UPMC Health Plan

www.upmchealthplan.com/PSHB

Customer Service 833-288-6901

2025

A Health Maintenance Organization (Standard Option) and a High Deductible Health Plan

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 10 for details. This plan is accredited. See page 14.

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

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 19 for requirements.

Only Postal Employees and Annuitants may enroll in this plan.

Enrollment codes for this Plan:

G9D Standard Option – Self Only
G9F Standard Option – Self Plus One
G9E Standard Option – Self and Family

G9A High Deductible Health Plan (HDHP) – Self Only
G9C High Deductible Health Plan (HDHP) – Self Plus One
G9B High Deductible Health Plan (HDHP) – Self and Family

IMPORTANT

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-933

Important Notice for Medicare-eligible Active Employees from UPMC Health Plan About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the UPMC Health Plan prescription drug coverage for active employees is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your PSHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your PSHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of UPMC Health Plan, Inc. under contract (CS 2856 PS) between UPMC Health Plan, Inc., as a legal entity and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. Customer service may be reached at 833-288-6901 or through our website: www.upmchealthplan.com/PSHB. The address for UPMC Health Plan's administrative offices is:

UPMC Health Plan

U.S. Steel Tower

600 Grant Street

Pittsburgh, PA 15219

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) or our Medicare Advantage Prescription Drug (MAPD) EGWP if you choose to enroll in our MAPD EGWP. If you choose to enroll in our MAPD EGWP, you must be enrolled in our Standard Option HMO. You do not have a right to benefits that were available before January 1, 2025, under the FEHB Program unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means UPMC Health Plan.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans’ brochures have the same format and similar descriptions to help you compare plans

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 833-288-6901 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain family members on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain PSHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

Ask questions if you have doubts or concerns.

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

1. **Keep and bring a list of all the medications you take**.
    - Bring the actual medication or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
    - Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
    - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
    - Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
    - Read the label and patient package insert when you get your medication, including all warnings and instructions
    - Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
    - Contact your doctor or pharmacist if you have any questions.
    - Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

2. **Get the results of any test or procedure.**
    - Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
    - Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
    - Ask what the results mean for your care.

3. **Talk to your doctor about which hospital or clinic is best for your health needs.**

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

4. **Make sure you understand what will happen if you need surgery.**

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

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

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

- https://psnet.ahrq.gov/issue/national-patient-safety-foundation The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.

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

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

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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

It is the policy of UPMC Insurance Services Division to monitor, identify and investigate the occurrence of Serious Reportable Adverse Events (SRAEs) and Hospital Acquired Conditions (HACs).

Healthcare facilities and providers may not knowingly seek payment from UPMC Insurance Services Division or from a UPMC Health Plan member for a SRAE or for any services required to correct or treat the problem created by a SRAE when that event occurred under their control. However, in those circumstances where payment is sought for a SRAE, UPMC Insurance Services Division: (1) notifies the relevant healthcare facility/provider that such claim for payment is inappropriate; (2) conducts a quality of care investigation; and (3) denies or recovers payment for any services required to correct or treat the problem created by a SRAE when the SRAE occurred under the healthcare facility/provider's control.

PSHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
• **Minimum essential coverage (MEC)**	Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
• **Minimum value standard**	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
• **Where you can get information about enrolling in the PSHB Program**	See https://health-benefits.opm.gov/PSHB/ for enrollment information as well as: • Information on the PSHB Program and plans available to you • A health plan comparison tool Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System. Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you: • When you may change your enrollment • How you can cover your family members • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire • What happens when your enrollment ends • When the next Open Season for enrollment begins We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office. Once enrolled in your PSHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.
• **Enrollment Types of coverage available for you and your family**	Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/PSHB/. For assistance with the PSHB System, call the PSHBP Helpline at (844) 451-1261. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please, report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one PSHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another PSHB or FEHB plan.

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

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

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

  - If you have no PSHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
  - If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
  - If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM

  As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the PSHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

  If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for PSHB coverage, you must continue your PSHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

  For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

- **Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)**

  Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please, contact CMS for assistance (833)-288-6901 or our UPMC *for Life* Medicare sales team at 844-761-0083. Our hours of operation are Oct. 1 – March 31 seven days a week from 8 a.m. to 8 p.m. and April 1 – Sept. 30 Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 9 a.m. to 3 p.m. TTY users should call 711.

- **When benefits and premiums start**

  The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When PSHB coverage ends**

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

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

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

  If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

- **Upon divorce**

  If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- **Medicare PDP EGWP**

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at (833)-288-6901.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn 26.

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

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

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

- **Converting to individual coverage**

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

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

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

Your benefits and rates will differ from those under the PSHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 833-288-6901 or visit our website at www.upmchealthplan.com/PSHB.

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that PSHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. UPMC Health Plan holds the following accreditations: a rating of Excellent from the National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation(s), please visit the following websites: www.ncqa.org. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory or visit our website at www.upmchealthplan.com/PSHB. We give you a choice of enrollment in a Standard Option or a High Deductible Health Plan (HDHP).

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

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

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

All of our Plan options include a Health Incentive opportunity

Take a Healthy Step

Take a Healthy Step rewards you for making healthy choices. By completing healthy activities, you earn points. There are many activities to choose from, each with a point value. The first step is to complete the *My*Health Questionnaire. Then, every time you complete an eligible activity, you will earn points. The points are tied to levels. Each time you complete a level, UPMC will deposit reward dollars onto a debit card. You can use the reward dollars you earn on your debit card to help pay your out-of-pocket medical expenses, including deductible, coinsurance, and pharmacy copayments.

If you have the Standard Option HMO, any unused reward dollars (up to two times your annual deductible) will roll over to the next year. You can earn up to $250 for yourself or $500 for your family during the plan year.

If you have the High Deductible Health Plan Option: The reward dollars will be deposited into your HSA account available on your HSA debit card. Up to $75 for Self or $150 for Self plus One or Self plus Family per plan year. Please include the reward dollars you earn in the HSA in your yearly contribution maximums of $4,300 for Self and $8,550 for Self plus One or Self plus Family.

If you have an HRA because you are not eligible for an HSA it will be applied automatically to your debit card to be used toward deductible, coinsurance or copayment incurred.

Take a Healthy Step is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary well-being assessment or "health questionnaire" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the health questionnaire.

Although you are not required to complete the health questionnaire only employees who do so will receive the selected reward dollars.

Additional incentives as noted above may be available for employees who participate in certain health-related customized activities. If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting UPMC Health Plan at 833-288-6901.

The information from your health questionnaire will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as recommended healthy activities. You also are encouraged to share your results or concerns with your own doctor.

General features of our Standard Option

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

Preventive care services

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

Calendar year deductible

The calendar year deductible must be met before Plan benefits are paid for care other than preventive care services. Office visits and prescription medications only require a copayment and are not subject to the calendar year deductible.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Under the Standard Option, after your share of coinsurance, copayments and deductibles total $6,000 for Self Only, or $12,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year and copayments are waived for the remainder of the calendar year. Funds paid from the HIA apply to the annual out-of-pocket maximum. See page 27 if you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).

We have Open Access benefits

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

You pay a copayment each time you visit the doctor. Under the Standard Option, most other medical and surgical services are payable at 80% after you meet the plan deductible. These benefits include inpatient and outpatient hospital services, diagnostic services, medical therapy (such as radiation and dialysis), and other services prescribed by a participating physician such as home healthcare or durable medical equipment and supplies.

For non-emergency services, you must use a participating provider. The Standard Option covers emergency services at any medical facility, whether or not that medical facility participates in the UPMC Health Plan's HMO Premium Network.

Using your Reward Dollars with the Standard Option

Reward dollars earned on your debit card can be used toward your deductible, pharmacy copayments and coinsurance which you and or your family incur. Any unused reward dollars at the end of the plan year carry over from year to year, up to two times the annual deductible.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of PSHB plans. PSHB Program HDHPs also offer Health Savings Accounts (HSA) or Health Reimbursement Arrangements (HRA). Please see below for more information about these savings features.

Preventive care services

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

Calendar year deductible

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

This plan option is a Preferred Provider Organization (PPO)

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

You pay a coinsurance each time you visit the doctor. Under the HDHP, most medical and surgical services are payable at 85% after you meet the Plan deductible. If you receive care from an out-of-network provider, coinsurance is 60%. These benefits include inpatient and outpatient hospital services, diagnostic services, medical therapy (such as radiation and dialysis), and other services prescribed by a participating physician such as home healthcare or durable medical equipment and supplies.

Using your Reward Dollars with the HDHP Option

Reward dollars earned are deposited into your HSA account debit card for you to use to reimburse any qualified 213B expense. If you have an HRA because you are not eligible for an HSA you will receive a debit card with your reward dollars to use toward deductible, coinsurance or copayment incurred by anyone enrolled in your plan.

