Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.
- Lost or broken lenses and frames, unless you reach your normal interval for service when seeking the replacement. See the Maximum Benefits on for details.

Applying for Benefits
If you receive care from a network provider, you do not have to file a claim for benefits. Once you receive your validated VBA benefit form and meet the necessary copay requirement, the Health Plan automatically pays the full cost of your covered service.

If you receive care from a non-network provider, you pay the provider’s fee in full, and the Health Plan reimburses you up to the scheduled benefit amount. To receive a benefit form, contact the vision plan administrator through the UPMC DirectLink at 1-800-994-2752, option 2, option 4.
How to File a Benefit Form
To be reimbursed for your covered expense, submit a vision care benefit form to the administrator:

Vision Benefits of America
300 Weyman Plaza
Pittsburgh, PA 15236-1588

Be sure to include the following (should be on the itemized receipt):

- The patient’s name;
- Date services began;
- The services and materials received;
- The type of lenses received (single, bifocal, trifocal, etc.);
- UPMC (your employer’s name); and
- The participant’s name, mailing address, Social Security number, and date of birth.

You are reimbursed according to the schedule of benefits. There’s no guarantee, however, that the Health Plan’s scheduled benefit amount will cover the full cost of your exam or materials.

If a Claim Is Denied
If disagreements arise regarding your benefits, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a benefits-related decision. See the ERISA Appeals section for details regarding the appeals process.
Subrogation and Reimbursement

The UPMC Health Plan may pay a benefit to you or on behalf of you and/or your dependents. If this is the case, the UPMC Health Plan is — to the extent of any such payment — subrogated to all the rights of recovery of you and/or your dependents that may arise out of another claim or cause of action against any third party responsible for the condition that gives rise to the plan’s payment. The UPMC Health Plan has the right to a full and complete subrogation of all payment it makes to or on behalf of you and/or your dependents, even if you and/or your dependents have not or will not be fully compensated or made whole by the responsible third party for the injuries or damages. You and/or your dependents must fully cooperate with the UPMC Health Plan so that it may exercise its right of subrogation. This may include — but is not limited to — allowing the UPMC Health Plan to pursue legal actions and claims in the name of you and/or your dependents. You and/or your dependents must not do anything to prejudice the UPMC Health Plan’s subrogation rights.

If you and/or your dependents obtain any recovery — regardless of how it’s designated or structured — from or on behalf of any insurance company or any third party responsible for the condition giving rise to the medical expense, you and/or your dependents must fully and completely reimburse the UPMC Health Plan for all payments made by the UPMC Health Plan to or on behalf of you and/or your dependents for such a medical expense. The UPMC Health Plan has the right to a full and complete reimbursement from you and/or your dependents of all payments made by the plan, from any recovery you and/or your dependents obtain from any insurance company or any responsible third party even if you and/or your dependents have not or will not be fully compensated or made whole for the injuries caused by the responsible third party.

In exercising its right of recovery through either subrogation or reimbursement, the UPMC Health Plan is not responsible for any fees, expenses, attorneys’ fees, or representatives’ fees that you and/or your dependents may incur to obtain the funds needed to reimburse the UPMC Health Plan or pay the plan’s subrogation interest.

These provisions shall not apply where subrogation is specifically prohibited by law.
Applying for Benefits

Depending on the coverage option you select and whether you receive coordinated care from a UPMC Health Plan Network provider or you receive self-referred care outside the UPMC Health Plan Network, you may or may not have to file a claim before the Health Plan pays benefits.

Do You Need to File a Claim?
The chart below shows who needs to file claims for benefits.

<table>
<thead>
<tr>
<th>If you are a(n) …</th>
<th>Do You Need to File a Claim …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantage HMO participant</td>
<td>No*</td>
</tr>
<tr>
<td>PPO participant who receives care from a Network provider</td>
<td>No*</td>
</tr>
<tr>
<td>PPO participant who receives care outside the Network</td>
<td>Yes**</td>
</tr>
</tbody>
</table>

*Your Network provider deals directly with the Health Plan regarding your claims. You receive notification that benefits have been paid, as well as any amounts (if any) that you owe.

**Unless your provider submits the claim on your behalf.

How to File Claims
UPMC Health Plan will not be liable under the medical plans unless proper notice is furnished to UPMC Health Plan that covered services in this document have been rendered to a Member. Written notice must be given within ninety (90) days following the end of the calendar year in which the covered service was rendered. The notice must include the data necessary for UPMC Health Plan to determine benefits. A charge shall be considered incurred on the date a Member receives the service or supply for which the charge is made.

Failure to give notice to UPMC Health Plan within the time specified will not reduce any benefit if it is shown that the notice was given, as soon as, reasonably possible, but in no case will UPMC Health Plan be required to accept notice later than twelve (12) months after the end of the calendar year in which the charge for covered service was incurred.

If the Member (or if deceased, by his/her personal representative) is required to submit a claim for benefits, it must be received on the appropriate claim form. The claim forms may be obtained through UPMC Health Plan.

For Member submitted claims, the completed claim form, with all itemized bills attached, must be forwarded to UPMC Health Plan at the address below in order to receive payment for benefits provided under the plan provisions:

Claims Department
UPMC Health Plan
P.O. Box 2999
Pittsburgh, Pennsylvania 15230-2999
All Member submitted claims must be submitted to the UPMC Health Plan Claims Department no later than the end of the calendar year following the calendar year for which benefits are payable. To avoid delay in handling the Member's claim, answers to all questions on the claim form must be complete and correct.

Each claim form must be accompanied by itemized bills showing:

- Person or organization providing the service or supply;
- Type of service or supply;
- Date of service or supply;
- Amount charged;
- Name of patient.

In addition to the above, private duty nursing bills must contain the shifts worked, charge per day, professional status of the nurse, and signature of the professional provider prescribing the service. Professional providers’ bills must show specific treatment dates. Drug and medicine bills must show prescription number, date of purchase, and patient's name. The Member's attending professional provider must certify that he/she prescribed all services by signing his/her name on all bills, except doctor bills, hospital bills, or prescription drug bills. (Some bills requiring a signature of the professional provider are: ambulance, prosthetic devices, rental of durable medical equipment, private duty nursing, etc.). Itemized bills cannot be returned.

A request for payment of a claim will not be reviewed and no payment will be made unless all of the information and evidence of payment required on the claim form has been submitted in the manner described above. UPMC Health Plan reserves the right to require additional information and documents as needed to support a claim that a covered service has been incurred. Claims will be paid immediately upon receipt of adequate proof of claim.

For Provider submitted claims, UPMC Health Plan will not be liable under the plan provisions unless proper notice is furnished to UPMC Health Plan that covered services have been rendered to a Member. Written notice must be given within sixty (60) days after completion of the covered services. The notice must include the data necessary for UPMC Health Plan to determine benefits. A charge shall be considered incurred on the date a Member receives the service or supply for which the charge is made. UPMC Health Plan shall pay clean claims submitted by a provider within forty-five (45) days of receipt of a clean claim. A clean claim is one, which has no defects or impropriety (i.e. claim which has all required substantiating documentation), which prevents timely payment from being made on the claim. This does not apply to a claim from a provider under investigation of fraud and/or abuse.

**Fraud**

According to Pennsylvania statutes: Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
If a Claim is Denied
If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that’s not possible, formal procedures are in place so that you may appeal a decision. See the Appealing Denied Claims section for details regarding the appeals process.

Complaint and Grievance Procedures
If Members have any questions or concerns with UPMC Health Plan, they need to call the Member Services Department at 1-888-876-2756. Member comments are important to UPMC Health Plan to continually improve the quality of care and service that UPMC Health Plan provides to UPMC Health Plan Members.

When a Member calls Member Services, a Member Service representative will try to answer questions or respond to your concerns. At any point in the process, if a Member is not satisfied with the response, the Member may ask to file a Complaint or Grievance through the UPMC Health Plan Complaint and Grievance Procedure.

Under the provisions of the Pennsylvania HMO Act, Act 1998-68, and the Department of Health and Insurance Department regulations, UPMC Health Plan has established a set of formal procedures, which Members may use if they are in any way dissatisfied with UPMC Health Plan or a Participating Provider.

Complaint
If a Member has a dispute or objection regarding a Provider or the coverage, operations or management policies of UPMC Health Plan, the Member should contact the Member Services Department. Complaints can be regarding many different issues, including: quality of care or service issue, benefits exclusion, claim denial or coordination of benefits.

A Member may either file the complaint verbally over the phone with the Member Service Department representative with whom a Member speaks, or the Member may send a written complaint. The Member may also send any written data or other information to support the complaint. The Member may indicate in the complaint the remedy, resolution, or corrective action that is being sought.

In each step of the complaint process, it is recommended that the Member be as specific as possible as to the remedy being sought from UPMC Health Plan. For example, complaints many times deal with claim denials, and the remedy sought is payment of the claim by UPMC Health Plan.

At any time during the course of the complaint process, the Member may choose to designate a representative to participate in the complaint process on the Member’s behalf. The Member or the Member’s representative shall notify UPMC Health Plan of the designation.

Furthermore, at any time during the complaint process, should the Member or the Member’s representative wish, UPMC Health Plan can make available a UPMC Health Plan employee to assist the Member or Member’s representative (at no charge) in preparing the complaint, if a request for assistance is made by the Member or Member’s representative. This UPMC Health Plan employee who will be made available to the Member or Member’s representative will not have previously participated in any of the UPMC Health Plan’s decisions regarding the complaint in question.
There are two steps in the Complaint process:

**Initial Review:** Upon receipt of the complaint (either oral or written), UPMC Health Plan will provide written confirmation of receipt of the complaint to the Member or the Member’s representative. This written confirmation will also provide the following information:

- A summary of the basis of the complaint and confirmation that UPMC Health Plan considers the matter in question to be a complaint. There will also be instructions for the Member or Member’s representative should they wish to question this classification.

- Confirmation that the Member may designate a representative to act on the Member’s behalf at any time during the complaint process, as well as information to request that the UPMC Health Plan assign an employee who has not participated previously in any decisions concerning the issue under dispute to assist the Member or Member’s representative at no charge in preparation of the complaint.

- Confirmation that the Member or Member’s representative may submit additional material in support of their viewpoint to UPMC Health Plan to consider in its review. They also have the right to review information related to the complaint upon request. State regulation allows managed care plans to charge a reasonable fee for this service.

The Initial Complaint Review Committee (consisting of one or more employees of UPMC Health Plan who have not been involved in a prior decision in the issue under dispute) will investigate the details of the complaint. The Committee will make a decision within fifteen (15) days of receipt for a pre-service complaint or within thirty (30) days of receipt of a post-service Complaint. A written notification of the Committee decision, specifying the reasons for the decision, references to the specific plan provisions on which the decision is based, and an explanation of the process to request a second level review if the Initial Complaint Review Committee decision and the time frame in which to do so, will be sent to the Member and the Member’s representative within five (5) business days of the decision. If an internal rule, guideline, protocol or other similar criterion was relied upon in the decision-making process, either that specific rule, guideline, protocol, or criterion, or instructions on how to obtain the specific information indicated in the decision letter, will be provided.

The Initial Review Committee decision will be binding, unless the Member chooses to request a second level review of the Initial Complaint Review Committee decision.

**Second Level Review:** If the Member appeals the decision of the Initial Review Committee, the complaint will then go to UPMC Health Plan’s Second Level Complaint Review Committee, unless the complaint is in reference to a denied claim (whether for a non-covered service or exhausted benefit). To request a second level review of a denied benefit, refer to the Second Level Appeal process in the Appeals Process for Your Self-Insured Benefits, in the Appealing Denied Claims section at the end of this document.

Upon receipt of the request for the second level review, UPMC Health Plan will provide written confirmation to the Member or the Member’s representative. This written confirmation will also provide the following information:

- Explanation of the process for the Member or Member’s representative to request that the UPMC Health Plan assign an employee to assist the Member or Member’s representative in preparation of the second level complaint. This employee would be made available at no charge and will not have participated in previous decisions pertaining to the dispute in question.
• Notification that the Member and the Member’s representative have the right to appear before the second level complaint review committee and that UPMC Health Plan will provide the Member and Member’s representative with fifteen (15) days advance written notice of the date and time scheduled for that review.

The Second Level Complaint Review Committee consists of three (3) or more individuals who did not previously participate in the matter under review. At least one-third of the Committee is made up of UPMC Health Plan. Members enrolled in UPMC Health Plan, but who are not employed by UPMC Health Plan, or a related subsidiary or affiliate. The members of the committee have the duty to be impartial in their review of the information and decision.

The Member and the Member’s representative have the right, but are not required, to attend the Second Level Complaint Review Committee meeting. When arranging the meeting, UPMC Health Plan will notify the Member and the Member’s representative in writing fifteen (15) days in advance of the date scheduled for the second level complaint review, and will provide details of the review process and how the meeting will be conducted, including the Member’s rights at such meetings. The meeting will be held within fifteen (15) days of receipt of a pre-service, or within thirty (30) days for a post-service request for such a review. If the Member or Member’s representative cannot appear in person at the Second Level Review, UPMC Health Plan shall provide the Member the opportunity to communicate with the review committee by telephone or other appropriate means, and will be as flexible as possible in facilitating the participation of the Member and Member’s representative in the review.

The Second Level Complaint Review Committee will issue a written notification to the Member and the Member’s representative regarding the Second Level Complaint Review Committee’s decision within five (5) business days of the decision. This notice will include the basis for the decision; references to the specific plan provisions on which the decision is based, and an explanation of the Member’s appeal rights, and the process and time frame to file such an appeal to the Plan Administrator. If an internal rule, guideline, protocol or other similar criterion was relied upon in the decision-making process, either that specific rule, guideline, protocol, or criterion or instructions on how to obtain the specific information indicated in the decision letter, will be provided.

Appeal of a Complaint Decision
A Member has 180 days from the receipt of the second level review decision of the internal complaint process to file an appeal of the decision with the Plan Administrator. Refer to the
Appealing Denied Claims section.
**Internal Grievance Process:**
A grievance is different from a complaint. A grievance is a request on the part of a Member, a Member’s representative or a health care provider (with written Member consent) to have a managed care plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A grievance or an appeal may be filed regarding decisions to: fully or partially deny payment for a requested health service; approve a provision of a requested health care service at a lesser level or duration than requested, or disapprove payment for the provision of a requested service but approve payment for the provision of an alternative health care service. The term does not include a complaint.

While it is generally preferable to file a grievance or appeal in writing, the Member may call Member Services to request assistance and file a grievance or appeal orally, if there is some reason for which it is not possible to file in writing. Refer to the *Appeals Process for Your Self-Insured Benefits* in the *Appealing Denied Claims* section at the end of this document for more information.
An Introduction to Your Dental Benefits

Dental care is an integral part of your overall wellness. For this reason, UPMC offers eligible staff members dental coverage. See the Who is Eligible section for more details regarding who is eligible.

Dental coverage through CIGNA Dental provides participants access to a large national dental network. Eligible staff members may choose between CIGNA Dental Care and CIGNA Dental PPO.

CIGNA Dental Care
- Provides comprehensive benefits through a focused nationwide dental HMO-type plan.
- Providers have agreed to offer services at reduced fixed fees.
- No deductibles or dollar maximums.
- No charges for most preventive care.
- Specialty care available with approved referral.
- Both child and adult orthodontia is covered.
- No claim forms to file.
- Must choose a primary dental provider (PDP) from the CIGNA Dental Care network.
- Services rendered outside the CIGNA Dental Care network are not covered.

CIGNA Dental PPO
- Offers a large network of dental providers to choose from, or visit any licensed dentist you choose.
- Higher reimbursement levels and greater savings are available when visiting in-network dentists.
- Most preventive and diagnostic services covered at 100% when visiting a CIGNA network dentist.
- No referral necessary to see a specialist.
- Orthodontia is covered for children under age 19.

If you have any questions after reading this section, contact CIGNA’s Dental Customer Service through UPMC DirectLink at 1-800-994-2752, Option 2, or visit their web site at www.cigna.com.
Snapshot of the Options

You may choose from two coverage options. This section provides a snapshot of your coverage options. For more information about the types of covered services, see Covered Services later in this section.

Snapshot Charts:

CIGNA Dental Care (DHMO Type Plan)

<table>
<thead>
<tr>
<th></th>
<th>CIGNA Dental Care Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$0</td>
</tr>
<tr>
<td>Diagnostic/Preventive</td>
<td>Most preventive and restorative procedures covered at little or no cost to you. Refer to the CIGNA Dental Care patient charge schedule for your out-of-pocket costs for specific procedures. The schedule is available from the UPMC Employee Service Center, CIGNA Dental Member Services or on the Infonet</td>
</tr>
<tr>
<td>Basic Services</td>
<td>Refer to the CIGNA Dental Care patient charge schedule for your out-of-pocket costs for specific procedures. The schedule is available from the UPMC Employee Service Center, CIGNA Dental Member Services or on the Infonet</td>
</tr>
<tr>
<td>Major Services</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td></td>
</tr>
<tr>
<td>Orthodontia – Child</td>
<td></td>
</tr>
<tr>
<td>Orthodontia - Adult</td>
<td></td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum</td>
<td>24 month of interceptive or comprehensive service.</td>
</tr>
</tbody>
</table>

Please Note: Services rendered outside the CIGNA Dental Care network are not covered.

CIGNA Dental PPO Plan

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$0</td>
<td>$50 individual/$150 family</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Reimbursement Levels</td>
<td>Based on Reduced Contracted Fees</td>
<td>Based on Reasonable and Customary Allowances</td>
</tr>
<tr>
<td>Diagnostic/Preventive</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Major Services</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Orthodontia – Child (Under age 19)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

Please Note: The percentages of benefit noted is the amount the plan pays for your dental services.
How Your Dental Coverage Works

This section provides a brief overview of your coverage options, as well as how the features of your dental coverage work.

About Your Coverage Options
Your dental coverage includes two coverage options: CIGNA Dental Care and CIGNA Dental PPO. Both options generally cover the same types of services. The options differ in the networks, deductible, coinsurance and out-of-pocket maximums. See the “Snapshot Charts” in the beginning of this section to determine these amounts for either coverage option.

CIGNA Dental Care (DHMO)
You must choose a primary dentist from the dental care network and notify CIGNA of your selection. Services rendered outside the CIGNA Dental Care network are not covered. For more information on finding a participating dentist, see the Participating Dental Provider Section.

CIGNA Dental PPO
You do not need to designate a primary dentist for the PPO option. Under this option you receive benefits whether or not you and/or your eligible dependents visit a participating dentist. However, when you visit a participating dentist you have the opportunity to maximize your benefit with lower out-of-pocket expenses. For more information on finding a participating dentist, see the Participating Dental Provider Section.

Choosing Whom to Cover
In addition to selecting a coverage option, you need to decide whom to cover by selecting a coverage level. You can select from the following coverage levels:

- Employee Only coverage; or
- Family coverage.

Please see Who Is Eligible under the Overview section for a complete description of which family members are eligible for coverage.
How Benefits are Paid
A deductible, coinsurance, and annual and lifetime maximums may apply depending on the coverage option you select. Here is a brief description of each feature.

Deductibles
The deductible is a fixed dollar amount you may pay out of your pocket each year before you receive benefits. See the “Snapshot Charts” in this section to determine the deductible amount that applies. Please note: There is no deductible for the CIGNA Dental Care plan or in-network services under the CIGNA Dental PPO plan.