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

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not a HDHP (including a spouse's health plan, excluding specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not (except for veterans with a service-connected disability) or Indian Health Service (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending accounts (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, prescription copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. Your contributions are tax deductible up to the specified annual limit minus the amount contributed through your premium pass The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

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

- An HRA does not earn
- An HRA is not portable if you leave the Federal government or switch to another
- With the HRA you will receive a debit card and will be able to use to reimburse deductible, copayments and coinsurance which are incurred by anyone enrolled in your plan.
- You must let UPMC Health Plan know if you are not eligible for an HSA (see page 86 of this brochure).

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. UPMC has **separate** catastrophic out-of-pocket expense limits for its regular HMO and High Deductible Health Plan (HDHP).

High Deductible Health Plan (HDHP)

The IRS HDHP annual catastrophic out-of-pocket expenses for covered services, including deductibles, coinsurance and copayments, cannot exceed $8,050 for Self Only enrollment and $16,100 for Self Plus One or Self and Family enrollment. UPMC's catastrophic out-of-pocket limits for your High Deductible Health Plan (HDHP) **in-network** are $6,000 for Self Only enrollment and $12,000 for Self Plus One and Self and Family enrollment and **out-of-network** are $8,000 for Self Only enrollment and $16,000 for Self Plus One and Self and Family enrollment.

Health education resources and account management tools

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

Visit our website at www.upmchealthplan.com/PSHB and log in to UPMC Health Plan member site to access tools to help you learn more about your health, including information about specific diseases and conditions. You can also learn about your health plan benefits, and it can even help you track your personal health information. You can view personalized information about your physicians, view an electronic explanation of benefits (EOB), review prescriptions, receive important reminders for preventive screenings, and review options to help you manage your health:

- **Online tools for maximizing your health and wellness** and reaching your personal health You can check your symptoms online, update your medical history, and refill your prescriptions. You can also complete your MyHealth Questionnaire, which is the *Take a Healthy Step* well-being assessment. Your answers will automatically customize UPMC Health Plan member site for you. You will receive a summary of your current health status, and practical, personalized recommendations to improve your health and earn 50 points for completing the *My*Health Questionnaire.
- **Benefits information that helps you manage your healthcare finances** and maintain control over your healthcare dollars. You will find links to plan benefits, prescription savings, spending summaries, and claims You can also sign up to receive electronic explanation of benefits (EOBs).
- **Expanded online** You'll be able to order a new member ID card and select or change your PCP. You'll also be able to read frequently asked questions to popular health questions.

When you download the free **UPMC Health Plan Mobile App** to your smartphone you can:

- Access your UPMC Health Plan Member ID
- Contact your providers from a personalized
- Check the status of your claims

If you have an **HSA**,

- You can receive a monthly statement mailed to your home outlining your account balance and activity for a minimal monthly fee.
- Your HSA balance will be available through UPMC Health Plan member site. Visit www.upmchealthplan.com/PSHB and login to UPMC Health Plan member site using the member identification number on your member ID card.

If you have an **HRA**,

- Your HRA balance will be available through UPMC Health Plan member site. Visit www.upmchealthplan.com/PSHB and login to UPMC Health Plan member site using the member identification number on your member ID card.

Your rights and responsibilities

OPM requires that all PSHB plans provide certain information to their PSHB members. You may get information about us, our networks, and our providers. OPM's PSHB website www.opm.gov/healthcare-insurance/ lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence – 27 years
- Profit status – For-profit subsidiary under a non-profit parent company

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, UPMC Health Plan at www.upmchealthplan.com/PSHB. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 833-288-6901, or write to UPMC Health Plan Member Services, U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219. You may also visit our website at www.upmchealthplan.com/PSHB.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.upmchealthplan.com/PSHB to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington and Westmoreland counties.

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

Covered dependents (up to age 26) residing or attending school outside of the service area have access to UPMC Health Plan’s extended network. This network includes Medical Mutual of Ohio’s SuperMed PPO network and Cigna's PPO network. Covered dependents receive the highest level of benefits when utilizing participating providers in one of these networks. Please go to www.upmchealthplan.com/find/ to find the providers in the area. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. New for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to Section 5. Benefits.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the PSHB System enrollment confirmation.

Note: If you are enrolled in our Medicare Part D PDP EGWP, you may receive a second ID card for your prescription drug benefits.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 833-288-6901 or write to us at UPMC Health Plan Member Services, U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219. You may also request replacement cards through our website: www.upmchealthplan.com/PSHB.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers, but it will cost you more. If you use our Open Access program, you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network.

Balance Billing Protection

PSHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

Plan providers

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website: www.upmchealthplan.com/PSHB.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached 833-288-6901 or www.upmchealthplan.com/PSHB for assistance.

Plan facilities

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

What you must do to get covered care

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

Primary care

Your primary care provider can be an internist, pediatrician, family practitioner, or general practitioner. Your primary care provider will provide most of your healthcare, or refer you to a specialist. Individuals may select an ob/gyn to provide or coordinate all covered gynecological/obstetrical care. However, individuals are not required to see the same ob/gyn on a regular basis.

If you are enrolled in the Standard Option, you must register your selected primary care provider with us. If you want to change your primary care provider, you may do so at any time by contacting Member Services at 833-288-6901 or by visiting the website at www. upmchealthplan.com/PSHB. If your primary care provider leaves the Plan, call us and we will help you select a new one.

Specialty care

Your primary care provider will refer you to a specialist for needed care. However, a referral is not required to see a specialist.

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

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who can recommend another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - Lose access to your specialist because your coverage changed from the FEHB to the PSHB and your health plan does not participate in the PSHB; or
  - Lose access to your specialist because we drop out of the Postal Service Employees Health Benefits (PSHB) Program and you enroll in another PSHB program plan; or
  - Lose access to your specialist because terminate our contract with your specialist for other than cause;
  - Lose access to your specialist because we reduce our service area and you enroll in another PSHB plan.

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

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

Hospital care

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

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 833-288-6901. If you are new to the PSHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

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

Inpatient hospital admission

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

Other services

Your primary care provider has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. For the most up-to-date source of information on which procedures require your physician to obtain prior authorization, refer to www.upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx.

If you are considering an artificial insemination procedure, see requirements on page 39 or 105.

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

First, your physician, your hospital, you, or your representative, must call us at 833-288-6901 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

Non-urgent care claims

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

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

Urgent care claims

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 833-288-6901. You may also call Postal Service Insurance Operations (PSIO) at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 833-288-6901. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

Emergency inpatient admission

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

Maternity care

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

If your treatment needs to be extended

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

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 833-288-6901.

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

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

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

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

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
3. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See Section. 8(a) for information about the PDP EGWP appeal process.

Section 4. Your Cost for Covered Services

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

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive. Available funds in your Health Incentive Account will reduce your cost-sharing.

Copayments

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

Example: Under the Standard Option, when you visit a participating primary care provider you pay a $20 copayment.

Deductible

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

- The calendar year deductible under the Standard Option is $850 for a Self Only. Under Self Plus One or Self and Family enrollment, the deductible under the Standard Option is $1,700. For a Self Plus One or Self and Family enrollment, if one member meets the individual deductible, the deductible is satisfied for that member and the Plan will begin to pay benefits.
- The calendar year deductible under the HDHP is $2,000 for a Self Only enrollment. Under Self Plus One or Self and Family enrollment, the deductible under the HDHP is $4,000. Under Self Plus One or Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reaches $4,000. The deductible is combined for services received from both Plan and non-Plan providers.
- The calendar year deductible will be prorated for any mid-year member enrollment.

Note: If you change PSHB plans during Open Season, the effective date of your new PSHB plan is January 1 of the next year, and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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

Coinsurance

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

- Under the Standard Option, you pay 20% of our allowance for covered
- Under the HDHP, you pay 15% of our allowance for services received from participating providers; 40% for non-participating providers.

Differences between our Plan allowance and the bill

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

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

Under the Standard Option, after your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $6,000 for Self Only, or $12,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

Under the HDHP, after your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance for In Network total $6,000 for Self Only, or $12,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for In Network covered services. For Out of Network, after your out-of-pocket expenses total $8,000 for Self Only or $16,000 for Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for Out of Network covered services.

Example Scenario: Your plan has a $6,000 Self Only maximum out-of-pocket limit and a $12,000 Self Plus One or Self and Family maximum out-of-pocket limit. Under a Self Plus One enrollment, each enrollee will have an out of pocket maximum of $6,000 each calendar year. With a Self and Family enrollment, the out-of-pocket maximum is $12,000. One individual would have a $6,000 out-of-pocket limit, and a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified expenses up to a maximum of $12,000 for the calendar year before their qualified medical expenses begin to be covered in full.

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

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

For members enrolled in our Plan's associated MA-PD or PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s), unless specifically excluded below.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit the effective date of the change is January 1, and covered expenses that apply to this plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

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

When Government facilities bill us

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

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to https://bit.ly/upmchpNSAFEHB or contact the health plan at 833-288-6901.

Section 5. Standard Option Benefits

Page 176 and page 178 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. Standard Option Benefits Overview

This Plan offers both a Standard and HDHP. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and HDHP Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard Option benefits, contact us at 833-288-6901 or on our website at www.upmchealthplan.com/PSHB.

Each option offers unique features.