The individual deductible applies separately to each covered individual, and the family deductible applies collectively to all covered persons in the same family. Once you meet the family deductible, your remaining covered family members do not have to meet their individual deductible amounts for the rest of the year.

Coinsurance
This is the percentage of eligible expenses you are responsible for paying. Percentages apply after any applicable deductibles. The amount you pay depends on the type of coverage you select, and whether you receive care from an in-network dentist. See the “Snapshot Charts” in this section for the percentage paid for each type of eligible expense under your coverage option.

If you receive care from a non-participating dentist, the percentage paid applies only to eligible expenses that do not exceed reasonable and customary charges. You are responsible for any noncovered service including any amount that exceed the reasonable and customary charge. Please note: the coinsurance does not apply to the CIGNA Dental Care plan.

Annual Maximums
Benefits are limited for each covered person during each calendar year. See the “Snapshot Charts” in this section for the annual maximums that apply for your coverage option. Orthodontia expenses are not included in this limit. A separate lifetime limit applies to orthodontic services for each person eligible for these benefits. Please note: the annual maximum does not apply to the CIGNA Dental Care plan.

Orthodontic Lifetime Maximums
The individual lifetime maximum is the maximum amount paid for orthodontic expenses during the life of a covered individual. See the “Snapshot Charts” in this section for the orthodontic lifetime maximum that applied under your coverage option.
Pre-Determination of Benefits
If you want to find out what the Dental plan will pay before you receive services, it is a good idea to file a pre-treatment estimate for any procedure that exceeds $200. To do so, have your dentist complete and submit the regular dental claim form, indicating the type of work planned, and the cost. CIGNA will send you and your dentist a statement showing the estimate of benefits payable. Pretreatment review is not required, however, it is recommended to identify your payment responsibilities.

Participating Dental Providers
CIGNA Dental Care plan
Participants must choose a participating CIGNA Dental Care provider and notify CIGNA of the selection before receiving services. If needed, the PDP will refer the individual for all in network specialty services. Services rendered outside the CIGNA Dental Care network or without a selected provider will not be covered. To choose a participating CIGNA Dental Care Provider, refer to the CIGNA Dental Care Network information provided in your enrollment kit, contact CIGNA Dental Customer Service through DirectLink at 1-800-994-2752, option 2 or visit CIGNA’s website at www.cigna.com. Network directories are also available from the Employee Service Center.

CIGNA Dental PPO
Participants may choose a network provider or any other licensed provider. You do not have to report your choice of provider to CIGNA. Benefits paid are affected by to identify dentists participating in the CIGNA Dental PPO network refer to the CIGNA Dental PPO directory in you enrollment kit, contact CIGNA Dental Customer Service through DirectLink at 1-800-994-2752, option 2 or visit CIGNA’s website at www.cigna.com. Network directories are also available from the Employee Service Center.
Covered Services

Benefits are paid — up to the negotiated fee or the reasonable and customary charge — for eligible expenses that are necessary in terms of generally accepted dental standards. See the “Snapshot Charts” at the beginning of this section to see how benefits are paid for each covered service, as well as any benefit limits that may apply.

Class I — Preventive & Diagnostic Care
- Benefits are paid for the following preventive services.
- Oral examinations (twice a year).
- Prophylaxis (cleaning and scaling of teeth or perio maintenance) (twice a year).
- Topical fluoride applications for children under age 19 (once a year).
- X-rays, including:
  - Full-mouth x-rays (once every three years); and
  - Bitewing x-rays (two per year).
- Space maintainers, limited to non-orthodontic treatment.
- Sealants (Limited to posterior teeth for a person less than age 14; one treatment per tooth every three years).
- Emergency treatment necessary to relieve pain or necessary to avoid serious deterioration or risk of permanent damage to your health.

Class II — Basic Restorative Care
Benefits are paid for the following basic services.

- Fillings (amalgam, silicate, or resin), When alternate treatments are available, benefit payment will be based on the least costly procedure. Full cost of composite amalgams is not covered for teeth behind the second bicuspid when silver amalgam is available.
- Root canal therapy
- Osseous Surgery
- Periodontal Scaling and Root Planing
- Denture Adjustment and Repairs
- Extractions
- Oral Surgery
Class III— Major Restorative Care

- Benefits are paid for the following major services.
  - Installation of fixed bridgework or partial or full removable denture done for the first time.
  - Replacement of existing removable dentures or fixed bridgework that can not be repaired, and that is at least 10 years old.
  - Replacement by a new permanent full denture of an existing temporary full denture when the existing denture can not be made permanent (if installed within 12 months after the existing denture was installed).
  - Adding teeth to an existing partial removable denture or to bridgework when necessary to replace one or more natural teeth removed after the existing denture or bridgework was installed.
  - Restorations of inlays, onlays, and crowns (not more than one to the same tooth surface within five years of a prior restoration).

Class IV— Orthodontia

Benefits are paid for the following orthodontia services.

Orthodontia, including appliance therapy,

- CIGNA Dental Care (DHMO): Adult and Children
- CIGNA Dental PPO: Children under age 19

If an eligible dependent started an orthodontic course of treatment before coverage with CIGNA took effect and is receiving a benefit through the previous insurer, he or she receives a benefit on a prorated basis. The orthodontist must submit the treatment plan, including any insurance payments made through the previous insurer to CIGNA Dental to determine the available benefits.
Dental Expenses Not Covered

What Is Not Covered
You receive benefits for many dental expenses, provided they are necessary in terms of generally accepted dental standards and appropriate to properly treat a dental condition. However, some limits and exclusions do apply:

CIGNA Dental Care (DHMO type plan) Limitations and Exclusions

Limitations on Covered Services
- **Frequency** – The frequency of certain covered services, such as cleanings, is limited. The Patient Charge Schedule lists any limitations on frequency.
- **Specialty Care** – Payment authorization is required for coverage of services by a Network Specialist.
- **Pediatric Dentistry** – Coverage for referral to a Pediatric Dentist ends on an enrolled child’s 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. The Network General Dentist shall provide care after the child’s 7th birthday.
- **Oral Surgery** – The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

Exclusions
Listed below are the services or expenses which are **NOT** covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees.

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-Network Dentist except as described in your plan document or as otherwise required by law.
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- Services relating to injuries which are intentionally self-inflicted. (Ohio and Texas residents: Services relating to injuries which are intentionally self-inflicted are not excluded.)
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
• General anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.)

• Prescription drugs.

• Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) diagnose or treat abnormal conditions of the temporomandibular joint (“TMJ”), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or (3) restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

• The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage. (Texas residents: Pre-existing conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule.)

• Replacement of fixed and/or removable prosthodontic or orthodontic appliances that have been lost; stolen; or damaged due to patient abuse, misuse or neglect.

• Services associated with the placement or prosthodontic restoration of a dental implant.

• Services considered to be unnecessary or experimental in nature. (Maryland residents: This exclusion should read “Services considered to be unnecessary.” Pennsylvania residents: This exclusion should read “Services considered experimental in nature.”)

• Procedures or appliances for minor tooth guidance or to control harmful habits.

• Hospitalization, including any associated incremental charges for dental services performed in a hospital.

• Services to the extent you, or your Dependent, are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy. (Arizona and Pennsylvania residents: Services compensated under group medical plan, no fault auto insurance policies or insured motorists policies are not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or insured motorists policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)

• Crowns and bridges used solely for splinting.

• Resin bonded retainers and associated pontics.

Please note: Except as set forth above, preexisting conditions are not excluded.
CIGNA Dental PPO Limitations and Exclusions

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers’ compensation or similar law;
- For charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military service connected condition;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- To the extent that they are more than either the applicable Contracted Fee, applicable Reasonable or Customary Charges or applicable Scheduled Amount;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society; or
- When a new member has a missing tooth, the amount payable is 50% of the amount otherwise payable for the first replacement of the tooth that is missing when a person first becomes covered by CIGNA for these benefits and continues until the member is covered for a period of 24 months for these dental benefits.

No payment will be made for expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a “no-fault” insurance law or an uninsured motorist insurance law. CIGNA will take into account any adjustment option chosen under such part by you or any one of your Dependents.

If more than one dental service could provide suitable treatment based on commonly accepted dental standards, CIGNA will provide payment for the least costly alternate service. An example is that the plan will pay for amalgam (silver) fillings for posterior teeth even if you choose to have composite (white) fillings. In network, the plan payment will be based on the dentist’s contracted fee for amalgam fillings. Out of network, plan payment will be based on prevailing community charges for amalgam fillings. You or your dentist may apply this payment to the treatment of your choice; however, you are responsible to pay any expenses that exceed Covered Expenses. A predetermination of benefits is recommended when major dental services are needed so that you and your dentist know in advance what the plan will cover before treatment begins.
Exclusions
Covered expenses will not include, and no payment will be made for, expenses incurred for:

- Services performed solely for cosmetic reasons, including composite fillings on posterior teeth;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion; to include orthodontics for members and dependents age of 19 and over;
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second or third molars;
- Bite registrations; precision or semi-precision attachments; or splinting;
- A surgical implant of any type including any prosthetic device attached to it;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the “General Limitations” section.

In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.
Applying for Benefits

How to File Claims

CIGNA Dental Care
The CIGNA Dental Care plan (HMO-type plan) does not require participants to file claims.

CIGNA Dental PPO
If you choose The CIGNA Dental PPO and use a network provider the provider should file claims for you. If you use a non-network provider you may be required to submit claims for services. Claim forms are available from the UPMC Employee Service Center, or you can download a form from CIGNA’s web site at www.cigna.com. The group number is 3146648.

CIGNA Dental PPO claim forms should be submitted to:

CIGNA HealthCare
P.O. Box 188036
Chattanooga, TN 37422-8036

After each claim submission, CIGNA will mail you a concise Explanation of Benefits (EOB) showing charges and payments. Benefits will be paid to you, unless you assign payment to your dentist. If you have a claim inquiry or a benefits-related question, call CIGNA Dental Care at 1-800-367-1037 or CIGNA Dental PPO at 1-888-336-8258.

If you are required to file your own claim please make every reasonable effort to file claims within ninety (90) days after the end of the calendar year in which you incur the eligible expense. Claims are not processed more than one year after the end of the calendar year in which you incur the expense. For example, if you incur an expense in 2002 you must submit the claim for the expense before the end of 2003. Your claim may be denied if you do not submit it in a timely manner.

If a Claim Is Denied
If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that’s not possible, formal procedures are in place so that you may appeal a plan decision. See the Appealing Denied Claims section at the end of this document for details regarding the appeals process.
Life and Accidental Death and Dismemberment (AD&D) Insurance
An Introduction to Your Life and AD&D Benefits

While you are working, you and your dependents rely on your paycheck to meet day-to-day expenses. If you die or are seriously injured in an accident, your dependents’ financial security could be seriously affected.

As part of your total compensation package, UPMC offers eligible staff members life and accidental death and dismemberment (AD&D) insurance coverages to assist during these difficult times. See the Who is Eligible section for more details regarding who is eligible.

As you read about your benefit options, keep the following in mind:

- If you are an eligible staff member, UPMC automatically provides you with basic life and AD&D coverages. As a result, your designated beneficiary is eligible for life insurance benefits if you die for any reason. If you die as a result of an accident, your designated beneficiary is eligible for a basic AD&D benefit in addition to any life insurance benefits. And you are eligible for basic AD&D benefits in the event of your accidental dismemberment. UPMC pays the full cost of this coverage.

- In addition to the UPMC provided basic life insurance, you may purchase supplemental life insurance coverage for yourself. You pay for this additional coverage with after-tax payroll deductions.

- You may purchase supplemental life insurance coverage for your spouse. You pay for this coverage with after-tax payroll deductions. You must have purchased supplemental life insurance for yourself to be eligible to purchase coverage for your spouse.

- You may purchase supplemental life insurance for your dependent children. If you do, all of your dependent children are covered at a single rate, regardless of the number of children you have. You pay for this coverage with after-tax payroll deductions. You must have purchased supplemental life insurance for yourself to be eligible to purchase coverage for your dependent children.

- In addition to the UPMC provided basic AD&D insurance, you may purchase supplemental AD&D insurance coverage for yourself. This coverage provides additional protection in the event of your accidental death. It also pays you an additional benefit for dismemberment, such as the loss of an arm that results from an accident. You pay for this additional coverage with pretax payroll deductions.

If you have any questions after reading this section, contact the UPMC Employee Service Center.
## Snapshot of the Coverages

The chart below shows the various life and AD&D coverages available to eligible staff members.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Coverage Levels*</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Life and AD&amp;D Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full-time, flexible full-time, and job-share staff members</td>
<td>One times base annual salary (up to $1 million) $10,000</td>
<td>UPMC pays the full cost of coverages.</td>
</tr>
<tr>
<td>• Regular part-time staff members</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Supplemental Life Insurance for You</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One to five times base annual salary (up to $1 million)</td>
<td>You pay the cost of coverage with after-tax payroll deductions.</td>
</tr>
<tr>
<td><strong>Supplemental Life Insurance for Your Spouse</strong></td>
<td>In $10,000 increments (Up to $100,000)</td>
<td>You pay the cost of coverage with after-tax payroll deductions.</td>
</tr>
<tr>
<td><strong>Supplemental Life Insurance for Your Children</strong></td>
<td>$5,000 or $10,000 (per-child coverage)</td>
<td>You pay the cost of coverage with after-tax payroll deductions.</td>
</tr>
<tr>
<td><strong>Supplemental AD&amp;D Insurance</strong></td>
<td>Any multiple of $10,000 (up to $200,000)</td>
<td>You pay the cost of coverage with pretax payroll deductions.</td>
</tr>
</tbody>
</table>

*All coverage levels are rounded to the next higher $1,000.
How Your Life and AD&D Coverages Work

When you are first hired, and each year during annual enrollment, you can select the coverage option you need, or you can select a higher level of a specific coverage depending on your own personal situation.

Beneficiary
A beneficiary is someone who receives benefits in the event of your or your covered dependent’s death.

Naming a Beneficiary
When you enroll, you must name a beneficiary on your Beneficiary Designation form, and then submit your form to the UPMC Employee Service Center. If you purchase supplemental life insurance for your spouse and/or your dependent children, you are automatically the beneficiary if your covered spouse or dependent dies.

You can name one or more beneficiaries. If you name more than one beneficiary, you need to designate what portion of the entire benefit should be paid to each. You also need to indicate the beneficiaries’ relationship to you. For example, Debra A. Jones, wife — 50%; Mary T. Jones, daughter — 25%; Thomas R. Jones, son — 25%. If you fail to name a percentage when naming multiple beneficiaries, the benefit is paid in equal shares to the designated beneficiaries.

Changing Your Beneficiary
Because family situations can change, you may want to review your beneficiary designations from time to time. You may change your beneficiary at any time by submitting a new Beneficiary Designation form. Your new designation takes effect on the date the UPMC Employee Service Center receives your new form.

If You Do Not Name a Beneficiary
If you do not name a beneficiary or if your beneficiary dies before you do, the benefit is paid in one lump sum to those below in the following successive order:

- Your surviving legal spouse; or if none,
- Your surviving child(ren) (in equal shares); or if none,
- Your surviving parent(s) (in equal shares); or if none,
- Your surviving sibling(s) (in equal shares); or if none,
- Your estate (unless otherwise provided via a beneficiary assignment as explained in the following subsection).
Beneficiary Assignment
Your beneficiary may assign the life and AD&D insurance proceeds to anyone. For example, he or she may want to assign a portion of the life insurance benefit to a funeral home to cover funeral expenses.

The beneficiary(ies) should sign the assignment and include the group plan number, the amount of the assignment, and the staff member’s name and Social Security number. The UPMC Employee Service Center keeps a copy of any beneficiary assignment on file. Then, at the point the claim is filed, a copy of the assignment form is sent with the claim form when processing the benefit. See the Overview section for the full address and telephone number of the administrator.

Base Annual Salary
For full-time, flex full-time and job share staff members, your base annual salary determines your basic life, basic AD&D coverage and your supplemental life insurance coverage levels.

- For full-time salaried staff members, your base annual salary does not include overtime or any other types of pay.

- For full-time hourly staff members, your base annual salary is calculated by multiplying your hourly rate times 2,080. For example, if you make $15 per hour, your base annual salary is $31,200 ($15 × 2,080 = $31,200). Your basic life and basic AD&D coverage amounts are then rounded to the next $1,000. In this example, both coverages would equal $32,000.

- For flexible full-time or job-share staff members, your base annual salary is calculated by multiplying your authorized hours worked per pay period by your hourly rate and then multiplying the result by 26 (the number of pay periods in a year). For example, if you are a job-share staff member working 25 authorized hours per pay period and you make $12 per hour, your base annual salary is $7,800 (25 hours × $12 hourly rate × 26 pay periods = $7,800). In this example, coverages would not be rounded to the next higher $1,000.

Evidence of Insurability
When you choose certain amounts of supplemental life insurance for yourself or your spouse, you must provide evidence of good health or “evidence of insurability.” You need to provide evidence of insurability if:

- At your initial eligibility enrollment (new hire or change in job status), you elect supplemental coverage (for you) equal to more than three (3) times your base annual salary (or $500,000, whichever is less).

- You elect to increase coverage by more than one level, after your initial enrollment.

- At any time, you elect over $30,000 in supplemental life insurance coverage for your spouse.
If You Become Disabled
If you become disabled, your basic life and basic AD&D coverages, as well as your supplemental life insurance coverage, continue at the amount in effect on the day of your disability begins. These coverages remain in effect for six months after your disability. During this time, you and/or UPMC continue to make premium payments. In addition, you must provide the administrator with proof of your disability.

If, after the initial six-month period, you meet the definition of totally disabled and the administrator approves your proof of disability and you are less than age 60 when your Total Disability started, you may be able to continue these coverages until you turn age 65 without paying any necessary premiums. This is called a waiver of premium. You must apply for a “Waiver of Premium” within six (6) to twelve (12) months after your disability began to be eligible for the waiver.

Imputed Income
Under current tax laws, you are required to pay income taxes on the “value” of your UPMC provided basic life insurance coverage over $50,000. The “value” is determined by your age and according to a schedule established by the Internal Revenue Service (IRS). This tax liability is called “imputed income” and is included on your W-2 Form at the end of the calendar year.

The chart below shows the rates used by the IRS (effective July 1, 1999) to determine annual imputed income. These rates are subject to change, but do not necessarily change annually.

<table>
<thead>
<tr>
<th>Age Bracket (At Year's End)</th>
<th>Annual Imputed Income (Per $1,000 of Coverage Above $50,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.60</td>
</tr>
<tr>
<td>25 to 29</td>
<td>$0.72</td>
</tr>
<tr>
<td>30 to 34</td>
<td>$0.96</td>
</tr>
<tr>
<td>35 to 39</td>
<td>$1.08</td>
</tr>
<tr>
<td>40 to 44</td>
<td>$1.20</td>
</tr>
<tr>
<td>45 to 49</td>
<td>$1.80</td>
</tr>
<tr>
<td>50 to 54</td>
<td>$2.76</td>
</tr>
<tr>
<td>55 to 59</td>
<td>$5.16</td>
</tr>
<tr>
<td>60 to 64</td>
<td>$7.92</td>
</tr>
<tr>
<td>65 to 69</td>
<td>$15.24</td>
</tr>
<tr>
<td>70 and above</td>
<td>$24.72</td>
</tr>
</tbody>
</table>

To show how this works, let’s assume you are age 45 and have $90,000 of basic life insurance coverage. Since you have over $50,000 of coverage, your annual imputed income is $72 ($40,000 [the amount of coverage over $50,000] of coverage x $1.80 per $1,000).