Your Health Incentive Account

Reward dollars earned are deposited onto UPMC Consumer Advantage debit card. The funds earned on the debit card can be used for out-of-pocket expenses like coinsurance, deductible, and pharmacy copayments. The reward dollars you earn carry over from year to year, up to two times the annual deductible. See page 78 for more details on earning reward dollars.

Standard Option

For all services, there is an annual deductible applied before coinsurance is applied. Once the deductible is met, you pay 20% of the allowable expense. When your out-of-pocket expense for deductible, copayments and coinsurance exceeds $6,000 for Self Only, or $12,000 for Self Plus One or Self and Family, in any calendar year, your 20% coinsurance and copayments are eliminated for the remainder of the calendar year.

The deductible is waived for preventive care services.

If you are retired and covered by Medicare Parts A and B, your coinsurance cost-sharing is waived under the Standard Option. If you are covered by the Standard Option HMO and Medicare Parts A and B, and you choose to enroll in the UPMC *for Life* PSHB Retirees Medicare Advantage plan the benefits of that plan will apply. If you are covered by the Standard Option HMO and Medicare Parts A and B, and you choose not to enroll in the UPMC *for Life* PSHB Retirees then your coinsurance will be reduced to 0% after the calendar year deductible is met. Whichever option you choose you will be eligible for $800 Medicare Part B premium reimbursement. UPMC will reimburse enrolled members up to $66.67 per month up to a maximum of $800 per year for Medicare Part premium. This reimbursement is available once a year.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $850 Self Only or $1,700 Self Plus One, or Self and Family under the Standard Option. Your actual deductible may be reduced by your participation in activities that fund your reward dollars. The deductible is waived for services that require a copayment. The deductible is also waived for preventive screenings and certain immunizations. We added "(No deductible)" to show when the calendar year deductible does not apply.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under Standard Option, after your share of deductibles, copayments and coinsurance total $6,000 for Self Only, or $12,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum, such as expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	**Standard Option**
Professional services of physicians • In physician's office	$20 per office visit for a PCP (No deductible) $50 per office visit for a specialist (No deductible)
Professional services of physicians • During a hospital stay • In a skilled nursing facility. Limited to 100 days per calendar year combined with Extended care facility admissions. • Office medical consultations • Second surgical opinion • Advance care planning • Professional interpretation of diagnostic test	$50 per office visit for a specialist (No deductible) 20% of the Plan allowance for other covered services
Professional services of physicians • At a convenience care clinic	$20 copayment per visit (No deductible)

Benefit Description	You pay
Telehealth services	**Standard Option**
• Physician services for a Virtual Visit	$5 per visit (No deductible)
Lab, X-ray and other diagnostic tests	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Non-routine mammogram • CT/CAT Scan • MRI • Ultrasound • Electrocardiogram and EEG • Professional interpretation of diagnostic testing r	20% of the Plan allowance
Preventive care, adult	**Standard Option**
Routine physical every 12 months by your PCP: **The following preventive services are covered at the time interval recommended at each of the links below:** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at www.hrsa.gov/womens-guidelines. • To build your personalized list of preventive services go to https://health.gov/myhealthfinder.	Nothing (No deductible)
Tobacco cessation counseling	Nothing (No deductible)
Routine Prostate Specific Antigen (PSA) test - one annually age 40 and older	Nothing (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Standard Option**
• Routine mammogram	Nothing (No deductible)
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at Vaccines & Immunizations | CDC Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing (No deductible)
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy - Examination, referral, and Counseling: obesity prevention for midlife members (ages 40-60); annual counseling for those with normal or overweight body mass index (18-29.9 kg/m2) to main weight or limit weight gain, and screening/ referral for those with a BMI $\geq$ 30 for intense, multicomponent behavioral interventions. Counseling may include an individualized discussion of healthy eating and physical activity. - Obesity screening annually through 18 years • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. - Lifestyle health coaching: Through virtual (Anywhere Care), telephonic, and digital (RxWell mobile app) modalities, health coaches may address lifestyle health needs. - Support and care during pregnancy - maternity care management supporting members through pregnancy along with counseling for healthy weight gain in pregnancy - Condition management coaching: A medical-behavioral approach to help manage chronic conditions and improve your health.	Nothing (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Standard Option**
- Case management: Case management coaches are licensed nurses, social workers, and other clinical professionals who help you manage your health by coordinating with your providers and providing access to resources. See also Section 5(h) for Wellness and Special Features.	Nothing (No deductible)
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a) for cost share requirements for anti-obesity medications.	
• When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See section 5(b) for Surgery requirements and cost share.	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**Standard Option**
Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org Children's immunization's endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at Vaccines & Immunizations | CDC	Nothing (No deductible)
• You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing (No deductible)

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**Standard Option**
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy - Examination, referral, and Counseling: obesity prevention for midlife members (ages 40-60); annual counseling for those with normal or overweight body mass index (18-29.9 kg/m2) to main weight or limit weight gain, and screening/ referral for those with a BMI ≥ 30 for intense, multicomponent behavioral interventions. Counseling may include an individualized discussion of healthy eating and physical activity. - Obesity screening annually through 18 years • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. - Lifestyle health coaching: Through virtual (Anywhere Care), telephonic, and digital (RxWell mobile app) modalities, health coaches may address lifestyle health needs. - Support and care during pregnancy - maternity care management supporting members through pregnancy along with counseling for healthy weight gain in pregnancy - Condition management coaching: A medical-behavioral approach to help manage chronic conditions and improve your health. - Case management: Case management coaches are licensed nurses, social workers, and other clinical professionals who help you manage your health by coordinating with your providers and providing access to resources. See also Section 5(h) for Wellness and Special Features.	Nothing (No deductible)
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a) for cost share requirements for anti-obesity medications.	
• When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**Standard Option**
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Immunizations, boosters and medications for travel or work-related exposure*	*All charges*
Maternity care	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression	Nothing (No deductible)
Breastfeeding and lactation support, supplies and counseling for each birth Note: Here are some things to keep in mind: You do not need to precertify your vaginal delivery; see page 37 for other circumstances, such as extended stays for you or your baby.	Nothing (No deductible)
• As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period.	Nothing (No deductible)
• You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	Nothing (no deductible)

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**Standard Option**
Baby Steps is a maternity program available to all UPMC Health Plan members. This program connects you with maternity health coaches who provide support, education, and resources. Some examples of what you can talk about include prenatal vitamins, a birthing plan, breastfeeding, and signs of postpartum depression. We want to help increase your chances of having a healthy pregnancy, baby, and postpartum recovery. This program is provided to you at no-cost as part of your benefits. How frequently you communicate with your coach is up to you, with both phone and in-person options available. Contact us to learn more about the Baby Steps program and get in touch with a health coach. Coaches are available Monday through Friday from 8 a.m. to 6 p.m. • **Phone**: 1-866-778-6073 (TTY:711) • **Chat via UPMC Health Plan member site**: Sign in to UPMC Health Plan member site | Register for UPMC Health Plan member site • **Email: maternitycoaches@upmc.edu** (Coaches will schedule a phone call based on your availability.) • **UPMC Health Plan Maternity Program** Any member who is identified as having active or a history of chronic hypertension or PIH is stratified as high risk and targeted for active Case Management outreach for program participation. If one of the Case Managers is working with a member that develops hypertension during pregnancy, they can help facilitate receipt of a blood pressure cuff and work with the member and her provider to ensure the member is comfortable with self-monitoring BP at home and notifying their provider with signs/ symptoms of worsening symptoms. Member can receive a blood pressure • Provider Directory | Find Care | UPMC Health Plan	Nothing (No deductible)
Family planning	**Standard Option**
Contraceptive counseling on an annual basis	Nothing (No deductible)
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera)	Nothing (No deductible)

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**Standard Option**
• Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f) or 5(f)(a). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing (No deductible)
Voluntary male sterilization	Nothing (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*
Infertility services	**Standard Option**
Infertility is the documented inability of a person under the age of 35 years to conceive a child within a 12-month period or a person 35 years or older to conceive a child within a six-month period: (a) of unprotected coitus (sexual intercourse); or (b) egg-sperm contact through artificial insemination. Infertility may also be established through evidence of medical history and diagnostic testing. **Medical Description** Refer to MP.017 – Infertility – Treatment policy. Note that treatment of the causes of infertility is not addressed in this policy. **Specific Indications for Diagnosis** • Member must fit the definition for infertility (as indicated in Section 10 Definitions) • Members must be pre-menopausal and reasonably expect fertility as a natural state; or if menopausal, should have experienced it at an early age **Diagnosis and treatment of Infertility**	20% of the Plan allowance