Imputed income may apply for your supplemental life insurance coverages as well. However, the amounts you pay with after-tax dollars offset against the imputed income.
Basic Life and AD&D Insurance Coverage

You automatically receive basic life and basic AD&D insurance coverages as an eligible staff member. See the Overview section for details regarding eligibility.

Basic Life Insurance Coverage
The amount of your coverage and how coverage is calculated depends on your employment classification.

Full-Time, Flexible Full-Time, and Job-Share Staff Members
As a full-time, flexible full-time, or job-share staff member, you are eligible for basic life insurance coverage equal to one times your base annual salary, up to a maximum of $1 million. Coverage is rounded up to the next $1,000. (For a definition of base annual salary, see the Basic Annual Salary section.)

Regular Part-Time Staff Members
As a regular part-time staff member, you are eligible for basic life insurance coverage equal to $10,000.

Basic AD&D Insurance Coverage
Your basic AD&D coverage equals an additional one times your base annual salary (or $10,000 for regular part-time staff members). If you die as a result of an accident, your beneficiary receives this basic AD&D benefit in addition to the basic life insurance benefit as explained above.

In the event of an accidental dismemberment (you lose your sight, a hand, a foot, or you experience another covered loss), you receive a portion of your basic AD&D benefit, as shown on the next page under Covered AD&D Losses.

If you are seriously injured in an accident, contact the UPMC Employee Service Center to obtain an Accidental Dismemberment or Blindness claim form. You need to submit this form to the insurance carrier along with any newspaper clippings, official reports, or a letter outlining the circumstances of the accident.
**Covered AD&D Losses**

AD&D benefits for loss of life, dismemberment, and paralysis are shown in the chart below.

**Schedule of Covered AD&D Losses**

<table>
<thead>
<tr>
<th>Loss …</th>
<th>Percent of Coverage Amount Payable …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100% to your beneficiary</td>
</tr>
<tr>
<td><strong>Dismemberment</strong></td>
<td></td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>100% to you</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100% to you</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100% to you</td>
</tr>
<tr>
<td>One hand or one foot and sight in one eye</td>
<td>100% to you</td>
</tr>
<tr>
<td>Speech and hearing in both ears</td>
<td>100% to you</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>50% to you</td>
</tr>
<tr>
<td>Sight in one eye</td>
<td>50% to you</td>
</tr>
<tr>
<td>Speech</td>
<td>50% to you</td>
</tr>
<tr>
<td>Hearing in both ears</td>
<td>50% to you</td>
</tr>
<tr>
<td>Thumb and index finger on the same hand</td>
<td>25% to you</td>
</tr>
<tr>
<td><strong>Paralysis (total)</strong></td>
<td></td>
</tr>
<tr>
<td>Both upper and both lower limbs (quadriplegia)</td>
<td>100% to you</td>
</tr>
<tr>
<td>Both lower limbs (paraplegia)</td>
<td>75% to you</td>
</tr>
<tr>
<td>Upper and lower limbs on one side of body (hemiplegia)</td>
<td>50% to you</td>
</tr>
</tbody>
</table>

A covered loss must be incurred within ninety (90) days of the accident (365 days for paralysis).

In the event of multiple losses from one accident, you receive AD&D benefits up to the full coverage amount. Once the full benefit is paid, losses from the same accident that occur later and losses from any future accident are not covered.

**Special Benefits**

Your beneficiary receives an additional 10% of your AD&D coverage amount (up to $10,000) if you die as a result of an accident in a private passenger car and you were wearing a properly fastened seat belt (subject to police verification). Your beneficiary is not eligible for this benefit if you were driving under the influence of alcohol or drugs.

A passenger car means any validly registered, four-wheel, private passenger vehicle. It does not include any commercially licensed vehicle or private passenger vehicle that is used for commercial purposes.

A seat belt is any restraint device that meets published federal safety standards, has been installed by the car manufacturer, and has not been altered after installation. The correct position of the seat belt must be certified by the investigating officer. A copy of the police report must be submitted with the claim.
Exclusions

- Basic life and basic AD&D benefits are not payable if your death or injury results from:
- Participation in an assault, crime, or illegal occupation;
- Suicide or attempted suicide (applies for AD&D benefits only);
- Intentionally self-inflicted injuries;
- Disease, or medical or surgical treatment of a disease (applies for AD&D benefits only);
- Infection, except as the result of an accidental cut or wound (applies for AD&D benefits only);
- Any act of war;
- Intoxification or drug use (unless administered or consumed based on a physician’s advice);
- Injury rising out of (or in the course of) any work for wage or profit (whether or not you are working with UPMC);
- Travel or flight in any vehicle that is used for aerial navigation that is not intended or licensed for the transportation of passengers;
- An injury incurred while performing as a pilot or a crew member of any aircraft, or while riding as a passenger in an aircraft that is owned, leased, or operated by UPMC (applies for AD&D benefits only); or
- Hazardous sports, such as scuba diving, bungee jumping, skydiving, parachuting, hang gliding, or ballooning.

Age Reductions

If you continue to work beyond age 65, your basic life and basic AD&D coverages reduce at age 70. At age 70, your coverages reduce to 50% of what they were before you turned age 70. For example, if before age 70, your basic life and basic AD&D coverages are $76,000 (based on one times your base annual salary of $75,500, rounded to the next $1,000), your coverages at age 70 are $38,000 ($76,000 × 50% = $38,000).

Living Benefit

You are eligible for a “living benefit” (accelerated death benefit) provision. With this feature, you receive the lesser of:

- 50% of your basic life and basic AD&D coverage amounts; or
- $250,000.

If you become terminally ill while you are covered, you may request to receive benefits under this living benefit provision. You must provide a physician’s statement certifying that your life expectancy is six months or less due to being terminally ill with a medical condition. The remainder of the benefit is then paid to your beneficiary at your death.
Your living benefit option is a voluntary option. Also, your beneficiary’s consent is not required. Generally, benefits provided under the living benefits provision are exempt from federal income taxes. However, you should consult your tax advisor regarding possible tax implications.

If you become terminally ill and need to exercise this living benefit option, contact the UPMC Employee Service Center. The Center will send you the Living Benefit claim form.

**How and When Benefits Are Paid**

Benefits are paid based on the coverage in effect:

- On the date of death for basic life and basic AD&D insurance.
- On the date of the accident for basic AD&D insurance, even if a covered loss occurs after the accident date.

Basic life and basic AD&D benefits are paid as a lump sum to your beneficiary.

If you are seriously injured in a covered accident or you die from serious injuries received in a covered accident, you or your beneficiary receive the AD&D benefit within ninety (90) days of the covered accident. Benefits for injuries are paid to you after the insurance carrier receives satisfactory proof of your loss. You receive all or a portion of the covered amount, depending on the nature of the injury. See *Schedule of Covered AD&D Losses* section.
Supplemental Life Insurance

For additional protection, you may purchase supplemental life insurance coverage for yourself, your spouse, and/or your dependent children. Each of these coverages provide a life insurance benefit provided you are an eligible staff member and a participant at the time of your (or your dependent’s) death.

Supplemental Life Insurance for You
If you want additional coverage beyond the UPMC provided basic life insurance coverage, you may purchase supplemental life insurance for yourself from the following options, up to a maximum of $1 million.

- One times base annual salary;
- Two times base annual salary;
- Three times base annual salary;
- Four times base annual salary; or
- Five times base annual salary.

You can purchase supplemental life insurance for yourself, up to three times base annual salary or $500,000 (whichever is less) without providing evidence of insurability. You also can purchase supplemental life insurance of up to five times base annual salary (up to $1 million) if you provide evidence of insurability.

Keep in mind, after your initial enrollment; you can only increase your supplemental life insurance by one level each year during annual enrollment without evidence of insurability. This limit does not apply if you need to change your coverage during the year because of a qualified change in status. See the Overview section for a definition of qualified change in status.

Supplemental Life Insurance for Your Spouse
You may want to purchase supplemental life insurance for your spouse. This coverage pays a benefit to you in the event of your spouse’s death.

You can purchase supplemental life insurance for your spouse in $10,000 increments, up to a maximum of $100,000.

You are required to provide evidence of insurability anytime you elect supplemental life insurance coverage for your spouse over $30,000. See the How Your Life and AD&D Coverage Works section for details regarding evidence of insurability.

You are required to purchase supplemental life insurance for yourself to be eligible to purchase supplemental life insurance for your spouse.
Supplemental Life Insurance for Your Dependents
You may want to purchase supplemental life insurance for your eligible dependent children. You can elect coverage equal to $5,000 or $10,000.

When you elect this coverage, all of your eligible dependent children are covered. Also, your after-tax payroll deduction to pay for this coverage is the same regardless of how many children you cover.

You do not have to provide evidence of insurability for your dependents if you purchase this supplemental life insurance.

You are required to purchase supplemental life insurance for yourself to purchase supplemental life insurance for your dependents.

Exclusions
- Basic life and basic AD&D benefits are not payable if your death or injury results from:
- Participation in an assault, crime, or illegal occupation;
- Suicide or attempted suicide (applies for AD&D benefits only);
- Intentionally self-inflicted injuries;
- Disease, or medical or surgical treatment of a disease (applies for AD&D benefits only);
- Infection, except as the result of an accidental cut or wound (applies for AD&D benefits only);
- Any act of war;
- Intoxification or drug use (unless administered or consumed based on a physician’s advice);
- Injury rising out of (or in the course of) any work for wage or profit (whether or not you are working with UPMC);
- Travel or flight in any vehicle that’s used for aerial navigation that’s not intended or licensed for the transportation of passengers;
- An injury incurred while performing as a pilot or a crew member of any aircraft, or while riding as a passenger in an aircraft that’s owned, leased, or operated by UPMC (applies for AD&D benefits only); or
- Hazardous sports, such as scuba diving, bungee jumping, skydiving, parachuting, hang gliding, or ballooning.

Eligible Dependent Children
See the Overview section for a definition of who is eligible for supplemental life insurance coverage. Be sure to notify the UPMC Employee Service Center if your covered dependent no longer meets the...
Supplemental AD&D Insurance

If you want additional coverage beyond the UPMC provided basic AD&D coverage, you may purchase supplemental AD&D insurance for yourself. This provides additional protection to ease the financial strain in the event of an accident to you.

**Supplemental AD&D Insurance for You**
You can purchase supplemental AD&D coverage in increments of $10,000 up to a maximum of $200,000. You do not need to provide evidence of insurability if you elect this coverage.

In the event of an accidental death, your beneficiary receives the full amount of your supplemental AD&D coverage. This is in addition to any basic life and basic AD&D benefits.

In the event of an accidental dismemberment (you lose your limb, sight, hearing, or speech), you receive a portion of your supplemental AD&D benefit, as shown in the schedule of covered losses in the *Basic Life and AD&D Insurance Coverage* section. This is in addition to any basic AD&D benefits you may receive.
Situations Affecting Your Life and AD&D Benefits

Certain situations could affect your life and AD&D benefits. For additional information regarding how long these coverages continue, see the Overview section for details.

Converting to an Individual Policy
When your employment or eligibility for basic life and supplemental AD&D coverage ends, you may be able to convert your group coverage to an individual policy. Conversion is the exchange of your group term life insurance policy for a permanent individual life insurance policy without undergoing a medical examination. To convert your coverage you must apply and pay for the coverage within thirty-one (31) days after the group coverage ends. See the Overview section for details.

Continuation of Coverage
If your, your spouse’s, or your dependent’s supplemental life insurance group coverage ends you, your spouse or dependent(s) may be able to continue all or part of the coverage without evidence of insurability, by paying the premiums to the insurance carrier. You must elect to continue optional coverage for yourself to be eligible to continue coverage for your spouse and/or dependents. You must elect to continue optional coverage within thirty-one (31) days of losing coverage to be eligible.

Please Note: Staff members whose employment or eligibility ends prior to May 1, 2003 may continue term life coverage on a temporary basis for up to twelve (12) months. Staff members whose employment or eligibility ends after May 1, 2003 may continue or convert term life coverage.

To be eligible for conversion or continuation coverage, you and your spouse must be under age 70 (children must be under age 25), and you must be actively at work on the day before your employment terminates. You, your spouse, and your eligible dependents are eligible to apply for this coverage except if:

- Premiums are not paid;
- UPMC terminates the coverage but replaces it within thirty-one (31) days with coverage from another group plan;
- You, as a staff member, retire; or
- The end of coverage is due to injury or illness.

In addition, your spouse or dependent child is eligible to apply for this coverage if coverage ends because of your death, a divorce, or dependent loses dependent status.
Applying for Benefits

If you or a covered dependent dies or if you are seriously injured in an accident, you or your beneficiary should notify UPMC immediately by calling the UPMC Employee Service Center at 1-800-994-2752, option 3.

How to File Claims
Your beneficiary should contact the UPMC Employee Service Center as soon as possible after your death. UPMC Employee Service Center will provide your beneficiary with the information he or she needs to receive benefits.

Remember, you are the beneficiary for any supplemental life insurance coverage for your spouse or dependent children. If your spouse or child dies, contact the UPMC Employee Service Center as soon as possible to obtain the necessary information.

If a Claim Is Denied
If disagreements arise regarding your or your beneficiary’s claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you (or your beneficiary) may appeal a decision. See the Appealing Denied Claims section for details regarding the appeals process.
Disability
An Introduction to Your Disability Benefits

Your disability coverage is designed to help protect your income if you are unable to work because of an illness or injury. As you read about your coverage, keep the following in mind:

- As an eligible active full-time, flexible full-time, or job-share staff member regularly scheduled to work a minimum of 20 hours per week, you automatically receive short-term disability (STD) and long-term disability (LTD) coverage. Coverage takes effect the first of the month following your date of hire. For details regarding who is eligible, see the Overview section.

- If you are a part-time staff member, you are not eligible for the UPMC disability coverage. However, eligible part-time staff members may purchase STD coverage through AFLAC. Contact an AFLAC representative at 1-800-994-2752, option 5 for details.

- Staff members with employment contracts and some Senior Managers may be excluded from certain provisions of the disability plans or covered at different levels.

- Most physicians are not eligible for disability coverage, with a few grandfathered exceptions. The majority of physicians are eligible to purchase short-term disability (STD) coverage (does not apply to UPP physicians). UPP physicians are eligible for long-term disability (LTD) coverage under a separate LTD policy and you receive separate materials that describe this coverage.

- Staff Members covered by collective bargaining agreements should consult their collective bargaining agreements for specific benefit coverage information.

Disability Summary

- If you become disabled because of an illness or injury and qualify for benefits, you receive a portion of your base annual salary on a short-term basis. Your STD benefits continue for up to 26 weeks, provided your disability lasts that long.

- After 26 weeks of short-term disability benefits, you may be eligible for long-term disability benefits. You cannot receive STD and LTD benefits at the same time.

- Your STD and LTD coverages are made up of UPMC provided benefits and employee purchased voluntary benefits.

- UPMC pays the full cost of your core coverage.

If you have any questions after reading this section, contact the UPMC Employee Service Center at 1-800-994-2752, option 3.
Your Short-Term Disability (STD) Coverage

If you become disabled and are eligible for STD benefits, you continue to receive a percentage of your base salary.

Disability Defined
A disability can prevent you from doing your current job at UPMC. You are considered disabled because of a non-work related illness or injury, when the disability carrier determines that:

• You are limited from performing the material and substantial duties of your regular occupation due to your non work-related illness or injury; and
• You are under the regular care of a licensed physician (other than yourself, if you are a physician); and
• You have a twenty (20) percent or more loss in weekly earnings due to the same illness or injury.
• To be considered eligible for STD benefits you must be in an actively employed status, just prior to the occurrence of the disability.

Eligibility Waiting Period
STD coverage generally begins on the first day of the month on or after your date of hire (provided you are actively at work on that day).

STD benefits begin on the eighth day of an illness (the seven-day waiting period includes weekends). The STD waiting period may be covered by your PTO. If your disability is the result of an accident or results in a hospitalization of at least 24 hours, STD benefits may begin on the first day of your hospitalization.

How STD Coordinates With Paid Time Off (PTO) and the Extended Illness Bank (EIB)
Before STD benefits begin, you may use your Paid Time Off (PTO) or, in certain circumstances, your Extended Illness Bank (EIB) if available.
**STD Benefits**

Your STD benefit equals 60% of your weekly base salary.

To show how your STD benefit is calculated, let’s assume you are a regular full-time staff member who earns $10 per hour and you are out of work for 14 calendar days due to an illness that does not require hospitalization. Your STD benefit is calculated as shown below. (Since your disability does not require hospitalization, the first seven days of your illness may be covered by your PTO and not STD.

\[
\text{Weekly base salary} = \text{Rate} \times \text{Hours} = \10 \times 40 = \400 \\
\text{STD benefit} = \left( \frac{\text{Weekly base salary} \times 60\%}{7} \right) = \left( \frac{\400 \times 60\%}{7} \right) = \34.29 \\
\text{STD benefit for 14 days} = \34.29 \times 7 = \240.03
\]

Merit increases and general wage adjustments occurring after commencement of disability do not increase STD pay for that period of disability.

**When Benefits Begin**

The date your STD benefits begin depends on whether your disability is the result of an illness or an accident.

- STD benefits begin on the first day of disability due to an accident or hospitalization, and from the eighth consecutive calendar day of disability due to illness not requiring hospitalization. Staff member must be under the direct care of a physician to be eligible for disability benefits.
- “Hospitalization” means the period commencing with the day of an inpatient admission that equals or exceeds 24 hours.
- “Accident” means a sudden, unexpected, unintentional, and chance occurrence caused by an outside force, such as auto collisions, falls, burns, and fractures. Such incidents as colds, flu, or heart attacks are not considered accidents.
- Such hospitalization or accident that disables and causes a staff member to miss work qualifies the staff member for STD benefits on the first day of the occurrence.

You may elect to use your PTO or EIB beyond the “waiting period” for your disability. However, this will offset the STD benefits that remain for that disability. For example, if you go out on a maternity leave, you are eligible for six weeks of STD benefits. However, if you decide to use three weeks of your PTO or EIB, you are eligible for the remaining three weeks of STD benefits.

**How Benefits Are Paid**

You generally receive your STD checks weekly. The amount you receive is subject to federal income and Social Security taxes. Federal income taxes are withheld from STD benefits at 28 percent. If you want the disability carrier to withhold at a lower tax rate, you must request a W-4(S) from the disability carrier.
Other Disability Benefits
Disability carrier will subtract from your gross disability payment the following deductible sources of income:

- Social Security benefits
- Worker’s Compensation
- No Fault Insurance
- Salary Continuation, Extended Illness Bank (EIB), Paid Time Off (PTO)
- Third Party Benefits
- State Disability Programs

Benefits may be advanced for a period of time, subject to your written agreement to immediately repay the plan upon receipt of payment from the other insurance plan.

You are responsible for repaying any overpayment resulting either from a STD advance, an overpayment or from a later determination of ineligibility.

When Benefits End
Your STD benefits end once you are determined by the disability carrier/administrator to be no longer disabled, or after you are disabled for 26 weeks following the onset of the disability, whichever comes first. In addition, your STD benefits may end if you refuse work (offered by UPMC) that you are able to perform and for which you will be paid the same or similar rate of pay as your regular rate.

Successive periods of disability for the same illness or injury separated by fewer than 14 days of work are considered the same disability for purposes of the one-week waiting period (for illness) and duration of benefits. Periods of disability separated by 14 or more days are considered a new disability and you may be eligible for an additional 26 weeks of disability.

When a staff member has been on a medical leave for 26 weeks and has not returned to work the staff member is removed from the payroll and considered to be terminated from employment. Eligible staff members may have additional income protection benefits following exhaustion of the above STD benefits as described in the long-term disability section.

If You Return to Work
You may return to work on a part-time or full-time basis. Refer to Return to Work Assistance program for additional information. Below is a description of what happens to your STD benefits if you return to work:

- **Part time:** If you return to work part time while you are receiving STD benefits, your total pay cannot exceed 100% of your pre-disability earnings. Any pay you receive for sick pay, vacation pay, or other earnings can not be substituted or earned at a level that would allow your pay (including your STD benefits) to exceed 100% of your pre-disability earnings.
• **Full time:** If you return to work full time and within 14 days of returning to work you become totally disabled from the same or a related cause, you continue to receive STD benefits as if it were the same claim — unless your second disability is due to a different cause that occurs after your return.

• Refer to the Return to Work Assistance program for additional information.

**STD Procedures**

• When an absence is incurred that results from accidental injury, results in hospitalization, or an illness expected to last more than seven days, notify your department, Human Resources and report the disability to the insurance carrier as soon as possible. You may contact the disability carrier via UPMC DirectLink at 1-800-994-2752, option 2.

• Compensation will not be paid for the same day under PTO, EIB, STD or LTD. Staff members are not eligible for holiday pay, jury duty pay or bereavement time that occurs during a Leave of Absence (LOA). No paid time off (PTO) is accrued during the time of unpaid leave or while receiving STD. Paid time off accrues during the paid portion of the leave. The manager is responsible for assuring that time is submitted correctly while staff member is on leave.

• Staff members are responsible for their portion of the benefits premium while on leave. Staff may arrange to send payments directly to the Employee Service Center during the leave or the missed premiums will accumulate into an arrears balance to be deducted when staff member returns to work. If a staff member is unable to return to work due to illness, they are required to send payment for missed premiums to the Employee Service Center.

**Please Note:** For limitations and exclusions, refer to the end of the disability section.
Your Long-Term Disability (LTD) Coverage

Your LTD coverage works with other sources of disability coverage to provide income if you become totally disabled. If you are still disabled when your STD benefits end, LTD benefits may begin.

Disability Defined
You are considered disabled when the disability carrier determines that:

- You are limited from performing the material and substantial duties of your regular occupation due to your illness or injury; and
- You have a twenty (20) percent or more loss in your indexed monthly earnings due to the same illness or injury; and
- You are under the care of a licensed physician (other than yourself).
- After 24 months of payments, you are disabled when disability carrier determines that due to the same illness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

Eligibility Waiting Period
Your waiting period for eligibility purposes ends the first day of the month on or after your hire date (provided you are actively at work on that day). If you are not actively at work, the waiting period continues until you return to active employment.

LTD Benefits
Your LTD benefit amount equals 60% of your monthly base salary, up to a maximum of $15,000 per month. The minimum benefit you are eligible to receive is $100 per month, even if your disability benefit is reduced to recover any overpayment. Here’s how it works:

- The LTD benefit amount (60% of your monthly base salary) is calculated.
- Then, any other benefits for which you are eligible (such as Social Security, workers’ compensation dependent benefits, and auto insurance — including work-loss provisions) are taken into account.
- These other benefits — or offsets — are subtracted from the LTD benefit amount.
- The result is your UPMC provided LTD benefit.

For example, if you are a regular full-time staff member earning $10 per hour, your monthly base salary is $1,733. Your LTD benefit amount is $1,040 ($1,733 x 60% rounded to the nearest dollar).
Now let’s assume that $800 of that amount comes from other benefits like Social Security. Your UPMC provided LTD benefit is $240 ($1,040 – $800).

Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is given, the lump sum will be prorated over five years.

If you return to work for wage or profit while you are disabled, the work incentive benefit calculation applies. Please see the Return to Work Assistance Program in this section for details regarding how your benefit is calculated under this scenario.

When Benefits Begin
You begin to receive your LTD benefits after the elimination period (180 days) ends. In general, the elimination period includes the 26 weeks while you are receiving PTO income and STD benefits. Once these benefits end, your LTD benefits may begin.

How Benefits Are Paid
You generally receive your LTD checks from the administrator on a monthly basis. The amount you receive may be subject to federal income and tax withholdings.

Benefit Offsets
Disability carrier will subtract from your gross disability payment the following deductible sources of income:

- The amount that you receive or are entitled to receive under workers’ compensation law, or any other act or law with similar intent
- The amount that you receive or are entitled to receive as disability income payments under any state compulsory benefit act or law, other group insurance plan, or governmental retirement system as a result of your job with UPMC.
- The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan or any similar plan or act.
- The amount that you receive as retirement payments of the amount your spouse and children receive as retirement payments because you are receiving retirement payments under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan or any similar plan or act.
- The amount that you receive as disability payments under UPMC’s employer’s retirement plan; voluntarily elect to receive as retirement payments under UPMC’s retirement plan; receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in UPMC’s retirement plan.
When Benefits End

Your LTD benefits generally are paid until the earliest of the following:

- You recover and return to work;
- The end of the maximum benefit period;
- You do not meet the claims requirements (including the appropriate care of a licensed physician);
- The date you earn 80% or more of your pre-disability wages;
- The date the administrator determines you are no longer disabled;
- The day you refuse, without good cause, to fully cooperate in all required phases of the rehabilitation plan (benefits may resume if you agree to cooperate fully within 30 days of the date benefits originally terminated);
- The date you refuse, without good cause, to fully cooperate in a transitional work arrangement (benefits may resume if you agree to cooperate fully within 30 days of the date benefits originally terminated);
- The day you are no longer receiving appropriate care for your disability;
- The day you fail to cooperate (e.g., provide information or documents needed to determine whether benefits are payable or the actual benefit amount due) with the administrator who administers your claim; or
- You die.

For the first 12 months that monthly benefits are payable, your indexed monthly earnings equal your monthly earnings. After 12 monthly benefits are payable, your indexed monthly earnings equal your monthly earnings plus an increase. The increase is applied each anniversary of the date your monthly benefit became payable and equals the lesser of:

- 10% of your indexed monthly earnings during the year preceding your disability; or
- The rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

If You Become Disabled On or After Age 62

You may receive benefits beyond age 65. The duration of your benefits depends on your age when you become disabled, as follows:

<table>
<thead>
<tr>
<th>Age When You Become Disabled</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 or under</td>
<td>To age 65, or 42 months if later</td>
</tr>
<tr>
<td>63</td>
<td>36 months</td>
</tr>
<tr>
<td>64</td>
<td>30 months</td>
</tr>
<tr>
<td>65</td>
<td>24 months</td>
</tr>
<tr>
<td>66</td>
<td>21 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69 or older</td>
<td>12 months</td>
</tr>
</tbody>
</table>
Family Survivor Benefit
You are also eligible for a family survivor benefit. With this feature, your survivor receives a monthly survivor benefit if you die while you are receiving LTD benefits. The family survivor benefit equals 100% of your last month’s LTD benefit, plus any other earnings by which this benefit was reduced. Your survivor receives a single lump-sum payout equal to three monthly payments.

Your survivor may include your lawful spouse or your child(ren) (benefit is paid in equal shares). If you do not have a surviving lawful spouse or child, your estate receives the family survivor benefit.

Recurrent Disability Feature
If you return to work after you receive LTD benefits and then again become disabled from the same or a related cause, you do not have to meet another 180-day elimination period. Your subsequent disability is considered a continuation of your initial claim. This feature does not apply and you must file a new claim and meet a new elimination period if:

- Your subsequent disability recurs after you work more than six consecutive months and earn 80% or more of your Indexed Covered Earnings; or
- If your second disability results from a cause unrelated to the first.

Limitations
Certain limitations apply to your disability coverage.

Limitations to Mental/Nervous Conditions and Drug/Alcohol Abuse
The disability carrier will pay disability benefits on a limited basis during an employee’s lifetime for a disability caused, or contributed to, by any one or more of the following conditions. Once 24-monthly disability benefits have been paid, no further benefits will be payable for any of the following conditions:

- Alcoholism
- Anxiety disorders
- Delusional (paranoid) disorders
- Depressive disorders
- Drug addiction or abuse
- Eating disorders
- Mental illness
- Somatoform disorders (psychosomatic illness)

Self-Reported limitation
Disabilities due to illness or injury, which are primarily based on self-reported symptoms (soft-tissue injuries, chronic fatigue syndrome, etc.), have a limited pay period of 24 months.

For non-covered disabilities, refer to the Disabilities Not Covered section.
Return to Work Assistance Program
The Return to Work (RTW) Assistance Program is intended to protect the non-occupational injury/illness while it heals/recovers, reduce the financial impact on the staff member, and to minimize the amount of time lost from work.

The program is designed to help return staff members to work, when they are medically able to:

- To perform the essential functions of their current job with appropriate modifications; or
- to perform the essential functions of a temporary alternative work assignment (if alternative assignment is available); and
- must be able to work at least 50 percent of (pre-disability) scheduled hours; and
- must sign a RTW Assistance participation agreement to participate in the program.

Staff members will be assigned in his or her current position with appropriate job modifications that meet his or her physical capabilities (if possible) or a transitional work assignment (if available) that may be a vacant position or a temporary work assignment.

If there are no transitional or alternative work assignments available at the conclusion of the 26-week STD period, the staff member will be terminated from employment.

Staff members on STD who are unable to perform his or her work and are offered other work at a rate of pay the same as or at least 80% of his or her regular job, and refuses such job, ceases to be eligible for STD once FMLA entitlements have been exhausted.

Participation in the RTW program is limited to 26 weeks from the date the staff member enters the RTW assistance program within any 12-month period. If after 26 weeks of participation in the RTW Assistance program, the staff member has not found a regular position with UPMC, employment will be terminated.

The staff member is responsible for providing periodic medical evidence to RTW Coordinator and disability carrier to monitor progress and disability status, whether the staff member is receiving partial disability benefits or not.

The staff member must notify RTW Coordinator, Manager and Disability carrier when their physical condition has improved and they are able to resume their original position and duties (if still available).

If Your Employment Ends
If your employment ends, your LTD coverage also ends unless you are disabled on your last day of work.
Applying for Benefits

You need to apply to receive STD and LTD benefits.

To Report A Claim
1. Notify your supervisor to report your absence.

2. See your physician. Make sure you sign and date an authorization to release medical information in order for your physician to release medical information to the disability carrier.

3. Contact the disability carrier toll-free at 1-800-994-2752, option 2. You should call:

   - When you have an absence from work due to illness or injury that may extend beyond seven (7) days.
   - Up to two (2) weeks in advance of a planned disability absence (such as childbirth or prescheduled surgery).
   - When you contact the disability carrier, you will be asked to provide:
     - Your name, address, phone number, birth date, date of hire, Social Security number, and the address and phone number of your UPMC or affiliate department.
     - The date and cause of your disability and your anticipated return-to-work date.
     - Your doctor’s name, address, and phone number.

After you call to report your claim, a representative from the administrator will contact you periodically to discuss the claim process.
Disabilities Not Covered

Your STD and LTD coverages do not cover all types of disabilities.

Exclusions
You do not receive STD or LTD benefits if you do not provide the required documentation about your disability, or if you are not under the appropriate care of a licensed physician (other than yourself). You also do not receive benefits for any disability that results from or is caused by:

- Suicide, attempted suicide, or self-inflicted injury while sane or insane;
- a war or an act of war, whether or not declared;
- committing or attempting to commit a felony;
- active participation in a riot or terrorism;
- any period of disability during which you are incarcerated in a penal or correctional institution;
- cosmetic surgery;
- a work-related injury or illness (excluded under STD only, offset under LTD); or
- a pre-existing condition.

Pre-Existing Conditions
Long-term disability benefits will not be paid for any period of disability caused, contributed or resulting from, a pre-existing condition.

A pre-existing condition means any injury or illness for which a staff member received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed medicines in the three months just prior to the effective date of coverage. This applies if the disability begins in the first 12 months after the effective date.

In addition, you do not receive benefits for:

- Any days for which you receive pay for work, Paid Time Off (PTO), Extended Illness Bank (EIB) or holidays.
- Any injury or illness you may experience while serving on full-time active duty in any armed forces. If you send proof of service, the administrator refunds pro rata any premiums that have been paid for coverage during your service.
- The revocation, restriction, or nonrenewal of your license, permit, or certification necessary to perform the duties of your occupation (unless it is due solely to your injury or illness).
Flexible Spending Accounts (FSAs)
An Introduction to Your Flexible Spending Accounts (FSAs)

UPMC offers you a way to pay certain health and dependent care expenses with pretax dollars — Flexible Spending Accounts (FSAs). As you read about the FSAs, keep the following in mind:

- Each year at annual enrollment, you decide whether or not to use the accounts and how much to contribute.
- The two FSAs are designed to help you meet your financial needs. You can set aside pay in one or both accounts.
- You fund your accounts with pretax pay through payroll deductions. These funds remain in your account(s) until you file a claim for reimbursement. However, if at the end of the year your funds exceed the total amount of your claims, you forfeit the excess amount.
- Because your contributions are not considered taxable, you save by paying less in income tax. If you are paying these types of expenses and you are not using the FSAs, you are losing money. You may want to consider whether an FSA could help you pay less in taxes each year.
- The health care account is designed to help you pay for certain medical, dental, vision, and hearing expenses not covered under the UPMC Welfare Benefits Plan, or any other company-sponsored plan. See a list of eligible expenses later in this section.
- The dependent care account is designed to help you pay for eligible dependent care expenses you incur while you and your spouse (if you are married) are at work. See a list of eligible expenses later in this section.

If you have questions after reading this section, contact the UPMC Employee Service Center toll-free at 1-800-994-2752, option 3 for details.
A Snapshot of Your Flexible Spending Accounts (FSAs)

We are all looking for ways to save money. The FSAs can be one savings opportunity. By using pretax dollars to pay for certain eligible health and dependent care expenses, you may save significantly on taxes each year.

Snapshot Chart
Here’s a snapshot of the health care and dependent care FSAs.

<table>
<thead>
<tr>
<th>Type of FSA</th>
<th>Health Care</th>
<th>Dependent Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Expenses</td>
<td>• Medical, dental, vision, and hearing expenses not covered under the UPMC Welfare Benefits Plan, or another company-sponsored plan. • Deductibles and copayments.</td>
<td>• Eligible dependent care expenses you incur while you and your spouse (if you are married) are at work.</td>
</tr>
<tr>
<td>Qualified Dependents</td>
<td>• Anyone you claim as a dependent for tax purposes, including your spouse and your unmarried dependent children or stepchildren.</td>
<td>A child under age 13 whom you claim as a dependent on your income tax return. Also, an older dependent who: • Depends on you for at least half of his or her support; • Regularly spends at least eight hours a day in your household; and • Is physically or mentally unable to care for himself or herself.</td>
</tr>
<tr>
<td>Maximum Annual Contribution</td>
<td>$4,992 per year</td>
<td>$4,992 per year</td>
</tr>
</tbody>
</table>

How Your FSAs Work
Here’s a step-by-step look at how your FSAs work.

- **Estimate your expenses:** When you enroll, and at each annual enrollment, you determine in advance how much you expect to spend on health and/or dependent care expenses for the upcoming year. It is important to estimate carefully. Because of the FSAs’ tax advantages, IRS rules apply. As a result, you forfeit any unused FSA funds at the end of the year.

- **Determine how much to contribute:** You then decide how much to contribute to your FSAs for the upcoming year, on a pretax basis. You may contribute up to $4,992 each year into one or both accounts. If you decide to participate, you must elect to contribute at least a minimum of $5.00 per month per account.
• After you decide on the dollar amount, divide the amount by 26 pay periods (12 if you are paid monthly). This amount is deducted (before taxes) in even amounts from your bi-weekly paychecks. These funds are then deposited into the appropriate FSA, and remain there until you file a claim for reimbursement. Remember, you forfeit any contributions that remain in your accounts at the end of the year.

• **Incurred expenses:** The accounts reimburse you for eligible expenses incurred during the plan year. Any expense incurred before your enrollment does not qualify for reimbursement.

• **Receive reimbursement:** Submit a claim form along with the appropriate supporting documentation.

You are reimbursed for the eligible expense with pretax dollars. For the health care FSA, you are reimbursed up to the total amount you elect to contribute for the year — even if you incur the expense at the beginning of the year. For the dependent care FSA, you are reimbursed up to the amount you have in your account on the date your claim is processed. A minimum reimbursement amount of $25.00 has been established. Claims for eligible expenses will be accumulated until they exceed $25.00.

• **If you terminate employment:** Only the expenses incurred while you are an active employee and contributing to the account are eligible for reimbursement, unless you continue your participation in the health care FSA through COBRA.

### How FSAs Save You Money

**Orthodontia and Co-Payments Example:**
Jane Doe makes $30,000 annually and elects to contribute $840 or $70 per month to her health care FSA account. She plans to use her FSA for her child’s braces and medical plan co-payments. The braces will cost $3,065. Her out of pocket charge is $1,400, which is spread over 24 months. She estimates $700 for the braces with $140 remaining for other covered medical care expenses.

At the end of the year, Jane paid a total of $840 out of pocket as follows: $700 for braces, two PCP sick visit co-payments totaling $20 and three brand name mail order prescription co-payments totaling $120. She is able to claim reimbursement for the full $840 balance she contributed to her FSA account.

<table>
<thead>
<tr>
<th></th>
<th>Without FSA</th>
<th>With FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Pay</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Less: out-of-pocket medical expense pretax</td>
<td>$0</td>
<td>-$840</td>
</tr>
<tr>
<td>Taxable income</td>
<td>$30,000</td>
<td>$29,160</td>
</tr>
<tr>
<td>Less: federal taxes (based on 27%)</td>
<td>-$8,100</td>
<td>-$7,873</td>
</tr>
<tr>
<td>Less: state taxes (based on 2.8%)</td>
<td>-$840</td>
<td>-$816</td>
</tr>
<tr>
<td>Less: FICA taxes (based on 7.65%)</td>
<td>-$2,295</td>
<td>-$2,231</td>
</tr>
<tr>
<td>Less: out-of-pocket medical expense after-tax</td>
<td>-$840</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Income after medical expenses</strong></td>
<td><strong>$17,925</strong></td>
<td><strong>$18,240</strong></td>
</tr>
<tr>
<td><strong>Taxes saved</strong></td>
<td><strong>$0</strong></td>
<td><strong>$314.58</strong></td>
</tr>
</tbody>
</table>
**Laser Vision Correction Surgery Example:**
John Doe makes $30,000 annually and elects to contribute $3,000 or $250 per month to his health care FSA. He plans to use his FSA for laser vision correction surgery. He estimates the cost of the surgery at $3,000 for both eyes. John paid $3,000 for the surgery and is able to claim reimbursement for the full balance.