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**Standard Option**
Depending on the member's unique medical situation, the following diagnostic tests to diagnose fertility in males and females may be considered medically necessary: • History & Physical • Sperm function tests • Hysterosalpingogram • Hysteroscopy • Sonohysterogram • Prediction of Ovarian Reserve Hormone Evaluation • Evaluation of folliculogenesis • Endometrial biopsy • Diagnostic laparoscopy • Follow-up Conference • Artificial insemination: - Intravaginal insemination (IVI) - Intrauterine insemination (IUI) - Intracervical insemination (ICI) • Artificial reproduction: - Assisted Reproductive Technologies (ART)- all clinical and laboratory treatments in which both human oocytes and sperm, or embryos, are manipulated outside of the body with the intent of establishing pregnancy. - In vitro fertilization, embryo transfer, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), services, IVF drugs and supplies related to covered ART procedures, cost of donor sperm and cost of donor egg. All included within the lifetime maximum of $25,000 per member. There are no annual cycle limits. • Iatrogenic infertility (Fertility Preservation) - Coverage includes cryopreservation of embryos, eggs, sperm, and ovarian and testicular tissues in the case of medically necessary chemotherapy, radiation or pharmacological treatment with a likely side effect of infertility. • Infertility prescription drugs - subject to cost sharing shown in Section 5(f) Prescription Drug Benefits in UPMC Health Plan 2025 postal brochure RI 73-933 and included in the Lifetime maximum benefit per member.	20% of the Plan allowance

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**Standard Option**
• Lifetime maximum benefit per member is $25,000 and includes all of the above except artificial insemination which is exempt from the lifetime maximum of $25,000. Coverage of member's preserved specimen is only available while the member is enrolled in UPMC Health Member is responsible for the cost once the member's enrollment terminates or reaches the $25,000 maximum lifetime benefit. **Limitations/Contraindications** Normal physiological causes of infertility such as menopause • Infertility resulting from voluntary sterilization • The following diagnostic tests are considered investigational: - Tests to assess/improve sperm movement, or computer-assisted sperm analysis (CASA) - Analysis of adenosine triphosphate (ATP) in ejaculation - Tubaloscopy - Anti-zona pellucida antibodies - Hyaluronan binding assay (HBA) - Sperm washing and swim-up when performed as part of insemination In order to assess medical necessity for infertility services, adequate information must be furnished by the treating physician. Necessary documentation includes, but is not limited to the following: • Member's age, clinical history, physical and functional status; • Documentation of infertility, testing if done, and treatment history • Documentation of any history of substance abuse, including smoking; • Social Service evaluation • Lab results: HIV antibody Diagnostic tests for infertility may be ordered by a participating provider. However, most anti-retroviral therapy drugs and procedures should only be ordered or performed by credentialed Reproductive Endocrinologists.	20% of the Plan allowance

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**Standard Option**
If a member lives in an out-of-network area, then the credentials of the nearest Reproductive Endocrinologist or OB/Gynecologist must be reviewed by the Credentials Specialist prior to approval for coverage. Refer to plan-specific infertility riders. The procedure regarding a member acting as a surrogate mother is only covered if the couple has a relationship under which the PSHB Program recognizes each partner as a spouse of the other.	20% of the Plan allowance
• Fertility drugs (See Section 5f or 5(f)(a), if applicable page 67 or 73)	
Not covered: • *Member acting as a surrogate mother and all services and supplies associated with surrogate motherhood are not covered by the UPMC Insurance Services Division, nor are supplies and services related to the following:* - *Pre-pregnancy evaluations* - *Prenatal care* - *Perinatal care* - *Postnatal care*	*All charges*
Allergy care	**Standard Option**
• Testing and treatment • Allergy injections	20% of the Plan allowance
Allergy serum	20% of the Plan allowance
Treatment therapies	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 51. • Respiratory and inhalation therapy • Cardiac rehabilitation following a qualifying event/condition is provided for up to 12 weeks of sessions • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	20% of the Plan allowance

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**Standard Option**
• Medical nutrition therapy to treat a chronic illness or condition; includes nutrition assessment and nutritional counseling by a dietitian or facility-based program which is ordered by a participating physician - Chronic Renal Disease, Diabetes Mellitus, and High Risk Obstetrical Symptomatic Conditions: unlimited number of visits when medically necessary - Morbid Obesity: limited to an initial assessment and five follow-up visits for a total of six visits per calendar year - Heart Disease, Symptomatic HIV/AIDS, and Celiac Disease: limited to two visits per calendar year • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page x. • Pain management Note: Pain management is covered if you are diagnosed with refractory chronic pain of at least six months duration. The provider must demonstrate that they anticipate these services to result in substantial improvement to your medical condition.	20% of the Plan allowance
Nutritional products	**Standard Option**
Nutritional products that are specialty food products are covered when Medically Necessary and when under the direction of a physician on an outpatient basis, for the treatment of inborn errors of metabolism and some hereditary metabolic disorders in accordance with state law. Coverage is independent of whether the product is administered orally or enterally. These disorders include: • Phenylketonuria (PKU) • Branch-chain ketonuria • Galactosemia • Homocystinuria • Allergic reaction or malabsorption syndromes, specifically hemorrhagic colitis	20% of the Plan allowance (no deductible)

Benefit Description	You pay
Physical and occupational therapies	**Standard Option**
Rehabilitation services are limited to the greater of 60 consecutive days of coverage or 25 visits per outpatient condition, per calendar year. Habilitation services are also limited to the greater of 60 consecutive days of coverage or 25 visits per outpatient condition, per calendar year. • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a physician: • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed.	$20 per outpatient visit (No deductible) For therapy received during a covered inpatient admission - 20% of the Plan allowance
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**Standard Option**
Limited to the greater of 60 consecutive days of coverage or 25 outpatient visits per condition, per calendar year for Rehabilitation. Limited to the greater of 60 consecutive days of coverage or 25 outpatient visits per condition, per calendar year for Habilitation.	$20 per outpatient visit (No deductible) For therapy received during a covered inpatient admission - 20% of the Plan allowance
Not covered: • *Speech therapy provided for developmental delays*	*All charges*
Hearing services (testing, treatment, and supplies)	**Standard Option**
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices*.	20% of the Plan allowance
• Hearing allowance of $1,325 per ear in each 36 month period, for adults aged 21 and You must use a participating provider in Amplifon Hearing Healthcare's Network. To find a participating provider please visit https://www.amplifonusa.com/find-a-hearing-aid-clinic. Deductible and Coinsurance do not apply.	Nothing (No deductible)

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

Benefit Description	You pay
Hearing services (testing, treatment, and supplies) (cont.)	**Standard Option**
Note: To obtain services from Amplifon Hearing Healthcare, you must schedule an appointment with an Amplifon Hearing Healthcare participating provider by calling the Amplifon Hearing Healthcare toll free number at 844-336-8951. Note: For routine hearing screening performed during a child's preventive care visits, see Section 5(a) *Preventive care, children.*	Nothing (No deductible)
Not covered: *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	20% of the Plan allowance
• Annual eye examination once every 24 months for adults and children To use your eye examination benefit, call us at 833-288-6901 or visit www.upmchealthplan.com/PSHB to locate a vision care provider.	Nothing (No deductible)
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	20% of the Plan allowance
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**Standard Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Hearing aids are covered at the applicable coinsurance level after the calendar year deductible is met for adults age 21 and over. The benefit limit is $1,500 per ear in each 36 month period • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.*	20% of the Plan allowance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads, and heel cups (covered only with a diagnosis of diabetes or peripheral vascular disease)* • *Hearing aids for children under age 21* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices (gradient compression stockings may be covered for certain diagnoses)* • *Prosthetic replacements when it is determined by us that a repair costs less than 50% of a replacement*	*All charges*
Durable medical equipment (DME)	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches	20% of the Plan allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**Standard Option**
• Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps Note: Call us at 833-288-6901 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of the Plan allowance
Not covered: • *Audible prescription reading devices* • *Replacement or duplication except when necessitated due to a change in the patient's medical condition or the cost to repair the item exceeds 50% of the price of a new item* • *Comfort or convenience items, for your comfort or convenience or the comfort or convenience of your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, phones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty services, guest service or similar items, even if recommended by a professional provider.* • *Medical equipment and supplies that are:* - *expendable in nature (i.e. disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and* - *primarily used for non-medical purposes, regardless of whether recommended by a professional provider*	*All charges*
Home health services	**Standard Option**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	20% of the Plan allowance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*

Benefit Description	You pay
Chiropractic	**Standard Option**
• Manipulation of the spine and extremities. Limited to 25 visits per calendar year • Must be medically necessary *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application. Children under the age of 13 must receive prior authorization for chiropractic care.*	$20 per office visit (No deductible)
Alternative treatments	**Standard Option**
Acupuncture – by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner Dry Needling – by a licensed or certified practitioner [if still covered]	20% of the Plan allowance
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture, other than listed*	*All charges*
Educational classes and programs	**Standard Option**
Diabetic Self-Management Education (DSME) - Outpatient diabetes self-management training and education program is a program of self-management, training, and education, for the treatment of diabetes. You do not need a physician prescription and no referral is required. You must have a chronic condition and your care must be medically necessary. There is no visit limit for this service.	Nothing (No deductible)
Nutritional Counseling - the assessment of a person's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or nutritional therapies to treat a chronic illness or condition. Services must be delivered by a dietitian or facility-based program, ordered by a participating physician and offered by a participating provider. Coverage is limited to two visits per calendar year. Also see *Medical nutrition therapy* under *Treatment therapies* on page 43.	20% of the Plan allowance
Tobacco Cessation - individual, group, phone counseling provided by UPMC Health Plan, call 800-807-0751, and over-the-counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence. You must have a written prescription from your doctor for all medications, including OTC, in order to obtain coverage. See *Prescription drug benefits*.	Nothing (No deductible)