<table>
<thead>
<tr>
<th>Without FSA</th>
<th>With FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Pay</strong></td>
<td>$30,000</td>
</tr>
<tr>
<td>Less: out-of-pocket medical expense pretax</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Taxable income</strong></td>
<td>$30,000</td>
</tr>
<tr>
<td>Less: federal taxes (based on 27%)</td>
<td>-$8,100</td>
</tr>
<tr>
<td>Less: state taxes (based on 2.8%)</td>
<td>-$840</td>
</tr>
<tr>
<td>Less: FICA taxes (based on 7.65%)</td>
<td>-$2,295</td>
</tr>
<tr>
<td>Less: out-of-pocket medical expense after-tax</td>
<td>-$3,000</td>
</tr>
<tr>
<td><strong>Income after medical expenses</strong></td>
<td>$15,765</td>
</tr>
<tr>
<td><strong>Taxes saved</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

**Please Note:** The examples above are intended for illustration purposes only. Tax savings results may vary based on your personal situation and income level.

**Legal Limits**
If you participate in the health care FSA and your spouse participates in a similar FSA account through his or her employer, you and your spouse may not use both of your respective accounts to reimburse the same eligible health-related expenses. In addition, if you use your health care FSA to reimburse expenses, you give up the opportunity to take an income tax deduction on those same items when you file your taxes. See the *A Word About Taxes* section for details regarding the income tax deduction.

Under federal law, if you participate in the dependent care FSA and your spouse participates in a similar account through his or her own employer, your combined contributions to the account may not exceed $5,000. This limit applies whether you have one or more dependents receiving care. If you and your spouse file separate income tax returns, the most each of you may contribute is $2,500. In addition, if you are married, your dependent care FSA contributions may not exceed the annual income of the lower-paid spouse.

In general, you may not participate in the dependent care FSA if your spouse does not work outside the home. There are two exceptions: if your spouse does not work outside the home and is physically or mentally unable to care for himself or herself, or if he or she is a full-time student. In either of these cases the IRS considers your spouse’s earned income to be:

- $200 a month ($2,400 a year) if you have one dependent; or
- $400 a month ($4,800 a year) if you have two or more dependents.

As a result, these are the maximum amounts you may contribute to the dependent care FSA. If you participate, it is your responsibility to comply with the above limits.
Two Accounts Treated Separately
One additional consideration when estimating your expenses: the health care and dependent care FSAs are treated separately. This means you cannot use money deposited in your health care FSA to pay dependent care expenses, and you cannot use money from your dependent care FSA to pay for health related services.

Changing Your Contributions
In general, you cannot change your contributions during the year unless you have a qualified change of status that affects your participation. See the Overview section for more details.

Forfeiture of Contributions
Your FSAs only reimburse eligible expenses you (or your family members) incur during the year while you participate. In other words, any expense incurred after you terminate employment is not eligible for reimbursement. Only expenses incurred while you are an active staff member and contributing are eligible (unless you continue participating in the health care FSA through COBRA).

If you do not use the entire balance in your account(s) by the end of the year, the IRS requires you to forfeit the remaining funds. This money is not available for future expenses or a refund. UPMC uses the forfeited funds to offset administrative costs.

You do have until April 30 of the next year to submit claims for expenses incurred between the previous January 1 through December 31 period. This grace period enables you to submit any eligible expense you may incur shortly before the end of the year.

This IRS-imposed forfeiture rule simply means you need to carefully estimate how much to contribute to your FSAs each year.
A Word About Taxes

FSA contributions reduce your taxable income, meaning you pay less in taxes. Your FSA contributions are not subject to:

- Federal income taxes;
- Social Security (FICA) taxes; and
- In many cases, state and local income taxes.

Rules vary, and state and local taxes are subject to frequent change.

An Example of How FSAs Help You Save
This chart illustrates the potential tax savings when using the FSAs:

<table>
<thead>
<tr>
<th>If You Contribute:</th>
<th>Your Tax Savings Could Be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500</td>
<td>$127.25</td>
</tr>
<tr>
<td>$1,000</td>
<td>$254.50</td>
</tr>
<tr>
<td>$1,500</td>
<td>$381.75</td>
</tr>
<tr>
<td>$2,000</td>
<td>$509.00</td>
</tr>
<tr>
<td>$3,000</td>
<td>$763.50</td>
</tr>
<tr>
<td>$4,000</td>
<td>$1,018.00</td>
</tr>
</tbody>
</table>

These tax savings are based on the minimum federal income tax rate of 15%, PA state income tax rate of 2.8% and the Social Security (FICA) rate of 7.65%. If your income tax rate is higher, and/or you also pay other state and local taxes, you will save even more in taxes by using the FSAs.

As you can see, contributing to the FSAs can make your spendable pay go further.

Effect of Pretax Contributions on Your Other Benefits
Pretax contributions reduce the Social Security taxes you pay. Therefore, the eventual Social Security benefit you may be eligible to receive will be reduced. Because Social Security benefits are based on your career earnings, in most cases, this reduction will be minimal. For more information, contact your local Social Security Administration office.
Alternate Tax-Savings Approaches
You may be eligible to take a deduction or tax credit on your income tax return for eligible health and/or dependent care expenses.

Health Care FSA vs. the Income Tax Reduction
Under current tax laws, expenses reimbursed through your health care FSA are normally deductible on your federal income tax return if they exceed 7.5% of your adjusted gross income. When you use your FSA to reimburse these expenses, however, you give up the opportunity to take a tax deduction for these same items. So, when you consider whether or not to enroll in the FSA, decide whether you want to take the deduction on your income tax return, or reimburse the expenses through the FSA. Generally, if you do not itemize deductions, or if your health care expenses are less than 7.5% of your adjusted gross income, it may be better to use the health care FSA.

Dependent Care FSA vs. the Income Tax Credit
An alternative to using the dependent care FSA is the tax credit. You may want to consider the tax advantages of both alternatives before you participate.

Under current law, you can pay for eligible dependent care expenses with after-tax dollars. In addition, you can apply some or all of those expenses to the after-tax dependent care tax credit when you file your federal income tax return. Even though you may not apply the same expense to both tax-savings methods, you may apply a portion to the credit and then reimburse yourself from your FSA for any remaining amounts.

As a general rule:

- If your family’s total annual adjusted gross income is above $24,000, you probably will save more if you use the dependent care FSA.
- If your family’s total annual adjusted gross income is at or below $24,000, the best method to use will vary according to your individual circumstance. You may want to estimate your tax savings using both methods and compare the results.
- For the care of one dependent, you can generally take a tax credit of up to $2,400 in expenses each year. For two or more dependents, the credit is $4,800. The tax credit amount varies depending on your income. And, if you use your FSA and the tax credit, the maximum amount deducted through the tax credit is reduced by any amount you receive as reimbursement from the dependent care FSA.
**Comparison Snapshot**

Here is a brief comparison of the tax alternatives.

<table>
<thead>
<tr>
<th>Dependent Care FSA</th>
<th>Income Tax Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate savings using pretax dollars.</td>
<td>Deferred savings when you file taxes.</td>
</tr>
<tr>
<td>No taxes paid on up to $4,992 of eligible dependent care expenses for one or more eligible dependents.</td>
<td>Tax credit of 20-30% on maximum of $2,400 of expenses for one dependent or $4,800 for two or more.</td>
</tr>
<tr>
<td>Forfeit any funds that remain in your account at the end of the year.</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced federal, Social Security, and many state and local taxes.</td>
<td>Does not reduce Social Security, but reduces federal and many state and local taxes.</td>
</tr>
</tbody>
</table>

**Regarding the Tax-Saving Approaches**

It is important to note that any tax savings that may result from your participation in the FSAs depend on your own personal situation and income level. Tax information included in this handbook is only general information. Because tax laws are complicated and subject to frequent change, you should talk with a qualified tax advisor before you decide whether to use the FSAs or to take a tax deduction.

By law, UPMC cannot offer you tax advice, or advise you on your FSA-related decisions. This law is designed to protect you by ensuring that you always get the most up-to-date advice, and that advice is only available from a qualified tax advisor.
Health Care Flexible Spending Account (FSA)

You can use the health care FSA to reimburse your and your eligible dependents’ health-related charges that are:

- Not covered under a health, dental, or vision care plan;
- eligible for, but not used as, a tax deduction; and
- are incurred during the plan year in which you participate in the health care FSA.

Eligible Dependents
In addition to yourself, you can use the health care FSA to pay for out-of-pocket expenses for anyone you claim as a dependent for tax purposes. This includes your spouse and your unmarried dependent children or stepchildren.

Eligible Expenses
The following items are examples of eligible expenses under the health care FSA. There may be other expenses that qualify for reimbursement.

- Acupuncture;
- Alcoholism or drug dependency treatment and treatment centers;
- Ambulance charges;
- Charges that exceed reasonable and customary limits;
- Contact lenses and contact lens solutions;
- Copayments or coinsurance for prescription medications;
- Deductibles, coinsurance, and copayments under your health plan;
- Dental fees (other than cosmetic services)
- Eye examinations and prescription eyewear;
- Hearing aids and batteries;
- Laser/Lasik eye surgery;
- Orthodontia;
- Radial keratotomy; and
- Smoking cessation programs.
Expenses Not Covered
The following items are examples of expenses that are not eligible for reimbursement under the health care FSA.

- Cosmetic surgery, electrolysis, teeth bleaching, and hair transplants that are not medically necessary;
- Expenses not permitted as tax deductions on your federal income tax return;
- Health or dental premiums;
- Exercise fees, athletic fees, or health club memberships;
- Expenses incurred before your participation in the FSA begins;
- Marriage counseling;
- Maternity clothes or diaper services; or
- Household help (even if recommended by your doctor because you are unable to do housework).

The eligible and ineligible expenses listed here are only a guide. There may be other expenses in addition to the ones above that are or are not eligible. To learn more, see IRS Publication 502, or contact FlexBen via the UPMC DirectLink at 1-800-994-2752, option 2, option 2.
Dependent Care Flexible Spending Account (FSA)

You can use the dependent care FSA to pay for many types of dependent care situations. However, to qualify as an eligible expense, the following must be true:

Care for your dependent(s) must be necessary for you and your spouse (if you are married) to work, look for work, or go to school full time. In other words, expenses are not eligible if they are for services provided while you are out for the evening socially or on vacation.

The expenses must be incurred during the calendar year in which you participate.

Your care provider is anyone other than a person whom you claim as a dependent on your federal income tax return (a son or daughter who provides care must be at least age 19). In addition, you must provide your caregiver’s name, address, and Social Security number or taxpayer identification number when you file for reimbursement. You also must provide this information on your federal income tax return, unless your caregiver is a church or other religious organization.

Eligible Dependents
An eligible dependent is a child younger than age 13 whom you claim as a dependent on your income tax return. An eligible dependent also can be an older dependent who:

- Depends on you for at least half of his or her support;
- Regularly spends at least eight hours a day in your household; and
- Is physically or mentally unable to care for himself or herself.

Your dependent may be a disabled spouse, an elderly parent, or any other relative or dependent, as long as he or she meets all of the above requirements.

Eligible Expenses
The dependent care FSA can be used to pay for IRS-specified dependent care expenses you incur so that you may work or attend school full time. It’s important to contribute money only for dependent care expenses you know you will have during the upcoming year. Do not forget to subtract the times during which your dependent will not receive care, such as vacation or sick time.

Here are examples of the types of expenses that you can use the dependent care FSA for:

- Dependent care provided in your home, including care provided by a babysitter or housekeeper. The provider may be a relative, provided he or she is not your child under age 19, your spouse, or any other person whom you claim as a dependent.
• Dependent care provided outside your home, including care provided in a neighbor’s home or in an approved day care center, provided your dependent regularly spends at least eight hours a day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more individuals must comply with all federal, state, and local regulations governing day care centers. The provider may be a relative if he or she is not your child under age 19, or any other person whom you claim as a dependent.

• Household services, such as housekeeping or maid services, provided they’re necessary to run your home for the well-being and protection of your eligible dependent.

• Education for your child not yet in the first grade (for example, nursery school, preschool, or kindergarten tuition).

• Before- and after-school programs for children under age 13.

• Day camp services for children under age 13, but not overnight camp.

**Expenses Not Covered**
Some expenses do not qualify for reimbursement through the dependent care FSA, including:

• Dependent care expenses incurred before your FSA participation begins.

• Expenses you claim as an after-tax dependent care tax credit on your federal income tax return, or expenses paid by any other similar reimbursement plan.

• Care provided by a round-the-clock nursing home.

• Services provided by your spouse, your child under age 19, or someone you or your spouse claim as a dependent on your tax return.

• Educational expenses for a child in the first grade (or higher).

• Payments to a housekeeper while you are home from work because of illness.

• Child or dependent care provided while:
  — You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
  — You and your spouse are doing volunteer work (even if a nominal fee is paid); or
  — You or your spouse are not working (such as weekend or evening babysitting fees).

• Transportation expenses to and from the care site.

• Expenses for overnight camp.

• Expenses for food, clothing, and entertainment of a qualified dependent, unless charges are incidental and cannot be separated easily from the overall dependent care cost.

The eligible and ineligible expenses listed here are only a guide. There may be other expenses in addition to the ones above that are or are not eligible. To learn more, see IRS Publication 503, or contact FlexBen via the UPMC DirectLink at 1-800-994-2752, option 2, option 2.
Applying for Reimbursement

Reimbursement from your FSA is available only after the service for which you are seeking reimbursement has been performed and you have received reimbursement from all other sources. To be reimbursed for your health care or dependent care expenses, you must file a claim.

If you have any claim questions, please call the FSA administrator, FlexBen, through UPMC DirectLink at 1-800-994-2752, option 2, then option 3.

Health Care Claims
Expenses eligible for reimbursement from another medical or dental plan must be submitted to that plan first. After a payment determination is made, you can submit the unreimbursed expense for reimbursement from your FSA.

The full annual amount you elect to contribute to your Health Care FSA (less any previous reimbursements) is available for reimbursement of eligible health care expenses, regardless of the amount contributed to date. Contributions continue to be deducted from your pay to cover any claims already fully reimbursed from the health care FSA.

To obtain reimbursement for an expense, complete and submit a health care FSA claim form along with:

- The explanation of benefits (EOB) from the insurance company; or
- An itemized bill for services not covered by insurance, including the name of the service provider, cost of the service, and description of the services rendered.

You can obtain a health care FSA claim form from the UPMC infonet (http://infonet.upmc.edu/forms) or by calling FlexBen through UPMC DirectLink at 1-800-994-2752, option 2, option 3. Forms are also available in the Employee Service Center, Forbes Tower, Suite 8033.

Once you pay at least $25 in expenses, you may submit a claim. Reimbursement checks are cut and direct deposits are made each Thursday. If you submit a claim for reimbursement that is less than $25, the reimbursement is processed when additional claims are submitted that equal or exceed $25.

Dependent Care Claims
For dependent care FSA claims, only your current account balance is available to reimburse claims. If the dependent care services exceed your dependent care account balance, you will receive a partial reimbursement. You receive the unreimbursed portion of the claim as you make additional contributions to your dependent care FSA. To obtain reimbursement, complete and submit a dependent care FSA claim form, along with your provider’s bill or itemized receipt. In addition, you
must submit your dependent care provider’s name, address, and Social Security or federal tax identification number.

You can obtain a dependent care FSA claim form from the UPMC infonet (http://infonet.upmc.edu/forms) or by calling FlexBen through UPMC DirectLink at 1-800-994-2752, option 2, option 3. Forms are also available in the Employee Service Center, Forbes Tower, Suite 8033.

Once you pay at least $25 in expenses, you may submit a claim. Reimbursement checks are cut and direct deposits are made each Thursday. If you submit a claim for reimbursement that is less than $25, you receive the reimbursement when additional claims are submitted that equal or exceed $25 (as long as your account balance is at least $25).

**Filing Deadline**
You may file claims at any time after you incur the expense. You have until April 30 of the following year to submit claims for expenses incurred between January 1 and December 31 of the previous year.

**Remember, you forfeit any money that remains in your FSA after April 30.**

**If a Claim Is Denied**
If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision. See the **Overview** section for details regarding the appeals process.
Other Benefits
An Introduction to Your Other Benefits

UPMC has a number of policies and programs that add to the UPMC Welfare Benefits Plan. Adoption Assistance, the Employee Assistance Program (EAP), Paid Time Off (PTO), Pretax transportation, Tuition Assistance, Voluntary Benefits and Severance are a few of the programs offered.

If you have any questions after reading this section, contact the UPMC Employee Service Center at 1-800-994-2752, option 3.
Adoption Assistance Program

UPMC recognizes the importance of family. Because of this, UPMC provides assistance to eligible staff members who adopt children through the adoption assistance program.

Eligibility
You are eligible to participate in the adoption assistance program if you are a regular full-time, flexible full-time, job-share, or regular part-time staff member who has been employed with UPMC for at least six months.

If you are a staff member represented as part of a collective bargaining unit, you may participate in this program only if an agreement that allows for your participation exists between UPMC and your collective bargaining unit.

About the Program
This program is intended to comply with Internal Revenue Code Section 137 by providing reimbursement for certain qualified adoption expenses incurred by eligible staff members. Generally, the reimbursement amount is not subject to federal income tax withholding. However, it is subject to Social Security, Medicare, state, and local taxes and will be included on your W-2 for those purposes.

If you are a regular full-time or flexible full-time staff member, you may be reimbursed for up to $2,000 of eligible adoption-related expenses. If you are a job-share or regular part-time staff member, your adoption benefit is prorated based on the number of hours you are scheduled to work. This benefit is available once the adoption is final.

Eligible Expenses
Qualified adoption expenses include reasonable and necessary expenses associated with the adoption of an eligible child. Eligible expenses include:

- Legal fees, such as court costs and attorney’s fees;
- Travel expenses associated with the adoption;
- Other expenses directly related to, or for which the principal purpose is, the legal adoption of an eligible child.

Eligible Child
For purposes of the Adoption Assistance Program, an eligible child is any child under age 18, or any child who is physically or mentally incapable of caring for himself or herself. Your stepchild is not considered an eligible child for purposes of this program.
Expenses Not Covered
Certain expenses are not covered as part of the Adoption Assistance Program. The following expenses are not covered:

- Medical expenses related to the birth of the child (includes natural mother’s and child’s expenses);
- Expenses incurred for surrogate parenting arrangements; or
- Expenses related to the adoption of a stepchild.

Applying for Reimbursement
As part of the program, you must provide reasonable substantiation that the payments you want reimbursed constitute a qualified adoption expense. Substantiation materials may include:

- Copies of your bills or invoices;
- Expense amounts;
- Dates;
- The purpose for the expenses; and
- Final adoption certificate;
- Birth Certificate.

You must complete an Adoption Assistance Program Reimbursement Request form, which you can get by calling the UPMC Employee Service Center. Submit your completed form and any supporting materials to the UPMC Employee Service Center. Translation documents must be submitted with any foreign adoptions.

The UPMC Employee Service Center reviews and verifies the amount of available adoption assistance and calculates your reimbursement. Your authorized reimbursement amount is included in your paycheck as soon as administratively possible.
Employee Assistance Program (EAP)

Staff members and limited part-time staff members and their family members are eligible to participate in the Employee Assistance Program (EAP). The EAP is a professional assessment, consultation, and referral service designed to help you resolve personal problems. UPMC contracts with an independent outside firm to provide this program. Everything discussed with an EAP counselor is completely confidential.