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: $850 Self Only or $1,700 Self Plus One or Self and Family under the Standard Option. The calendar year deductible applies to almost all benefits in this Section. Your actual deductible may be reduced by your participation in activities that fund your reward dollars. The deductible is waived for services that require a copayment. We added "(No deductible)" to show when the calendar year deductible does not apply.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under Standard Option, after your share of deductibles, copayments and coinsurance total $6,000 for Self Only, or $12,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum, such as expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of severe obesity (bariatric surgery) See criteria: MP.PA.040 • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns	20% of the Plan allowance

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**Standard Option**
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	20% of the Plan allowance
Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a)	
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*
Reconstructive surgery	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Prosthetic devices) - Gender Affirming Surgery • All medically necessary gender-affirming care surgeries are covered, including facial surgeries with prior authorization. • For female to male surgery: mastectomy, oophorectomy, salpingoophorectomy, hysterectomy, vaginectomy, metoidioplasty, phalloplasty, and scrotoplasty.	20% of the Plan allowance

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**Standard Option**
• For male to female surgery: orchiectomy, penectomy, penile inversion vaginoplasty, breast augmentation and labiaplasty and facial feminization surgeries. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	20% of the Plan allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*
Oral and maxillofacial surgery	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures • Surgery for TMJ disorder Note: In order for surgery to be covered, documentation in the medical record must support that treatment of TMJ disorder with conventional non-surgical therapy has not resulted in adequate improvement. • Other surgical procedures that do not involve the teeth or their supporting structures.	20% of the Plan allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis] • Cornea	20% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
• Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	20% of the Plan allowance
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	20% of the Plan allowance
Blood or marrow stem cell transplants **The Plan extends coverage for the diagnoses as indicated below.** Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	20% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
- Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma	20% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
- Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors • Hematopoietic Stem Cell Transplant (HSCT)	20% of the Plan allowance
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	20% of the Plan allowance
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols.	20% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	20% of the Plan allowance
• Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia	
• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
• Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis UPMC Health Plan utilizes the top transplant centers in Pennsylvania. Should care not be available in Pennsylvania, UPMC Health Plan will arrange for services out of the area.	20% of the Plan allowance
National Transplant Program (NTP) - Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	20% of the Plan allowance
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient de[artment • Skilled nursing facility. Limited to 100 days per calendar year combined with Extended care facility admissions. • Ambulatory surgical center	20% of the Plan allowance

Anesthesia - continued on next page

Benefit Description	You pay
Anesthesia (cont.)	**Standard Option**
• Office	20% of the Plan allowance

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The calendar year deductible is $850 Self Only or $1,700 Self Plus One or Self and Family under the Standard Option. Your actual deductible may be reduced by your participation in activities that fund your reward dollars.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under Standard Option, after your share of deductibles, copayments and coinsurance total $6,000 for Self Only, or $12,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increase to 100% for the remainder of the calendar year. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum, such as expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% of the Plan allowance
Other hospital services and supplies, such as: • Operating, recovery and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	20% of the Plan allowance
Not covered:	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**Standard Option**
• *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals, and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Observation level of care Note: Observation is a level of care in an acute care hospital setting that is appropriate when a patient is receiving ongoing short-term treatment and assessments and it is not clear if inpatient level of care is needed. Reassessments are made during this time to determine if the patient requires inpatient admission,or may be discharged and receive follow-up in the outpatient setting. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	20% of the Plan allowance
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**
Extended care benefit: Limited to 100 days per calendar year combined with Skilled nursing facility admissions	20% of the Plan allowance
Skilled nursing facility (SNF): Limited to 100 days per calendar year combined with Extended care facility admissions	20% of the Plan allowance
Not covered: Custodial care	*All charges*

Benefit Description	You pay
Hospice care	**Standard Option**
Supportive and palliative care is covered for terminally ill patients, either in the home or in a hospice facility. Services include inpatient and outpatient care and family counseling. These services are provided under the direction of a physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	20% of the Plan allowance
Not covered: Independent nursing, homemaker services	*All charges*
End of life care	**Standard Option**
Advance directive information and forms are available to all members upon request. End of life care also includes face-to-face services with a patient, family member or surrogate in counseling and discussing advance directives.	20% of the plan allowance
Ambulance	**Standard Option**
Local professional ambulance service when medically appropriate	20% of the Plan allowance

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $850 Self Only or $1,700 Self Plus One and Self and Family under the Standard Option. The Self and Family and Self Plus One deductibles can be satisfied by one or more family members. Your actual deductible may be reduced by your participation in activities that fund your reward dollars.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under Standard Option, after your share of deductibles, copayments and coinsurance total $6,000 for Self Only, or $12,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increase to 100% for the remainder of the calendar year. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum, such as expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area

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

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

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

After you receive emergency room treatment or are admitted to the hospital, contact your personal physician as soon as possible**.**

Emergencies outside our service area

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

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

Benefit Description	You pay
Emergencies within our service area	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$20 per doctor's office visit (No deductible) $50 per office visit for a specialist (No deductible) $75 per urgent care center visit (No deductible) $150 per hospital emergency room visit (No deductible)
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Emergency outside our service area	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$20 per doctor's office visit (No deductible) $50 per office visit for a specialist (No deductible) $75 per urgent care center visit (No deductible) $150 per hospital emergency room visit (No deductible)
Not covered: • *Elective care, non-emergency care, and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All charges*
Ambulance	**Standard Option**
Professional ambulance service when medically appropriate Note: See 5(c) for non-emergency service.	20% of the Plan allowance
Not covered: Air ambulance	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $850 Self Only or $1,700 Self Plus One and Self and Family under the Standard Option. Your actual deductible may be reduced by your participation in activities that fund your reward dollars.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	**Standard Option**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. In order to ensure compliance with the Mental Health Parity and Addiction Equity Act, member cost-sharing may be reduced for certain services when received for the diagnosis or treatment of a mental health or substance use disorder or condition. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 per outpatient office visit (No deductible) 20% of the Plan allowance for other covered services

Benefit Description	You pay
Diagnostics	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disordertreatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	20% of the Plan allowance
Inpatient hospital or other covered facility	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	20% of the Plan allowance
Outpatient hospital or other covered facility	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	20% of the Plan allowance
Not covered: • *Services related to disorders that are not diagnoses listed in the most recent edition of the diagnostic and Statistical manual of Mental Disorders* • *Treatment for organic disorders, including, but not limited, to organic brain disease* • *Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder* • *Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies such as art or psychodrama, and hyperbaric or other therapy* • *Sex therapy, listed in the most recent edition of the diagnostic and Statistical manual of Mental Disorders and treatment for sexual addiction* • *Sedative action electrostimulation therapy* • *Sensitivity training* • *Twelve-step model programs as sole therapy for conditions, including, but not limited to, addictive gambling*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- **There is no calendar year deductible for prescription drug**
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under Standard Option, after your share of deductibles, copayments and coinsurance total $6,000 for Self Only, or $12,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increases to 100% for the remainder of the calendar year. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum, such as expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Some drugs may require prior authorization. Your doctor must consult with the Plan before prescribing it. Prior authorizations are set on a drug-by-drug basis and require specific criteria for approval based upon FDA and manufacturer guidelines, medical literature, safety concerns, and appropriate use. See *Other services* under *You need prior Plan approval for certain services* on page 23.
- Some drugs may require step therapy. This means that you must try specific medications first before we will cover the drug that requires step therapy. Step therapy is built into the electronic system that checks your medication history. A drug with step therapy will be automatically approved if there is a record that you have already tried the preferred drug(s). If there is no record that you tried the preferred drug(s) in your medication history, your physician must submit relevant clinical information to the UPMC Health Plan Pharmacy Services Department before it may be covered.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a participating retail pharmacy, or by mail for maintenance and specialty drugs. Participating retail pharmacies include most national chains as well as many independent pharmacies. Call Member Services at 833-288-6901 or visit www.upmchealthplan.com/PSHB for assistance in locating a participating pharmacy near you.
- **We have a managed formulary.** The Your Choice formulary applies. If your provider believes a name brand product is necessary or there is no generic available, your provider may prescribe a name brand drug from a formulary list. Preferred brand-name drugs are also included on the formulary at a lower cost than non-preferred brand name drugs. To request a Pharmacy formulary book, call Member Services at 833-288-6901. You can also visit www.upmchealthplan.com/PSHB. UPMC Health Plan makes changes to its formulary each January 1 and July 1. You will be notified by a separate letter if the prescription drug you are taking is affected by a negative formulary change. To order a prescription drug brochure, call 833-288-6901

- **These are the dispensing limitations.** Covered prescription drugs obtained at a participating retail pharmacy will be dispensed for a 30-day supply for one copayment or a 90-day supply for three copayments. Controlled substance medications are limited to a 30-day supply. Specialty prescription drugs obtained through the Plan's specialty pharmacy will be dispensed for up to a 30-day supply. Prescriptions for maintenance drugs obtained through the Plan's mail order pharmacy will be dispensed up to a 90-day supply. The copay for mail order equals two times the 30 day retail copay for Preferred Generic Medications, Preferred Brand and Generic Medications and Non-Preferred Medication tiers. Medications will be dispensed based on FDA guidelines.
- **Specialty medications.** Specialty medications usually treat complex and rare conditions. These drugs are created because of advancements in drug development. Many specialty drugs require close management by a physician. Physicians need to monitor these drugs due to potential side effects and the need for frequent dosage adjustments. Most specialty medications must be obtained through our designated specialty pharmacy providers, Accredo or Chartwell.