How the Program Works
You or your immediate family member may call the EAP any time. Some issues that you may want to discuss with a counselor include:

- Alcohol/drug dependence;
- Depression;
- Emotional troubles;
- Financial difficulties;
- Legal problems;
- Parent-child relationship problems;
- Marital/family/relationship problems; or
- Stress.

The EAP provides access to help for these problems through general assessment and referral services. You can contact the EAP via the UPMC DirectLink at 1-800-994-2752, option 6, or at 1-800-647-3327 24-hours a day.

An EAP counselor is available to help you identify your problem. The EAP is offered to you and your family members free of charge for up to six sessions per problem or event. If your problem requires more in-depth counseling, you may be referred to another professional for continued help. You are then responsible for any outside counseling costs. However, some of the expense may be covered under your medical plan, or you may be able to use your health care flexible spending account to reimburse the expenses.
Paid Time Off (PTO)

UPMC recognizes the need for staff members to receive pay for vacation, sickness, or personal time. You automatically earn PTO benefits through this program. As a result, you have the time and flexibility you need to take care of the things that are important to you.

PTO benefits do not replace UPMC’s absentee policy, reporting time off policy, or leave of absence policy. Refer to the UPMC Policy and Procedure Manual for details. Also, PTO benefits do not include time off for holidays, bereavement, jury duty, or military leaves.

Eligibility
You are eligible for PTO benefits immediately upon your hire date (or your transfer date if you become an eligible staff member). Temporary and casual staff members, physicians, and residents are not eligible for this benefit. In addition, staff members covered by a collective bargaining agreement are eligible for time-off benefits based on the terms of their agreement. Refer to the Overview section for details regarding eligibility.

The Paid Time Off You Receive
UPMC uses an accrual method to determine the PTO you earn. You earn PTO hours based on your position, length of service, and the number of eligible hours you are paid for each pay period (up to a maximum of 80 hours).

You accrue PTO for the following categories of hours that you work:

- Regular hours;
- Overtime;
- Approved scheduled or approved unscheduled PTO;
- PTO sick time;
- Call-in hours;
- Extended Illness Bank (EIB);
- Bereavement;
- Holidays off;
- Holidays worked;
- Low census/low volume hours (even if unpaid);
- Military leaves; and
- Jury duty.

You do not accrue PTO for any other unpaid hours.

Scheduled Time Off
Pre-scheduled absences for vacation, routine appointments, and pre-scheduled personal time.

Unscheduled Time Off
Absences for unforeseen personal illness, illness of a family member, or personal emergencies that are not pre-scheduled.

Extended Illness Bank (EIB)
Any sick hour balances you accrued before the PTO program was implemented were placed in an extended illness bank (EIB). The EIB is to be used in lieu of PTO and/or Short-Term Disability (STD) for long-term personal illness or injuries that prevent you from performing the essential functions of your job.

PTO Sick Time
Absences related to your nonwork related illness or injury, or an absence to care for an ill family member.
Depending on your position, you are categorized as one of the following when determining your PTO accruals:

- Group A: Typically includes nonexempt staff members;
- Group B: Typically includes exempt staff members; or
- Group C: Executives, Directors, or Department Heads.

The chart below shows the amount of PTO you accrue per hour of eligible time worked.

## Paid Time Off Hourly Accrual Schedule

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>.068 hours</td>
<td>.087 hours</td>
<td>.106 hours</td>
</tr>
<tr>
<td>Between 5-15 years</td>
<td>.087 hours</td>
<td>.106 hours</td>
<td>.106 hours</td>
</tr>
<tr>
<td>Over 15 years</td>
<td>.106 hours</td>
<td>.106 hours</td>
<td>.106 hours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>.054 hours</td>
<td>.073 hours</td>
<td>.092 hours</td>
</tr>
<tr>
<td>Between 5-15 years</td>
<td>.073 hours</td>
<td>.092 hours</td>
<td>.092 hours</td>
</tr>
<tr>
<td>Over 15 years</td>
<td>.092 hours</td>
<td>.092 hours</td>
<td>.092 hours</td>
</tr>
</tbody>
</table>

Changes to accruals based upon length of service are effective at the start of the next pay period after you reach the new length of service level.

The maximum annual amount of PTO you may accrue also depends on your position category, your eligible hours paid, and your length of service.
Paid Time Off Maximum Annual Accrual

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>141 hours or 17.625 days</td>
<td>181 hours or 22.625 days</td>
<td>221 hours or 27.625 days</td>
</tr>
<tr>
<td>Between 5-15 years</td>
<td>181 hours or 22.625 days</td>
<td>221 hours or 27.625 days</td>
<td>221 hours or 27.625 days</td>
</tr>
<tr>
<td>Over 15 years</td>
<td>221 hours or 27.625 days</td>
<td>221 hours or 27.625 days</td>
<td>221 hours or 27.625 days</td>
</tr>
</tbody>
</table>

For Regular Part-Time and Limited Part-Time Staff Members:

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>112 hours or 14 days</td>
<td>152 hours or 19 days</td>
<td>192 hours or 24 days</td>
</tr>
<tr>
<td>Between 5-15 years</td>
<td>152 hours or 19 days</td>
<td>192 hours or 24 days</td>
<td>192 hours or 24 days</td>
</tr>
<tr>
<td>Over 15 years</td>
<td>192 hours or 24 days</td>
<td>192 hours or 24 days</td>
<td>192 hours or 24 days</td>
</tr>
</tbody>
</table>

You may accumulate and carry up to a maximum of one-and-a-half times your annual maximum amount of paid time off.

How PTO Works
PTO accrual begins on your hire date and increases each anniversary of that date according to the accrual schedule. At the end of each pay period, your PTO is adjusted by adding to the balance the amount of time you earned during that pay period and by subtracting the amount of PTO you used during that same period.

PTO balances cannot be negative. You can only use accrued time. This eliminates PTO advances.

Nonexempt staff members may use PTO in a minimum of .1 (1/10) hour increments, and you must be paid in accordance with regularly scheduled hours. Exempt staff members must use PTO in one-hour increments.

Scheduled vs. Unscheduled Absences
You may schedule your PTO for vacations, routine appointments, and prescheduled personal time. Be sure to provide your department or business unit with the minimum advance notice required (policy varies by department or business unit). Request PTO as far in advance as possible to provide sufficient time to plan and schedule service needs.

You also may use PTO for unscheduled time off for personal emergencies that are not prescheduled. Be sure to report any unscheduled PTO in accordance with your department’s or business unit’s established policy. Any unauthorized absence may result in an unpaid absence and/or disciplinary action. In instances where an additional absence results in a critical staffing shortage, the unscheduled PTO may be denied. Also, proof of an emergency situation may be required.
If an absence is due to a personal illness or injury and the absence is authorized, regardless of whether it is scheduled or unscheduled, you:

- Must use PTO sick time for the first 40 hours during the year.
- May choose to use PTO, your EIB (if available), or your STD benefits (if eligible), after the first 40 hours. See the definition of EIB at the beginning of this section.

If you are accidentally injured or hospitalized for more than 24 hours, you may be eligible for STD or EIB before using 40 hours of PTO sick time.

**PTO Sick Time**
PTO sick time may be used for time off for personal illness or injury, or the illness or injury of a family member. Be sure to report PTO sick time according to the policies and procedures established by your department or business unit. You may be required to provide proof of your illness or injury by submitting whatever medical certification is required by your department or business unit.

**Extended Illness Bank (EIB)**
Any sick hour balances you had before the PTO program was implemented were deposited into an EIB. This bank does not continue to grow each year since your new sick hours are included in the PTO schedule.

Because the EIB was previously earned, provided, and banked in lieu of a short-term disability, you are allowed to access any EIB balance in the same way in which STD would be accessed. However, you need to use PTO during the calendar year before you can access your EIB. Please refer to your PTO policy for details. Any subsequent sick days you use during the year, you may use PTO or EIB (if available).

**Unauthorized/Unapproved PTO**
You may not use PTO to make up tardiness or to supplement your earnings if you are suspended for any length of time. If you do not comply with your department’s or your business unit’s policy regarding scheduling or reporting time off, your manager may not approve the hours you took for pay under the PTO program or through your EIB — even if you have enough hours in your PTO bank or EIB. You cannot use PTO or EIB to make up an unauthorized absence.

**Mandatory Use of PTO**
You may not voluntarily elect to have an unpaid absence. Any time that you take off for reasons other than an unauthorized absence, workers’ compensation, jury duty, military leave, bereavement, STD, LTD, or time that can be paid through your EIB, it is charged to your PTO bank in accordance with your normal scheduled hours (provided you have a bank balance).

**If You are Rehired**
If you terminate employment and are subsequently rehired within one year of your termination date, you retain your original service date for purposes of calculating your PTO. You accrue PTO based on the PTO schedule in affect on your subsequent hire date.

You forfeit your EIB. Unused EIB is not reinstated when you are rehired.
PTO Buy
You may purchase PTO for use during the year. During the annual open enrollment and/or at their initial hire eligible staff members may purchase up to 40 hours of additional PTO with pretax dollars.

- PTO is purchased in one-hour increments with a minimum purchase of eight hours.

- Beginning with the first pay in January (or first pay of the month following a new employee’s hire date), a pretax deduction will be taken based on the following formula:

- The number of elected hours multiplied by the hourly rate in effect when the election was made, divided by the number of payroll periods remaining in the calendar year.

- The purchased PTO hours are added to the PTO balance upon the election and are available for use in the first full pay period after the effective date of the election.

- Accrued PTO earned as of the prior December 31st must be used prior to using purchased PTO.

- Elections are made through annual open enrollment elections or new hire enrollment election.

- PTO Buy that has not been used as of the last pay of the year will be automatically paid out in the last pay of the year.

Please Note: When purchasing PTO during Open Enrollment, keep in mind it is not available for use until after January 1st and it is available for use at the discretion of your supervisor. Additionally, it is generally not available for use after mid December.

PTO Sell
At the discretion of your supervisor and business unit policy, you may be able to sell some of your accumulated PTO. Eligible staff members may sell, with supervisor approval, up to 40 hours of PTO anytime during the year.

- Hours are sold in eight-hour increments, enabling staff to sell back one to five days.

- Staff members must have a balance of at least 80 hours after the PTO is sold back.

- Payments are made in a separate check as soon as possible after receipt of the request by payroll.

- A PTO Sell form is submitted to the payroll department once approved by the staff’s supervisor. Forms are available on the Infonet at http://infonet.upmc.edu/

Please Note: You cannot sell PTO in the same year in which you bought PTO.
Tuition Assistance

UPMC provides financial assistance to staff members, their spouses and dependents to pursue further education and training through a tuition assistance program. The benefit assists staff members interested in health care professional and career development opportunities to pursue further education and training. Staff members’ dependents and spouses can receive tuition reimbursement for first-time baccalaureate work at the University of Pittsburgh, community colleges in defined communities and health care programs at technical schools in defined counties.

Staff under collective bargaining agreements, casual staff and temporary staff are generally not eligible for the benefit.

Staff Member Tuition Assistance
Staff members classified as regular full-time, flex full-time, job share, and regular part-time are eligible for tuition assistance immediately upon employment, provided the school term or class date begins on or after the employment date. Staff members who transfer from the Schools of the Health Sciences, the Veteran’s Administration Medical Center (Oakland) and Children’s Hospital of Pittsburgh are eligible for tuition assistance, provided their adjusted service dates precede the date of their enrollment in an educational program or course.

How the Tuition Program Works For Staff Members

- Regular and flex full time staff members are eligible to receive up to a maximum of $3,000 per academic year.

- Regular part-time staff and job-share staff members are eligible for tuition assistance on a prorated basis according to the authorized hours per week for the position.

- UPMC pays tuition assistance at the University of Pittsburgh at the prevailing, part-time tuition cost per credit rates. For schools other than the University of Pittsburgh, tuition assistance is at 50% of the part-time cost per credit at that institution.

- In the case of vocational programs or community colleges, UPMC pays tuition costs up to 100% of the prevailing in-county tuition rate of the Community College of Allegheny County (CCAC).
  - Tuition assistance for non-credit courses is calculated by comparing instructional hours and cost to those of the Community College of Allegheny College (CCAC), where one credit is equivalent to 15 hours of instruction.
  - Tuition assistance is not provided for any added costs for out-of-county fees for community colleges.
– Any non-repayable tuition assistance received by the staff member from other sources (i.e., grants, scholarships, and tuition assistance through a spouse’s employer) is deducted from the tuition assistance provided by UPMC. Repayable tuition assistance (i.e. a loan) is not deducted.

• Regular full-time, flex full-time, job share and regular part-time staff members are reimbursed for College Level Examination Program (CLEP) exams and challenge exams if credit is received for courses approved according to these guidelines. The dollar amount reimbursed for these exams are counted toward the tuition dollar total for which the staff member is eligible.

• Staff members must have regular employment status and be actively employed for the duration of the term to qualify for tuition assistance, either on an advancement or reimbursement basis.

• If a staff member’s active employment classification changes (excludes terminations or changes to an ineligible employment status) during the school term, the staff member receives the tuition assistance amount that was approved at the beginning of the term. If a staff member’s status changes from regular full-time or flex full-time to regular part-time or job share during the academic year and the staff member has exceeded the amount of tuition assistance permitted a part-time or job share staff member, the staff member is not eligible for additional tuition assistance for the remainder of the academic year.

• Staff members are not eligible for tuition assistance if they drop a course before completing it.

• Staff members may take courses or education programs that are directly related to a position in UPMC. Courses may be degree, non-degree, or non-credit.
  – The courses taken must be offered by an accredited institution of learning (high school, college, university, business, or trade school) that is recognized by the United States Department of Education or is a proprietary school affiliated with UPMC.
  – Proprietary Schools affiliated with UPMC are UPMC Shadyside School of Nursing, St. Margaret Memorial Hospital School of Nursing at UPMC St. Margaret and UPMC School of Radiologic Technology and have tuition assistance at 100% of the cost per credit rate up to the allowable maximum.
  – Requests for tuition assistance for individual credited courses taken for job advancement or job improvement that are not part of a degree program, should be identified as such on the Application for Tuition Assistance (available from the Employee Service Center, Tuition Assistance unit and on the infonet).

• Tuition assistance may be granted on a reimbursement or pre-paid basis (tuition advance), depending upon the program and provider involved.

• Tuition reimbursement is provided for the cost of examinations leading to recognized certification in a health care specialty (e.g., oncology nursing certification, critical care nursing, trauma nursing, emergency nurse certification, advanced cardiac life support, or diabetes educator) or professional certification used in health care (e.g. CPA). However, the certification must be related to the staff member’s present position in order to be reimbursable.

• Costs of college entrance exams and periodic renewal of licenses/certification are not eligible for tuition assistance.
Other Benefits

- Tuition assistance is provided for correspondence courses, external degree programs, independent study courses and on-line and distance learning provided accreditation standards are met.

- Continuing education seminars and conferences that provide continuing education units, but not academic credit, are not reimbursable under these guidelines.

- Staff members must achieve at least a “C” grade or equivalent in order to receive tuition assistance. A “P” or “S” grade for courses taken on a pass-fail basis is considered the equivalent of a “C” grade.

- Staff members who voluntarily terminate or change to an ineligible employment status within twelve (12) months of the course completion date will be required to repay any tuition assistance received within the preceding twelve (12) months from the termination date. Repayment will be deducted from the staff member’s final paycheck and any remaining repayment balance must be paid directly to UPMC.

How to Receive a Tuition Advance

- UPMC provides tuition advance benefits for staff members enrolled in courses at the University of Pittsburgh, the Community College of Allegheny County (CCAC), Bidwell Training Center and the Carlow College Accelerated Program (CAP), Weekend College and proprietary schools.

- Staff members who receive tuition advances are subject to payroll deductions for the amount of advancement if they do not complete the course(s) with a “C” grade or better. The staff member’s signature on the application for tuition assistance authorizes UPMC to receive the grade report from the college or university and to deduct the amount of tuition from the staff member’s pay in the event of unsuccessful completion of the course(s).

- All other terms of these guidelines apply to tuition advancement programs, including compliance with requirements of federal, state, and local tax policies regarding tuition assistance.

How to Apply for Benefits

Application forms for tuition assistance may be obtained from the Employee Service Center, Tuition Assistance unit or the infonet. The staff member should submit the completed application and accompanying paperwork to the Employee Service Center, Tuition Assistance unit prior to the beginning of the course to verify eligibility.

The completed application and the accompanying paperwork must be submitted every semester the staff member requests tuition assistance. Forms not received by the Employee Service Center, Tuition Assistance unit within thirty (30) days from the start date of class will not be eligible for Tuition Advancement. Applications received after the first 30 days of a class should be submitted for Tuition Reimbursement.

Procedures for tuition advance (pre-paid tuition assistance) vary by institution. Please contact the Employee Service Center, Tuition Assistance unit for procedures for University of Pittsburgh, Community College of Allegheny County (CCAC), Bidwell Training Center or Carlow’s CAP, Weekend College or proprietary schools.

Reimbursement Requests

Staff members who are not enrolled in a tuition advance program must forward to the Employee Service Center, Tuition Assistance unit, in addition to the completed application, a copy of the
Official grade report and proof of payment, which must be a copy of the institution’s invoice indicating payment, paid receipt, the front and back of a canceled check, or other valid payment receipt.

- Requests for reimbursement are honored up to one year after the course completion date.

Reimbursement amounts are included in the staff member’s regularly scheduled paycheck approximately four weeks after the Employee Service Center receives the final necessary information.

**General Information**
- Only tuition costs are eligible for tuition assistance. Tuition assistance is not provided for other educational costs.
- The tuition assistance program is administered in compliance with UPMC’s Equal Employment and Affirmative Action Policy.
- Information on financial aid and tuition deferral policies at educational institutions is available from the Employee Assistance Program staff.
- The UPMC complies with requirements of federal, state, and local tax policies regarding pre-payment of tuition and reimbursement to staff members for tuition assistance. Additional information about the taxation of tuition benefits is available from the Employee Service Center, Tuition Assistance unit.

**Spouses and Dependents of Staff Members Tuition Assistance Program**
These guidelines apply to the eligible staff members of UPMC, excluding University of Pittsburgh Physicians faculty and staff members who are also employees of the University of Pittsburgh. UPMC staff members covered by a collective bargaining agreement must refer to the collective bargaining agreement to determine eligibility for this tuition assistance benefit.

- Eligible staff members are UPMC employees classified as regular full-time, flex full-time, job share, and regular part-time are eligible for tuition assistance for spouses and dependents after one year of service, provided the school term begins on or after the eligibility date. Staff members must have authorized hours of at least 20 hours per week to be eligible.

- Only post secondary/post high school programs are covered. Spouses or dependents of eligible staff members may take any courses or educational programs towards a first baccalaureate degree or certificate at any branch of the University of Pittsburgh, a community college in the defined county area or proprietary school. A list of the defined counties is provided at the end of this section. Proprietary Schools affiliated with UPMC include, but are not limited to: UPMC Shadyside School of Nursing, St. Margaret Memorial Hospital School of Nursing at UPMC St. Margaret and UPMC School of Radiologic Technology.

- If the spouse or dependent attends a vocational or technical school in the defined county area, the program must be related to health care in order to be eligible for reimbursement. A list of approved healthcare programs is provided at the end of this section.
Other Benefits

- To be eligible for the tuition benefit, spouses and dependents must be pursuing their first baccalaureate degree or up to the equivalent amount of credit hours in a credit program at a community college or technical school.

- Tuition assistance is provided for correspondence courses, external degree programs, independent study courses and on-line and distance learning provided all other criteria are met.

- Spouses and dependents are eligible for this benefit for a maximum of 12 semesters over a continuous six-year period, beginning when the spouse or dependent first uses the benefit. Total credits allowed for spouses and dependents not pursuing a baccalaureate is 150 credit hours over the continuous six year, twelve semester period of eligibility.

- Spouses can be full time or part time students; dependents must be full time students (generally a minimum of 12 credit hours).

- Dependents who cannot attend school full time because of a documented disability may be eligible for tuition reimbursement and should contact the Employee Service Center.

- Dependents can utilize the tuition assistance benefit in the summer semester, provided they were enrolled as a full time student the prior semester (spring). The summer semester will count towards the twelve-semester limit.

- Spouses and dependents of staff members must achieve at least a 2.0 GPA or equivalent for the semester, in order to receive tuition assistance. A “P” or “S” grade for courses taken on a pass-fail basis is considered the equivalent of a “C” grade.

- Any non-repayable tuition assistance received by the staff member from other sources (i.e., grants, scholarships, and tuition assistance through a spouse’s employer) factors into the allowable tuition assistance provided by UPMC. Repayable tuition assistance (i.e. loans) is not deducted.

- The tuition benefit covers only tuition costs and does not cover fees, books, room and board, etc. Costs of college entrance exams and periodic renewal of licenses/certification are not eligible for tuition assistance.

**Tuition Assistance Benefit**

- Spouse: The tuition assistance benefit is up to a maximum of $2,000 per academic year for spouses of regular and flex full time staff members. $1,000 per academic year for spouses of regular part time and job share staff.

- Dependents: The tuition assistance benefit is up to a maximum of $4,000 per academic year for dependents of regular and flex full time staff members. $2,000 per academic year for dependents of regular part time and job share staff.

- Spouses and dependents of regular and flex full time staff members are reimbursed at a rate of 50% of the prevailing rates. Spouses and dependents of regular part time and job share staff are reimbursed at the rate of 25% of the prevailing rates.

- The reimbursement rates of 50% and 25% are based on the following:
  - Tuition assistance at the prevailing in-state rates at the University of Pittsburgh.
  - For community colleges within the defined county area, tuition is based on the prevailing in county tuition costs at Community College of Allegheny County (CCAC).
Other Benefits

– In the case of vocational programs, the programs must be health care related and within the defined county area. UPMC pays tuition fees based on the prevailing in-county tuition rates of the Community College of Allegheny County (CCAC).

– For proprietary schools of UPMC, reimbursement rate will be based on the tuition costs at that school.

- Tuition assistance for courses taken at vocational or technical schools is calculated by comparing instructional hours and cost to those of the Community College of Allegheny College (CCAC), where one credit is equivalent to 15 hours of instruction.

- Dependents or spouses of regular full-time, flex full-time, job share and regular part-time staff members may be reimbursed for College Level Examination Program (CLEP) exams and challenge exams taken if credit is received for courses, provided all other eligibility criteria are met under these guidelines. The percentage reimbursed will be the same percentage the spouse or dependent would receive for other tuition reimbursement, not to exceed what that reimbursement would be for the prevailing cost per credit. The dollar amount reimbursed for these exams is counted toward the tuition dollar total for which the spouse or dependent is eligible.

- All staff members must be actively employed and meet all other eligibility criteria for the duration of the term to qualify for tuition assistance for their spouse or dependent.

- A staff member who terminates employment, becomes a temporary or casual staff member, is on workers’ compensation or who is on an approved leave of absence prior to the beginning of a course is not eligible for tuition assistance for spouse and dependents.

- Staff members who are receiving workers’ compensation benefits are eligible for tuition assistance for spouse and dependents for the remainder of the term if the course began prior to the work-related illness or injury, providing they furnish documentation of the beginning date of such illness or injury.

- Staff members who are on an approved leave of absence are eligible for tuition assistance for spouses and dependents for the remainder of the term if their course began prior to the leave of absence.

- Staff members receiving workers compensation or on an approved leave of absence cannot receive tuition assistance for spouses or dependents for a new term until they return to active employment status.

- If a staff member’s active employment classification changes (excludes terminations or ineligible employment status) during the school term, the staff member receives the tuition assistance for their spouse or dependent in the amount that was approved at the beginning of the term. If a staff member’s status changes from regular full-time or flex full-time to regular part-time or job share during the academic year and the staff member has exceeded the amount of tuition assistance permitted a part-time or job share staff member, the staff member is not eligible for additional tuition assistance for the remainder of the academic year.

- If a staff member’s dependent or spouse has a change in dependent or spousal status during the school term, the staff member receives the tuition assistance for the spouse or dependent in the amount that was approved at the beginning of the term.
Other Benefits

- Tuition assistance for spouses and dependents is only offered on a reimbursement basis. Dependent/spouse tuition benefit will be reimbursed after the course completion date, through the UPMC payroll system.

- If UPMC employs both husband and wife, the spousal benefit does not apply and the dependent benefit cannot be doubled.

- Admission decisions are the sole responsibility of the University of Pittsburgh, community colleges, and technical schools. Eligibility to receive the tuition benefit does not guarantee admission.

- If a staff member voluntarily terminates employment or changes to an ineligible employment status within one year of the course completion date for which he or she received tuition assistance for a spouse or dependent, the staff member will be required to repay all tuition assistance UPMC paid within the preceding 12 months from the date of termination. Repayment will be deducted from the staff member’s final paycheck and any remaining repayment balance must be made directly to UPMC. If a staff member voluntarily terminates and still has a balance to pay for the tuition assistance received in the preceding 12 months, he or she cannot utilize the benefit through a spouse, until the amount owed is repaid.

Application Procedures
Application forms for tuition assistance for spouses and dependents may be obtained from the Employee Service Center, Tuition Assistance unit or the Infonet (infonet.upmc.edu). The Employee Service Center, Tuition Assistance unit is responsible for administering the program and maintaining current records. The staff member should submit the completed application and accompanying paperwork to the Employee Service Center, Tuition Assistance unit prior to the beginning of the course to verify eligibility. UPMC may require documentation to verify dependency or spousal status for each academic year.

- A completed Application and the accompanying paperwork must be completed every semester the staff member requests tuition assistance for their spouse or dependent.

- At the end of the semester, staff members should forward a copy of the completed application (if not previously submitted), official grade report and proof of payment, which must be a copy of the institution’s itemized invoice indicating tuition costs, paid receipt, the front and back of a canceled check, or other valid payment receipt.

- Requests for reimbursement are honored up to ninety (90) days after the course completion date.

- Reimbursement amounts are included in the staff member’s regularly scheduled paycheck approximately four weeks after the Employee Service Center, Tuition Assistance unit receives the final necessary information.

- UPMC complies with requirements of federal, state, and local tax policies regarding tuition reimbursement to staff members for tuition assistance for spouses and dependents. Additional information about the taxation of tuition benefits is available from the Employee Service Center, Tuition Assistance unit.
How To Appeal a Tuition Assistance Decision
The Employee Service Center, Tuition Assistance Coordinator has the initial authority to decide whether an individual is eligible to participate and the amount of benefits that are payable. Even though it does not happen often, occasionally disagreements about benefit eligibility or amounts arise. In most cases, they are resolved quickly by the Tuition Assistance Coordinator. However, if disagreement is unresolved, there is a formal appeal process in place.

First Level Appeal
Write to the Tuition Assistance Coordinator to request further review and reconsideration of the claim within sixty (60) days from the day you receive the denial. If you do not make the request within this time frame, you waive your right to appeal. You may be asked to provide additional information to support the claim.

If your request or claim is denied or reduced (in whole or in part) following the review above, the Tuition Assistance Coordinator will send you a written notice of the denial within ninety (90) days (or 180 days if special circumstances arise). The notice will:

- Describe the specific reasons for the denial;
- Highlight the provisions on which the reasons are based;
- Outline how claims are reviewed;
- Explain the steps for an appeal; and
- Note any additional material needed to complete the claim.

If the Tuition Assistance Coordinator upholds the denial, you can appeal through the Employee Service Center, Benefits Manager as a second level appeal.

Second Level Appeal
If, after review by the Tuition Assistance Coordinator you believe you are eligible for tuition assistance, submit your written appeal to the Employee Service Center Benefits Manager within sixty (60) days of your denial. If you do not request a second level appeal within sixty (60) days, you waive your right to further review. Your second level appeal should include any new or additional information to support your claim. A written response of the review will be provided within sixty (60) days.

Appealing to the Plan Administrator
After you exhaust your opportunity to have the Tuition Assistance Coordinator and Benefits Manager review your claim, you, your beneficiary, or your legal representative may ask for a full review of the decision by writing to the Plan Administrator. Your appeal to the Plan Administrator must be made within sixty (60) days of the date you receive the denial. You or an authorized representative may review any documents related to the claim, and you may submit issues and comments in writing to the Plan Administrator.

The final decision regarding your claim will be made promptly (usually within sixty (60) days after your request for review is received). In any case, you will know the final decision no later than 120 days after the request for review is received. In this case, the Plan Administrator makes the final decision regarding your claim.
List of Approved Health-Related Programs For Technical/Vocational Schools in Defined Counties

- Blood bank technology/technician
- Cardiovascular Technology/technician
- Diagnostic Medical Sonography
- Electrocardiograph Technology/tech
- Emergency Medical/Paramedic
- Health Care Technician
- Health Information Technology
- Health Prof. & Related Sciences
- Home Health Aide
- Medical Assistant
- Medical Claims Processing
- Medical Coding
- Medical Lab Technician
- Medical Nutrition/Medical Terminology
- Medical Office Management
- Medical Physiology
- Medical Records Technology
- Medical Secretary
- Medical Transcriptionist
- Nuclear Medicine Technology
- Nurse
- Nurses Aide
- Nursing Assistant
- Occupational Safety & Health Technology/technician
- Occupational Therapy Assistant
- Optician/Dispensing Optician
- Orthotics/prosthetics
- Patient Information Coordinator
- Pharmacy Technician
- Phlebotomy
- Physical Therapist Assistant
- Practical Nursing
- Radiation Therapy Technology
- Radiologic Technologist
- Radiology Department Technology
- Respiratory Therapist
- Respiratory Therapy Technician
- Surgical/operating Room Technician
List Of Counties For Tuition Assistance Benefit

<table>
<thead>
<tr>
<th>Pennsylvania</th>
<th>Ohio</th>
<th>West Virginia</th>
<th>Maryland</th>
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</thead>
<tbody>
<tr>
<td>Allegheny</td>
<td>Belmont</td>
<td>Brooke</td>
<td>Allegany</td>
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<tr>
<td>Armstrong</td>
<td>Columbiana</td>
<td>Hancock</td>
<td>Garrett</td>
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<tr>
<td>Beaver</td>
<td>Jefferson</td>
<td>Marion</td>
<td>Mineral</td>
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<tr>
<td>Bedford</td>
<td>Mahoning</td>
<td>Marshall</td>
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<td>Blair</td>
<td>Trumbull</td>
<td>Monongalia</td>
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<tr>
<td>Butler</td>
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<td>Ohio</td>
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<td>Cambria</td>
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<td>Preston</td>
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<td>Cameron</td>
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<td>Washington</td>
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<td>Clarion</td>
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<td>Wetzel</td>
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<td>Clearfield</td>
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<td>Elk</td>
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<td>Fayette</td>
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<td>Greene</td>
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<td>Huntingdon</td>
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<tr>
<td>Indiana</td>
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<tr>
<td>Jefferson</td>
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<tr>
<td>Lawrence</td>
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<td>Mercer</td>
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<td>Somerset</td>
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<td>Venango</td>
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<tr>
<td>Washington</td>
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<td></td>
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<tr>
<td>Westmoreland</td>
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</tbody>
</table>

University of Pittsburgh Campus Locations

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>PHONE</th>
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<tbody>
<tr>
<td>University of Pittsburgh Oakland Campus</td>
<td></td>
</tr>
<tr>
<td>100 Craig Hall</td>
<td></td>
</tr>
<tr>
<td>Pittsburgh, PA 15260</td>
<td>412-624-8150</td>
</tr>
<tr>
<td>University of Pittsburgh Bradford Campus</td>
<td></td>
</tr>
<tr>
<td>300 Campus Drive</td>
<td></td>
</tr>
<tr>
<td>Bradford, PA 16701</td>
<td>814-362-7500</td>
</tr>
<tr>
<td>University of Pittsburgh Greensburg Campus</td>
<td></td>
</tr>
<tr>
<td>1150 Mt. Pleasant Rd.</td>
<td></td>
</tr>
<tr>
<td>Greensburg, PA 15601</td>
<td>724-836-9880</td>
</tr>
<tr>
<td>University of Pittsburgh Johnstown Campus</td>
<td></td>
</tr>
<tr>
<td>450 School House Road</td>
<td></td>
</tr>
<tr>
<td>Johnstown, PA 15904</td>
<td>814-269-7030</td>
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<tr>
<td>University of Pittsburgh Titusville Campus</td>
<td></td>
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<tr>
<td>504 East Main Street</td>
<td></td>
</tr>
<tr>
<td>Titusville, PA 16354</td>
<td>814-827-4400</td>
</tr>
</tbody>
</table>
Voluntary Benefits

UPMC offers more benefit options to help provide staff with additional financial security through employee-paid voluntary benefit programs.

Voluntary programs are paid 100 percent by staff at discounted group rates. Discounted rates have been negotiated with the various carriers specifically for the staff of UPMC. The voluntary programs provide supplemental insurance coverage in addition to the benefits provided by UPMC. Staff members may enroll or drop after-tax voluntary programs at anytime. Pretax programs will remain in effect for the entire year and can only be changed during open enrollment or as a result of a qualifying event, such as a change in family or job status. Refer to the Changes to Your Coverages section in the Overview portion of this document.

Premium payments are automatically withheld through payroll deductions for the convenience of staff members. Voluntary programs are also portable, allowing staff members to continue coverage through direct billing should you change jobs or retire.

Summary of Voluntary Benefits

<table>
<thead>
<tr>
<th>Voluntary Program</th>
<th>Paid by</th>
<th>Payroll deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Cancer Protection Plan</td>
<td>Staff</td>
<td>Pretax</td>
</tr>
<tr>
<td>Personal Accident Expense Plan</td>
<td>Staff</td>
<td>Pretax</td>
</tr>
<tr>
<td>Personal Recovery Plus</td>
<td>Staff</td>
<td>Pretax</td>
</tr>
<tr>
<td>Personal Short-term Disability</td>
<td>Staff</td>
<td>After tax</td>
</tr>
<tr>
<td>Pre-Paid Legal Services</td>
<td>Staff</td>
<td>After tax</td>
</tr>
</tbody>
</table>

Available Voluntary Benefits

AFLAC - Personal Short-Term Disability Plan

- Help provide you with a source of income if you become disabled due to sickness or off-the-job injury.
- Up to 10% additional income replacement above the 60% provided by UPMC. No more than 70% of income replacement is guaranteed.
- Participation based on average hours worked and salary.
- Part-Time employees, working between 20 and 30 hours per week, not eligible for the UPMC disability program, can purchase up to 66 2/3% disability protection.
- Monthly benefits range from $500 to $3,000, subject to income requirements.
Other Benefits

- Benefit periods: 3 months, 6 months, 12 months or 24 months.
- Coverage stays with you regardless of job changes.
- Guaranteed-Renewable to age 70.
- Benefits paid directly to you unless otherwise specified.
- Benefit paid regardless of any other insurance.

**AFLAC - Personal Accident Expense Plan**
- Helps to cover expenses associated with accidental injury.
- Family coverage for staff member, spouse and dependent children.
- Provides flat dollar amount reimbursement for the following:
  - Accident emergency treatment;
  - Accident follow-up treatment;
  - Initial accident hospitalization;
  - Accident hospital confinement;
  - ICU confinement;
  - Accident specific-sum benefits;
  - Accidental death and dismemberment;
  - Physical therapy;
  - Prosthesis and appliance benefit;
  - Blood and plasma benefit;
  - Ambulance benefit;
  - Transportation benefit;
  - Family lodging;
  - Wellness benefit;

- Benefits paid directly to you unless otherwise specified.
- Benefits paid regardless of any other insurance.

**AFLAC - Personal Recovery Plus Plan**
- Family coverage for staff member, spouse and dependent children
- Pays a flat dollar first-occurrence hospital confinement and continuing care benefits for the following:
  - Heart attack and Coronary artery bypass surgery
  - Stroke
  - End-stage renal failure
  - Major human organ transplant
  - Major third degree burns
  - Coma
  - Paralysis

- Other benefits include: Ambulance, transportation, and lodging benefits
- Waiver of premium and continuation of coverage benefits
AFLAC - Cancer Policy

- Family coverage for staff member, spouse and dependent children
- Pays first occurrence benefit and lump sum benefits with a cancer diagnosis to help with out-of-pocket expenses for the following:
  - Hospital confinement benefit
  - Radiation and chemotherapy benefit
  - Skin cancer surgery benefit
  - Nursing services benefit
  - Prosthesis benefit
  - Transportation benefit
  - Lodging benefit
  - Extended care facility benefit
  - Home health care benefit
- Includes a $75 wellness benefit
- Guaranteed renewable
- Benefits paid directly to you unless otherwise specified
- Benefits paid regardless of any other insurance

Pre-Paid Legal Service Services, Inc.

- Provides professional legal assistance with top rated firms
- Covers staff members, spouse and dependent children
- Legal insurance for the following services:
  - Preventive (preparation of a will, document review, phone consultations)
  - Motor vehicle (moving traffic violations, driver’s license assistance)
  - Trial Defense
  - IRS audit legal services
- Other legal services at a 25 % discount

Disclaimer: All voluntary products described are available through payroll deduction and completely funded by the employee. Election and enrollment into the voluntary products is at the sole discretion of the employee. UPMC presents the programs to provide additional choices for each staff member. The decision to enroll in a given program is exclusively up to the staff members based on their own circumstances.

To learn more about these plans please contact a voluntary benefits representative through UPMC DirectLink at 1-800-994-2752, option 5.
Pretax Transportation

As an eligible staff member, you can pay for your parking lease on a pretax basis through convenient payroll deductions. You also have access to pretax monthly bus passes.

How the Pretax Parking Program Works
This program allows you to pay up to $175 per month pretax for parking at any UPMC parking garage or lot. By paying for this on a pretax basis, you reduce your federal income tax, Social Security, and Medicare tax (FICA) by the amount that you pay for parking.

There are no forms to complete, and participation is automatic. If you are a leaseholder for UPMC parking, you receive notification about this benefit in the mail. Remember: Any pretax deductions may slightly lower your Social Security benefit at retirement. For more information, or for lease information, call Parking Operations at (412) 647-3194.

Pretax Bus Passes
UPMC also offers pretax monthly bus passes. These are deducted from the first and second paychecks of the month for the following month’s expenses. The payroll office (located in the 302 Iroquois Building) can provide you with the necessary Bus Pass Authorization Forms. Vanpool transportation also is available.

Contact the University of Pittsburgh’s Ride-Share office at (412) 624-0687 for more information.
Severance

UPMC offers a severance package to staff members whose employment is terminated under certain circumstances. The Displaced Staff Member Severance Policy provides income for a specific period of time in certain circumstances. It also provides job search support to staff members whose positions are eliminated — not due to poor performance — but as a result of a change in business conditions.