If you will be away from home for an extended period of time, or if you will be traveling outside of the country, consider using mail-order so that you can receive a 90-day supply prior to traveling. If you need an emergency supply of medication, call Member Services at 833-288-6901.

- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a brand-name. If you receive a brand-name drug when a FDA approved generic drug is available, you have to pay the difference in cost between the brand-name drug and the generic. If your physician has specified "Dispense as Written" for a brand-name drug when a generic is available, your physician must submit information to UPMC Health Plan stating that the brand-name drug is medically necessary and the reasons why the generic equivalent was ineffective. If approved by UPMC Health Plan, you will pay the non-preferred brand-name copayment for your brand-name medication.
- **Why use generic drugs.** A generic drug is the chemical equivalent of a corresponding brand-name drug. Generic drugs are less expensive than brand-name drugs, so the copayment is lower. You can lower your out-of-pocket expense by using generic drugs, when available.
- **When you do have to file a claim.** You typically pay your copayment at the point of purchase. However, if there is a circumstance in which you pay the full cost out-of-pocket, you can be reimbursed by completing a prescription drug reimbursement form. You will be reimbursed 100% of the prescription cost less the applicable deductible and/or copayment as long as you used a participating pharmacy. Call Member Services at 833-288-6901 to obtain a prescription drug reimbursement form.

Benefit Description	You pay
Covered medications and supplies	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies limited to disposable needles and syringes for the administration of covered medications • Drugs for the treatment of infertility including IVF, Artificial Insemination and cryopreservation - We cover injectable fertility drugs under the prescription drug and medical benefits and oral fertility drugs under the prescription • Drugs for sexual dysfunction • Tobacco cessation drugs, including over-the-counter (OTC) drugs approved by the FDA to treat tobacco dependence (See page 48)	**Retail (up to a 30-day supply)** $0 copayment for select generic medications $20 copayment for preferred generic drugs $50 copayment for preferred brand medications and generic medications $100 copayment for non-preferred generic or brand-name drugs 90-day maximum retail supply available at certain retail outlets for three copayments **Specialty Prescription Drugs (up to a 30-day supply)** 50% coinsurance up to a maximum of $250 **Mail Order (up to a 90-day supply)** $0 copayment for select generic medications $40 copayment for preferred generic drugs

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
• Drugs to treat gender dysphoria for gender-affirming services are covered under your prescription benefit plan and include testosterone, estrogen, and Luteinizing Hormone Releasing Hormone (LHRH) agents. Some of these medications may require prior authorization prior to approval. • Medications prescribed to treat obesity	**Retail (up to a 30-day supply)** $0 copayment for select generic medications $20 copayment for preferred generic drugs $50 copayment for preferred brand medications and generic medications $100 copayment for non-preferred generic or brand-name drugs 90-day maximum retail supply available at certain retail outlets for three copayments **Specialty Prescription Drugs (up to a 30-day supply)** 50% coinsurance up to a maximum of $250 **Mail Order (up to a 90-day supply)** $0 copayment for select generic medications $40 copayment for preferred generic drugs $100 copayment for preferred brand medications and generic medications. $200 copayment for non-preferred brand-name drugs *Specialty prescription drugs are not covered through Mail Order* Notes: • If there is no generic equivalent available, you will still have to pay the brand name copayments • Deductible and Copayments are waived for tobacco cessation drugs
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy.	Generic and brand name drugs covered on the formulary are available at no copayment.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
• UPMC Health Plan offers the full range of contraceptive methods. At this time, the only products that are not readily available without cost share are multi-source brand drugs. In order to get a multi-source brand contraceptive covered at $0, your provider will need to complete and submit a Cost Sharing Exception request form. This form is included with the Preventive Services Resource Guide as part of your plan documents or may be downloaded from the Pharmacy Prior Authorization section of our website (upmchealthplan.com). Your provider can also directly submit an electronic version of the exception request through UPMC's PromptPA Portal. In order to be approved for a cost-sharing exception, your provider must attest that the prescribed medication is medically necessary and explain why it is a necessary form of contraception for you. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. • If you paid out-of-pocket for an OTC contraceptive product with a prescription from your provider and were not assessed $0 cost share, you can request a Pharmacy Direct Reimbursement Claim Form by calling our Health Care Concierge team at the phone number listed on the back of your member ID card or by logging into UPMC Health Plan member site. You must submit the completed form and your pharmacy label to UPMC Health Plan for review. Please note, a prescription is not required for reimbursement for Opill. Note: For additional Family Planning benefits see Section 5(a)	Generic and brand name drugs covered on the formulary are available at no copayment.
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	See *Tobacco Cessation Educational Classes and Programs in Section 5(a)*
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
• *Vitamins, nutrients, and food supplements not listed as a covered benefit even if a physician prescribes or administers them are not covered except medically necessary formulas that are equivalent to a prescription drug for the treatment of phenylketonuria (PKU) branched-chain ketonuria, galactosemia, and homocystinuria as administered under the direction of a physician or listed as a covered benefit* • *Nonprescription medications, unless specifically indicated elsewhere* • *Medications prescribed for foreign travel*	*All charges*
Preventive medications	**Standard Option**
Preventive Medications with USPSTF A and B recommendations are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy, with the exception of Opill. These may include some over the counter vitamins, nicotine replacement medications, and low dose aspirin. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations The pharmacy benefit plan includes coverage for some preventive medications at no cost share when certain criteria in accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA) are met. The following drugs are eligible for ACA coverage. Generic products are required when available. • Bowel preps for members age 45-75. Coverage is for generic products limited to 2 prescriptions per year. • Smoking cessation products for all members age 18 and older. Coverage is limited to 24 weeks of therapy per year. • Aspirin (81 mg) for members of child- bearing potential • Contraceptives coverage includes a full range of generic and single-source brand Food and Drug Administration (FDA) approved classes. • Breast cancer medications (generic tamoxifen, raloxifene, aromatase inhibitors) used for prevention in members age 35 and older who are at increased risk for breast cancer and at a low risk for adverse medication effects. • Statins for members age 40-75. Statin must be low to moderate intensity and the member must have no history of cardiovascular disease, with at least one cardiovascular risk factor.	Nothing (No deductible)

Preventive medications - continued on next page

Benefit Description	You pay
Preventive medications (cont.)	**Standard Option**
• Pre-Exposure Prophylaxis (PrEP) for members who are not infected with HIV who are at high risk for HIV infection. • Folic acid supplements (400 and 800 mcg) for members of childbearing age. • Fluoride tablets, solution (not toothpaste, rinses) for children age 6 months through 16 years. Preventive Medications with USPSTF A and B recommendations are covered without cost share when prescribed by a healthcare professional and filled by a participating pharmacy, with the exception of Opill. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing (No deductible)
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a participating pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance athttps://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/.	Nothing (No deductible)
Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.	

Important phone numbers:

For questions about your pharmacy benefits and participating retail locations, call UPMC Health Plan at: **833-288-6901.**

For specialty drug orders, call Accredo at **888-773-7376 (TTY: 711)** or Chartwell at **800-366-6020 (TTY:711).**

For mail-order maintenance drug orders, call Express Scripts at **877-787-6279 (TTY:711).**

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at (833)-288-6901.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network where members can fill prescriptions at any in-network pharmacy of their choice and can have low copays when filling at one of our preferred retail or mail-order pharmacies. Some preferred retail pharmacy locations include Giant, Giant Eagle, Rite Aid, Sam's Club, Walgreens, Walmart, and Weis. To find a preferred pharmacy, go to www.upmchealthplan.com/pshb
- You also have prescription drug benefits under your Standard HMO plan that may reduce your cost share or cover medications that are not included in the UPMC *for Life* drug formulary.

We cover drugs, medications, and supplies as described below and on the following pages.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- Starting Jan. 1, 2025, Medicare members with high prescription drug costs can get help with their payments through the Medicare Prescription Payment Plan. This new payment option allows you to spread your prescription drug costs across monthly payments throughout the year instead of paying them up front at the pharmacy. Contact 833-869-6924 or to go to our website to learn more about the program https://www.upmchealthplan.com/medicare/prescription-payment-plan
- There is no Medicare Part D calendar year deductible. This deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage.
- You need to present both your UPMC *for Life* and PSHB commercial member ID cards at the pharmacy to take advantage of your full prescription drug benefits.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at 844-761-0083.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our MAPD and receive PSHB Program Prescription Drug Coverage.

In order to enroll in the UPMC *for Life* PSHB Retirees HMO Custom plan, you must be enrolled in the UPMC Health Plan Standard Option PSHB plan. To enroll in UPMC Health Plan's Standard Option HMO, please use the PSHB System.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance 844-761-0083.

Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope.

Please note that this UPMC *for Life* PDP identification card is separate from your PSHB UPMC Health Plan identification card. You will need to present both cards when receiving prescription drugs.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You may fill prescriptions at any network pharmacy. For assistance locating a PDP EGWP network pharmacy, visit our website at www.upmchealthplan.com/pshb, or call us at 833-869-6924 TTY
- **We have a managed formulary.** Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. You may view our formulary on our website at www.upmchealthplan.com/pshb or call us at 833-869-6924
- **You also have prescription drug benefits under your commercial plan that may reduce your cost share or cover medications that are not included in the UPMC *For Life* drug formulary**. Your out-of-pocket drug costs can also change as you move through your prescription drug coverage stages, the pharmacy you use and the tier of your drug. Refer to Section 5(f) for information on your commercial plan prescription drug benefits.
- **These are the dispensing limitations.** For certain prescription drugs, our plan limits the amount of the drug that we will cover. Prescription drugs with quantity limits are listed in your plan's comprehensive formulary (list of covered drugs). To see if any of your prescription drugs have a quantity limit, check your plan's comprehensive formulary for Requirements/ Limits.
- **We may require Utilization Management strategies.** For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan. For certain drugs, you are required to try another drug before we will cover the drug for you. This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called step therapy.
- **You may request a Formulary Exception.** The forms linked below can be used to request prior authorization, coverage determination and redetermination, or an exception for prescription drugs.

1. Select and open the appropriate form:
   - **Use this link to submit a request for a drug not currently covered under your plan:** UPMC for Life Prescription Drug Coverage Determination/Exception Request Form (PDF)
   - **Use this link to submit a request or redetermination of a drug coverage request denied within the past 60 days:** UPMC for Life Medicare Prescription Drug Coverage Redetermination Request Form (PDF)

3. Fill out the form and save it to your computer's hard drive.

4. Submit your request form using our online submission tool

- **A generic equivalent will be dispensed if it is available** unless your physician specifically requires a brand name drug. If you receive a brand name drug when an FDA approved generic drug is available, and your physician has not specified Dispense as Written for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- **Why use generic drugs?** A generic drug is the chemical equivalent of a corresponding brand-name drug. Generic drugs arelessexpensivethanbrand-namedrugs,sothecostislower.You can lower your out-of-pocket expense by using generic drugs, when available.
- **When you do have to file a claim.** If you are a UPMC *for Life* member, and recently paid cash for a covered medication, complete the form below to apply for reimbursement for Part D prescription drugs. Please follow these steps to submit a prescription drug claim reimbursement form to us.

1. Open this form:
   - UPMC for Life Prescription Drug Claim Reimbursement Form
   - UPMC for Life Complete Care (HMO D-SNP) Prescription Drug Claim Reimbursement Form

3. Print the form. Follow the instructions on the form and fill out as completely as possible.

4. For your claim to be processed, you will need to get your prescription receipts or patient history printout from your pharmacy.

5. Mail the form and your receipts to us at the address below. Please do not staple or attach your receipts to another piece of paper.

UPMC *for Life*/UPMC *for Life* Complete Care Pharmacy Services Department

U.S. Steel Tower, 12th Floor

600 Grant Street

Pittsburgh, PA 15219

- **If we deny your claim and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). Medicare PDP EGWP Disputed Claims Process. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

UPMC *for Life* members may ask for a coverage determination or redetermination (appeal) for a Part D prescription drug. Members can request a coverage determination/exception by completing and signing the form below. It can be mailed or faxed to UPMC Health Plan. You may also call our Member Services Department to file an appeal, get information about this process, check on the status of a request, or obtain an aggregate number of appeals, grievances, and exceptions for our plan. Please contact us by:

- **Phone**: UPMC *for Life* HMO/PPO members can call our Member Services Department at 833-869-6924 **(TTY: 711)**. From Oct. 1 – March 31, we are available seven days a week from 8 a.m. to 8 p.m. From April 1 – Sept. 30, we are available Monday through Friday from 8 a.m. to 8 p.m.
- **Fax**: 412-454-7722
- **Mail**: UPMC Health Plan Pharmacy Department
  U.S. Steel Tower, 12th Floor
  600 Grant Street
  Pittsburgh, PA 15219

UPMC for Life Prescription Drug Coverage Determination/Exception Request Form

Redetermination (Appeal) Request

Members can request a redetermination (appeal) by completing and signing one of the forms below. It can be mailed or faxed to UPMC Health Plan. You may also call our Member Services Department to file an appeal, get information about this process, check on the status of a request, or obtain an aggregate number of appeals, grievances, and exceptions for our plan. Please contact us by:

- **Phone:** UPMC *for Life* HMO/PPO members can call our Member Services Department at 833-869-6924 **(TTY: 711).** From Oct. 1 – March 31, we are available seven days a week from 8 a.m. to 8 p.m. From April 1 – Sept. 30, we are available Monday through Friday from 8 a.m. to 8 p.m.
- **Fax:** 412-454-7920
- **Mail:** UPMC Health Plan
  ATTN: Appeals and Grievances
  PO BOX 2939
  Pittsburgh, PA 15230-2939

UPMC for Life Medicare Prescription Drug Coverage Redetermination Request Form

PDP EGWP Catastrophic Maximum

Your total yearly drug costs will be capped at $2,000. Once the costs paid by you and your plan reach $2,000, you will move into the catastrophic coverage stage. In this stage, you won't pay anything for your covered drugs. You will stay in this stage through the end of the year.

Benefit Description	You pay
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for the treatment of infertility including IVF, Artificial Insemination and cryopreservation - We cover injectable fertility drugs under the prescription drug and medical benefits and oral fertility drugs under the prescription • Drugs for sexual dysfunction • Tobacco cessation drugs, including over-the-counter (OTC) drugs approved by the FDA to treat tobacco dependence (See page 48) • Drugs to treat gender dysphoria for gender-affirming services are covered under your prescription benefit plan and include testosterone, estrogen, and Luteinizing Hormone Releasing Hormone (LHRH) agents. Some of these medications may require prior authorization prior to approval. • Medications prescribed to treat obesity	**Retail (up to a 30-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $15 at a standard pharmacy Generic medications: $10 copayment at a preferred pharmacy; $20 at a standard pharmacy Preferred brand medications: $47 copayment at both preferred and standard pharmacies Non-Preferred brand medications: $100 copayment at both preferred and standard pharmacies Covered Insulins: $35 copayment at both preferred and standard pharmacies **Specialty Prescription Drugs (up to a 30-day supply)** 33% coinsurance **Retail (up to a 100-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $30 at a standard pharmacy Generic medications: $20 copayment at a preferred pharmacy; $40 at a standard pharmacy Preferred brand medications: $129.50 copayment at a preferred pharmacy; $141 at a standard pharmacy Non-preferred medications: $300 copayment at both preferred and standard pharmacies

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
• Medical Foods	**Retail (up to a 30-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $15 at a standard pharmacy Generic medications: $10 copayment at a preferred pharmacy; $20 at a standard pharmacy Preferred brand medications: $47 copayment at both preferred and standard pharmacies Non-Preferred brand medications: $100 copayment at both preferred and standard pharmacies Covered Insulins: $35 copayment at both preferred and standard pharmacies **Specialty Prescription Drugs (up to a 30-day supply)** 33% coinsurance **Retail (up to a 100-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $30 at a standard pharmacy Generic medications: $20 copayment at a preferred pharmacy; $40 at a standard pharmacy Preferred brand medications: $129.50 copayment at a preferred pharmacy; $141 at a standard pharmacy Non-preferred medications: $300 copayment at both preferred and standard pharmacies Covered insulins: $96.25 copayment at a preferred pharmacy, $105 at a standard pharmacy **Mail Order (up to a 100-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $30 at a standard pharmacy Generic medications: $20 copayment at a preferred pharmacy; $40 at a standard pharmacy Preferred brand medications: $117.50 copayment at a preferred pharmacy; $141 at a standard pharmacy Non-preferred medications: $300 copayment at both preferred and standard pharmacies Covered insulins: $87.50 copayment at a preferred pharmacy, $105 at a standard pharmacy
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines.	Nothing for generic and brand name drugs and devices