Eligibility
You are eligible for severance under this policy if:

- Your job is eliminated for reasons other than individual job performance;
- You are a regular full-time, flexible full-time, job-share, or regular part-time staff member who has been employed for at least six months;
- You have maintained an acceptable level of job performance for the six months immediately prior to your job’s elimination; and
- You sign an effective Separation Agreement and General Release.

You are **not eligible** for severance if:

- You elect to retire or resign;
- You are offered a position that does not reduce your base hourly rate or result in a change of the location at which you work of more than 30 miles;
- You accept an offered position, regardless of your base hourly rate or location;
- You currently work in or accept a limited part-time, temporary, or casual position; or
- You work in a position that’s fully funded through grants.

You may be eligible for severance if you transfer from a hard-funded position to a grant-funded position. Contact the UPMC Employee Service Center for details on severance eligibility if your position is or previously was funded through a grant.

In the event of an asset sale, stock sale, or other transaction that transfers all (or substantially all) of the assets of stock or other ownership or control of a facility subsidiary or business unit of UPMC and the purchaser or transferer offers employment to a UPMC staff member whose employment is affected by such matter, then the affected staff member is ineligible for severance.
**Other Benefits**

**How the Policy Works**
If UPMC decides to eliminate your job, you are notified of the effective date and informed of your eligibility for the Displaced Staff Member Severance Policy. You may be required to work in your job for a limited period of time to assist in the transitioning of work or other matters with which you are familiar or responsible.

Once you receive notice of your job elimination, you become eligible for placement opportunities. UPMC assists you with an internal job search. You are either offered an appropriate alternative job, or you are eligible to receive severance pay commensurate with your years of service. See the following *Severance Schedules*.

**Notification Period**
UPMC provides you with at least two weeks notice of your job elimination. Once you receive this notification, you are required to work at your current position during this two-week period (unless UPMC elects to pay you a lump sum in lieu of your working). This notification period also may be extended.

If UPMC wants you to continue working during this period, you must continue to report to work (other than for excused absences) and maintain a satisfactory level of job performance. If you do not, all eligible severance under this policy is cancelled and your employment is terminated immediately.

**Internal Job Search**
If you receive notice that your job is being eliminated, you should work with Human Resources and use the applicable job posting programs to pursue appropriate internal job vacancies. Human Resources can assist you in this search.

If you are offered — but you refuse to accept — an appropriate internal position, you are terminated and you are no longer eligible for severance under this policy. Typically, you are not eligible for severance pay if you decline an internal employment offer that does not reduce your base hourly rate or require a location change of more than 30 miles.

**When Severance Pay Begins**
If you do not receive an internal employment offer, your employment is terminated and you become eligible for severance pay. As soon as administratively possible, you receive your severance in regular bi-weekly installments (or, if approved, in a lump sum). Severance pay is subject to federal, Social Security, state, and local tax withholding.
**Severance Schedules**

Your severance pay is based on your staff member status (e.g., non-exempt, exempt, or Director level) and your years of service with UPMC, as shown in the schedule below. Years of service greater than one are rounded to the nearest whole year. In addition, your severance is based on your base hourly rate at the time of your termination.

### Non-Exempt Staff Members

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Severance Payment Period</th>
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<tbody>
<tr>
<td>Less than 6 months</td>
<td>0 weeks</td>
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<tr>
<td>6 months–2 years</td>
<td>2 weeks</td>
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<tr>
<td>3–5 years</td>
<td>4 weeks</td>
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<tr>
<td>6–10 years</td>
<td>6 weeks</td>
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<tr>
<td>11–15 years</td>
<td>8 weeks</td>
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<tr>
<td>16–19 years</td>
<td>10 weeks</td>
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<tr>
<td>20+ years</td>
<td>12 weeks</td>
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### Exempt Staff Members

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<thead>
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<th>Years of Service</th>
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<tbody>
<tr>
<td>Less than 6 months</td>
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<tr>
<td>6 months–2 years</td>
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<td>3–5 years</td>
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<td>6–10 years</td>
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<td>11–15 years</td>
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<td>16–19 years</td>
<td>14 weeks</td>
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<td>20+ years</td>
<td>16 weeks</td>
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### Director Level and Above

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<th>Years of Service</th>
<th>Severance Payment Period</th>
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<tbody>
<tr>
<td>Less than 6 months</td>
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<td>6 months–2 years</td>
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<td>6–10 years</td>
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<td>11–15 years</td>
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<td>16–19 years</td>
<td>18 weeks</td>
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<tr>
<td>20+ years</td>
<td>20 weeks</td>
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</tbody>
</table>

**Severance and Your Other Benefits**

If your employment is terminated and you become eligible for severance pay, this may impact your other benefits. Please see *When Coverages End* in the *Overview* section for details.
Administering the Plans
Administrative Information

The UPMC Welfare Benefits Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974). This section provides important legal and administrative information you may need, including:

- How to identify the plan and each component of the plan;
- Information about the administrators (e.g., carriers and insurance companies) that provide or administer benefits and how to contact them;
- Who the plan administrator is and how to contact the plan administrator; and
- Other important information you may need to know regarding your health and welfare benefits.

If you have any questions about the administrative details surrounding the plan, call the UPMC Employee Services Center at 1-800-994-2752.

Official Plan Name and Plan Number

When dealing with or referring to your health and welfare benefits (for example in the event of a claim appeal or other correspondence), you will receive a more rapid response if you identify the plan fully and accurately. The official name of the plan is the UPMC Welfare Benefits Plan. The Plan number is 501.
### Benefit Type and Addresses of the Administrators/Insurance Carriers

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Administrators/Insurance Carriers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td><strong>UPMC Advantage HMO Option</strong>&lt;br&gt; <strong>UPMC Advantage PPO Option</strong>&lt;br&gt; <strong>UPMC Open Access PPO Option</strong>&lt;br&gt; <strong>UPMC Out-of-Area PPO Option</strong>&lt;br&gt; UPMC Health Plan P.O. Box 2999 Pittsburgh, PA 15230 1-888-876-2756</td>
</tr>
</tbody>
</table>
| **Dental**                   | **CIGNA Dental Care (DHMO type of plan)**<br> 1-800-367-1037<br> www.cigna.com  
**CIGNA Dental PPO**<br> CIGNA HealthCare P.O. Box 188036 Chattanooga, TN 37422-8036 |
| **Life and AD&D**            | **All Life and AD&D Options**<br> The Life and AD&D Insurance Options are administered by:<br> National Benefits Partners 303 East South Temple Street Salt Lake City, UT 84111 1-800-583-1571
All correspondence and communication should be directed to National Benefit Partners.  
Life and AD&D Options are insured by:<br> Combined Insurance Company of America 5050 Broadway Chicago, IL 60640
After May 1, 2003:<br> UnumProvident Group Life Customer Care Center PO Box 9061 Portland, ME 04104-5046 1-800-445-0402 |
<p>| <strong>Disability (STD)</strong>         | <strong>UNUM Provident</strong>&lt;br&gt; Portland Customer Care Center 2211 Congress Street Portland, ME 04122 1-888-673-9940 |
| <strong>Disability (LTD)</strong>         | <strong>UNUM Provident</strong>&lt;br&gt; Portland Customer Care Center 2211 Congress Street Portland, ME 04122 1-888-673-9940 |
| <strong>Flexible Spending Accounts</strong> | <strong>Health Care and Dependent Care Flexible Spending Accounts</strong>&lt;br&gt; FlexBen Corporation 2250 Butterfield Drive, Suite 100 Troy, MI 48084-3411 1-800-848-0428 |</p>
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<tr>
<th>Benefit Type</th>
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<td>UPMC</td>
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<td>UPMC Employee Service Center</td>
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<tr>
<td>• PTO</td>
<td>200 Lothrop Street, 8033 Forbes Tower</td>
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<tr>
<td>• Pretax Transportation</td>
<td>Pittsburgh, PA 15213</td>
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<tr>
<td>• Severance</td>
<td>1-800-994-2752, option 3</td>
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<td>• Tuition Assistance</td>
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<td>• Pre-Paid Legal Services</td>
<td>• AFLAC Personal Accident Expense Plan</td>
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<td>• AFLAC Personal Recovery Plus Plan</td>
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<td>• AFLAC Cancer Policy</td>
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<td>Columbus, GA 31999</td>
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<td>1-800-9923522</td>
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<td><a href="http://www.aflac.com">www.aflac.com</a></td>
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<tr>
<td><strong>Pre-Paid Legal Services, Inc.</strong></td>
<td>321 East Main Street</td>
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<td>PO Box 145</td>
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<td></td>
<td>Ada, OK 74820</td>
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<td>412-421-8952</td>
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<td><a href="http://www.prepaidlegal.com">www.prepaidlegal.com</a></td>
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</tbody>
</table>
Plan Sponsor and Administrator
UPMC sponsors the Plan, and is the official plan administrator. The plan administrator, operating through its ERISA Review Committee, has broad discretion to interpret the plan’s provisions. This includes, but is not limited to, interpreting ambiguous terms, finding facts, and then applying the plan’s provisions to the facts. In the case of the insured benefits under the plan, UPMC delegates its discretionary authority to the insurance company that provides benefits. All decisions of the plan administrator or its delegate are conclusive and binding on all parties. If you have questions that the UPMC Employee Services Center cannot answer satisfactorily, you may contact the plan administrator at:

UPMC
Benefits Plan Administrator
200 Lothrop Street, 8039 Forbes Tower
Pittsburgh, PA  15213
1-800-994-2752, option 3

The UPMC Employee Service Center is your best resource for your everyday questions regarding your health and welfare benefits.

How to Reach the UPMC Employee Service Center
The UPMC Employee Service Center is your primary source of information about the plan. The Center can be reached at:

UPMC
UPMC Employee Service Center
200 Lothrop Street, 8033 Forbes Tower
Pittsburgh, PA  15213

Telephone: 1-800-994-2752, option 3
Fax:  412-647-7860

Employer Identification Number
UPMC’s employer identification number (EIN) is 25-1423657.

Employers
UPMC is the employer with respect to its employees. Any other entity whose participation in the plan is approved by UPMC also is the Employer with respect to its employees. You may receive from UPMC, upon written request, information as to whether a particular entity is a participating employer in the Plan, and if so, that employer’s address.

Plan Year
For record keeping and accounting purposes, the UPMC Welfare Benefits Plan is operated on a calendar-year basis (January 1 through December 31).
Agent for Service of Legal Process
The agent for service of legal process on the plan is:

UPMC
200 Lothrop Street, 8039 Forbes Tower
Pittsburgh, PA 15213
1-800-994-2752, option 3

Legal process on the plan also may be served on the plan administrator.

Permanency of the Plan
UPMC intends to continue the plan indefinitely. However, UPMC reserves the right to make changes to the benefits provided under the plan, or even terminate the plan or any of the benefits provided under the plan. You may have the right to convert or take with you certain coverages if your group coverage ends. See each Plan option for details.

Official Plan Documents
This handbook serves as the official plan document for the UPMC Welfare Benefits Plan. Every attempt has been made to make this as detailed a handbook as possible. However, if this handbook inadvertently says anything that disagrees with the official contracts that govern each component of the plan, the contracts are followed to determine your benefits.
Your ERISA Rights

As a participant in the UPMC Welfare Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

- Examine (without charge) at the plan administrator’s office and at other specified locations — such as work sites and union halls — all plan documents. These may include insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information by writing to the plan administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive a written explanation of the reason for the denial if your claim for a benefit is denied — in whole or in part. You have the right to have the plan review and reconsider your claim.
- In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called “fiduciaries,” have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.
- No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your ERISA rights.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits which is denied or ignored — in whole or in part — you may file suit in a state or federal court.
- If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.
If you file suit against the plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory (Philadelphia Regional Office, The Curtis Center, Suite 870 West, 170 S. Independence Mall West, Philadelphia, PA 19106; 1-215-861-5300) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.
Claims and Appeal Procedures

A third-party administrator or insurance company has the initial authority to decide whether an individual is eligible to participate and the amount of benefits that are payable under this plan. Even though it does not happen often, occasionally disagreements about benefit eligibility or amounts arise. In most cases, they are resolved quickly by the administrator or the UPMC Employee Service Center.

Health Benefit Claims
The time frames for deciding initial health benefit claims and appeals of those claims will be based on the type of claim made by you. There are four different categories of claims: post-service, pre-service, urgent and concurrent (ongoing).

Urgent Care Claims
A “claim involving urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function;

(ii) in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a “claim involving urgent care” is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care” shall be treated as a “claim involving urgent care.”

Pre-Service Claim
A “pre-service claim” means any claim for a benefit under the plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Concurrent Care Decision
If the plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination.
Post-Service Claim
A “post-service claim” means any claim for a benefit under the plan that is not a pre-service claim.

Initial Benefit Determination
• Post-Service. Within a reasonable period of time, but not later than 30 days after receipt of the claim.

• Pre-Service Claim Not Involving Urgent Care. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.

• Urgent Care. As soon as possible, taking into account the medical urgency, but generally not later than 72 hours after receipt of the claim.

• Concurrent Care. For urgent claims involving ongoing care, as soon as possible, taking into account the medical urgency, but generally no longer than 24 hours. For non-urgent claims involving ongoing care, sufficiently in advance of a reduction or termination of a course of treatment to allow the claimant to appeal and obtain a review.

Special time frames apply to claims submitted without sufficient information, and pre-service benefit requests that do not follow a plan’s claims procedures. A 15-day extension may be allowed in certain circumstances for post-service and pre-service claims.

If you are unable to resolve a disagreement about benefit eligibility or the benefit amount, two formal appeals processes are in place — one for your self-insured benefits, and one for your fully insured benefits — to help you appeal a denied claim. For a list of your self-insured and fully insured benefits, see page 3.
**Appeals Process for Your Self-Insured Benefits**

Your appeal to the claims administrator noted below (including any subsequent appeals to the plan Administrator) must be made within 180 days of the date you receive the initial denial. In your appeal, you may submit such written comments, documents, records and other information, as you believe relevant to your claim for benefits. In addition, we will provide upon request and free of charge, reasonable access to and copies of all documents records and other information relevant to your claim for benefits.

If your request or claim is denied or reduced (in whole or in part) following the review above, the administrator will send you (or your beneficiary) a written notice of the denial within the time period noted below. The notice will:

- Describe the specific reasons for the denial;
- Highlight the provisions on which the reasons are based;
- Outline how claims are reviewed; and
- Note any additional material needed to complete the claim.
- Identify medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the determination.

Plan participants may appeal an adverse benefit decision for medical (including prescription drugs and vision claims) or dental PPO claims, by taking the following steps:

**Urgent Care Claim Appeals:** You should direct urgent care appeals directly to UPMC Health Plan for all medical claims and CIGNA Healthcare Service Center for dental claims. The claims administrator will review urgent care appeals. You may be asked to provide additional information to support the claim. See the *Administrative Information* section for address information. The administrator will make the final determination on these appeals and will send written notification of the decision on the urgent care claim within 72 hours.

**Concurrent Care Appeals:** You should direct concurrent care appeals directly to UPMC Health Plan for all medical claims and CIGNA Healthcare Service Center for dental claims. The claims administrator will notify you in writing of the benefit decision within 24 hours for urgent concurrent care appeals.

**Pre-Service Claims or Post-Service Claims Appeals:**

*First level appeal* – Pre and post-service appeals should be directed to UPMC Health Plan for all medical and CIGNA Healthcare Service Center for all dental claims for review. You, your beneficiary, or your legal representative may ask for a full review of the decision by writing to the claims administrator at the address located in the preceding section under ‘Administrative Information’. The claims administrator will notify you in writing of the benefit decision within 15 days, in the case of a pre service claim, or within 30 days, in the case of a post service claim.

*Second level appeal* – If you receive an adverse appeal decision from the claims administrator, you may appeal directly to the Plan Administrator (University of Pittsburgh Medical Center).
See Administrative Information for address information. You should include all relevant documents, comments and records you believe relevant to your claim for benefits.

The Plan Administrator will review your claim and all supporting documentation submitted. In most cases, the appeal will be submitted to the ERISA Review Committee. The Committee will review all the information submitted regarding your claim and make a final determination on the claim. The final decision regarding your claim will be made promptly and the ERISA Review Committee will issue written notification to you (or your beneficiary) on the decision within 15 days on pre-service claims, 30-days on a post-service claims. This notice will contain the same type of information as noted above with respect to first level appeals. In this case, the plan administrator makes the final decision regarding your claim. In the event that the denial of the claim is upheld on review by the ERISA Review Committee, you may file a lawsuit for the denied service against the UPMC Welfare Benefit Plan under Section 502(a) of ERISA.

**Appeals Process for Your Fully Insured Benefits**

Take the following steps to appeal a denied claim:

- Write to the insurance carrier to request further review and reconsideration of the claim within 180 days from the day you receive the denial. If you don’t make the request within this time frame, you waive your right to appeal. You may be asked to provide additional information to support your claim. For the full address of the insurance carrier, see the preceding *Administrative Information* section.

If your request or claim is denied or reduced (in whole or in part) following the review above, the insurance carrier will send you (or your beneficiary) a written notice of the denial within sixty (60) days for post-service claims, 30 days for pre-service claims and 72 hours for urgent care claims. The notice will:

- Describe the specific reasons for the denial;
- Highlight the provisions on which the reasons are based;
- Outline how claims are reviewed;
- Explain the steps for an appeal;
- Note any additional material needed to complete the claim; and
- Identify medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the determination.

- If the insurance carrier upholds its denial, you can request an appeal through the carrier’s appeals process (which may vary among insurance carriers).

- In this case, the insurance carrier makes the final decision regarding your claim. Unlike your self-insured benefits, there’s no opportunity for you to appeal your denied claim to the plan administrator.
Disability Claims and Appeals
Appeals for disability claims should be submitted directly to the disability carrier. Notification of an initial disability benefit decision will be no later than 45 days. The plan may request up to two 30-day extensions in special circumstances defined in the regulations. You will have up to 180 days to appeal the decision, and a decision on the appeal will be provided no later than 45 days, with a 45-day extension allowed in special circumstances defined in the regulations.

Other Benefit Appeals
Appeals for all other benefits should be directed to the Employee Service Center. These benefits include: Adoption Assistance, Employee Assistance Program, Paid Time Off, Pretax Transportation, Tuition Assistance and the Severance Plan. Your appeal to the Employee Service Center must be made within 180 days of the date you receive the denial for your post service claim. In your appeal, you may submit such written comments, documents, records and other information, as you believe relevant to your claim for benefits. In addition, we will provide upon request and free of charge, reasonable access to and copies of all documents records and other information relevant to your claim for benefit.

The final decision regarding your claim will be made promptly (usually within 60 days after your request for review is received). In any case, you will know the final decision no later than 120 days after the request for review is received. A written notification will be sent to you (or your beneficiary).
The institutions of UPMC Health System prohibit and will not engage in discrimination or harassment on the basis of race, color, religion, national origin, ancestry, sex, age, marital status, familial status, sexual orientation, disability, or status as a disabled veteran or a veteran of the Vietnam era. Further, the institutions will continue to support and promote equal employment opportunity, human dignity, and racial, ethnic, and cultural diversity. This policy applies to admissions, employment, and access to and treatment in UPMC Health System programs and activities. This is a commitment made by the institutions of UPMC Health System in accordance with federal, state, and/or local laws and regulations.