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • UPMC Health Plan offers the full range of contraceptive methods. At this time, the only products that are not readily available without cost share are multi-source brand drugs. In order to get a multi-source brand contraceptive covered at $0, your provider will need to complete and submit a Cost Sharing Exception request form. This form is included with the Preventive Services Resource Guide as part of your plan documents or may be downloaded from the Pharmacy Prior Authorization section of our website (upmchealthplan.com). Your provider can also directly submit an electronic version of the exception request through UPMC's PromptPA Portal. In order to be approved for a cost-sharing exception, your provider must attest that the prescribed medication is medically necessary and explain why it is a necessary form of contraception for you. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. • If you paid out-of-pocket for an OTC contraceptive product with a prescription from your provider and were not assessed $0 cost share, you can request a Pharmacy Direct Reimbursement Claim Form by calling our Health Care Concierge team at the phone number listed on the back of your member ID card or by logging into UPMC Health Plan member site. You must submit the completed form and your pharmacy label to UPMC Health Plan for review. Please note, a prescription is not required for reimbursement for Opill. Note: For additional Family Planning benefits see Section 5(a)	Nothing for generic and brand name drugs and devices

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	All charges
Preventive medications	**Standard Option**
Preventive Medications with USPSTF A and B recommendations are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy, with the exception of Opill. These may include some over the counter vitamins, nicotine replacement medications, and low dose aspirin. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations The pharmacy benefit plan includes coverage for some preventive medications at no cost share when certain criteria in accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA) are met. The following drugs are eligible for ACA coverage. Generic products are required when available. • Bowel preps for members age 45-75. Coverage is for generic products limited to 2 prescriptions per year. • Smoking cessation products for all members age 18 and older. Coverage is limited to 24 weeks of therapy per year. • Aspirin (81 mg) for members of child- bearing potential • Contraceptives coverage includes a full range of generic and single-source brand Food and Drug Administration (FDA) approved classes. • Breast cancer medications (generic tamoxifen, raloxifene, aromatase inhibitors) used for prevention in members age 35 and older who are at increased risk for breast cancer and at a low risk for adverse medication effects. • Statins for members age 40-75. Statin must be low to moderate intensity and the member must have no history of cardiovascular disease, with at least one cardiovascular risk factor.	Nothing (No deductible)

Preventive medications - continued on next page

Benefit Description	You pay
Preventive medications (cont.)	**Standard Option**
• Pre-Exposure Prophylaxis (PrEP) for members who are not infected with HIV who are at high risk for HIV infection. • Folic acid supplements (400 and 800 mcg) for members of childbearing age. • Fluoride tablets, solution (not toothpaste, rinses) for children age 6 months through 16 years.	Nothing (No deductible)
• Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing (No deductible)
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a participating pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/ Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.	Nothing (No deductible)

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is $850 Self Only or $1,700 Self Plus One or Self and Family under the Standard Your actual deductible may be reduced by your participation in activities that fund your reward dollars.
- You are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. Under Standard Option, after your share of deductibles, copayments and coinsurance total $6,000 for Self Only, or $12,000 for Self Plus One or Self and Family in any calendar year, benefits for covered services increase to 100% for the remainder of the calendar year. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum, such as expenses in excess of the Plan's benefit maximum, amounts in excess of the Plan allowance, or if you use non-participating providers.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Accidental injury benefit	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	20% of the Plan allowance
Dental benefits	**Standard Option**
We have no other dental benefits	

Section 5(h). Wellness and Other Special Features

Healthcare Concierge Team	You and your family members can call Member Services with questions or concerns. Our Healthcare Concierge team delivers fast, personal service, and strives to answer your question on the first call. To speak with a Healthcare Concierge, call 833-288-6901. Our Healthcare Concierge team is available Monday through Friday from 8 a.m. to 6 p.m. TTY/TDD users should call 711.
Reward Dollars	You and your covered spouse, if applicable, can earn reward dollars by completing healthy activities throughout the year. These activities have been specially designed by our team of doctors, nurses, nutritionists, exercise physiologists, and behavioral health experts. They will alert you to potential health issues and provide tools to help you address the issues. Activities include: • *My*Health Questionnaire: The confidential health risk assessment, is a 10–12-minute online survey you take once a year. The results can help you understand your health status and suggest ways to make improvements. You can earn 50 points by completing the well-being assessment. • Biometric Screening: This health screening measures your total cholesterol level and glucose Your doctor will also check your blood pressure, height, weight, and body mass index (BMI). It is a simple assessment that can be done at your doctor's office, a lab, or some convenience care clinics. Biometric screenings are recommended once every three years. You will earn 50 points for a biometric screening. • Condition or Lifestyle Management Coaching: A health coach for condition management will help you manage a chronic condition so you can live your healthiest life possible. Health coaches can help with heart disease, diabetes, asthma, COPD, depression, and much more. Lifestyle programs include smoking cessation, stress management, physician activity, weight management, and nutrition. You can earn 25 points for per coaching session • You will also receive points for completing activities uniquely customized just for you. You will find a full list of eligible activities by logging in to UPMC Health Plan member site, the website that powers *Take a Healthy Step*, UPMC Health Plan's member website. The reward dollars you earn will be placed on a debit card that you can use toward your deductible, copayments and coinsurance. In one plan year, you can earn up to $250 for Self Only coverage or $500 for Self Plus One or Self and Family coverage. Any unused reward dollars — at a value up to two times your annual deductible —automatically roll over to the next year. To learn more about *Take a Healthy Step*, visit www.upmchealthplan.com/PSHB or call a Healthcare Concierge at 833-288-6901. *Take a Healthy Step* is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary well-being assessment or "health questionnaire" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the health questionnaire or other medical examinations.

	However, employees who choose to participate in the wellness program can receive an incentive of up to $250 for Self Only and $500 for Self plus One or Self and Family for completing healthy activities that are customized for each member. Although you are not required to complete the health questionnaire or participate in the health screening (routine blood work), only employees who do so will receive the selected reward. Additional incentives as noted above may be available for employees who participate in certain health-related customized activities If you are unable to participate in any of the health- related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting UPMC Health Plan at 833-288-6901. The information from your health questionnaire will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as recommended healthy activities. You also are encouraged to share your results or concerns with your own doctor. Members receiving the COVID-19 vaccination are eligible to receive 50 points. The annual maximum reward dollars per year remains $250 for Self Only and $500 Self plus One and Self and Family.
***My*Health Health and Wellness**	You and your family members have access to *My*Health, A nationally acclaimed health and wellness program. *My*Health guides and motivates you to live your healthiest life possible through online programs, tools, and over-the-phone advice. *My*Health was developed by UPMC, one of the nation's top hospital systems. This gives us in-house expertise in condition management and lifestyle behavior change that no other health plan can match. *My*Health includes: • UPMC Health Plan member site • *My*Health Questionnaire • *My*Health Community • Health Coaching • *My*Health Advice Line For detailed descriptions, see below.
UPMC Health Plan member site	UPMC Health Plan member site is where you can go every day for practical tips, tools, and strategies for better health. You can also find a doctor, view your medical history, and get information on your health plan benefits. The site keeps all your health information, all in one place. At UPMC Health Plan member site, you can: *Earn and track your reward dollars*, so you know exactly how much you have in your account to spend on healthcare. (Remember, with *Take a Healthy Step*, you earn points when you do healthy activities throughout the year.) The points you earn will help you complete levels. Each level you complete will earn your reward dollars. *Enjoy discounts and savings*: Health and Wellness Discounts focuses on great discounts at health- and wellness- related retailers such as gyms, spas, salons, health food stores, sporting goods stores, and more. *Manage your healthcare information*: Access your doctor’s contact information, plan benefits, research prescription and treatment options, savings information, and view your spending summary and claims. You can even order a new member ID card if you lose it. You can also chat online with a Healthcare Concierge or Health Coach, read blogs from health experts, get advice on medical screenings and healthy activities, and set personal goals for managing your health.

	To get the most out of your benefits, log in to UPMC Health Plan member site at www.upmchealthplan.com/PSHB. To create an account click on Sign Up and use the number on your member ID card to register.
***My*Health Questionnaire**	Once you log in to UPMC Health Plan member site, complete your *My*Health Questionnaire. Not only will you earn reward dollars in your Health Incentive Account, but your answers generate a simple summary of your current health status and customize UPMC Health Plan member site with activities that benefit you the most.
Health and Wellness Discounts	You and your family can receive discounts through Health and Wellness Discounts. Visit UPMC Health Plan member site and log in or register to find great discounts near you, including Active&Fit. The Active&Fit Direct program allows you to choose from 16,000+ participating fitness centers nationwide for $28 a month (plus a $28 enrollment fee and applicable taxes). Learn more: https://www.activeandfitnow.com/. The Active&Fit Direct program is offered through American Specialty Health Fitness, Inc., one of the nation's leading fitness networks serving millions of members. Plus, you'll have access to your health information and tools that can help you get or stay healthy! Log in to UPMC Health Plan member site, click on **Better Health and Wellness** in the left-hand navigation, and then click on **Health and Wellness Discounts** to find great discounts near you.
Health Coaching	A UPMC Health Plan health coach can get you started on a healthy living plan today. Enroll in one of our proven lifestyle or chronic condition coaching programs and earn points toward reward dollars. A health coach can help you manage a variety of conditions, including asthma, diabetes, hypertension and low back pain. They can also help you lose weight, quit smoking, eat healthier, reduce stress, and make other lifestyle changes to improve your health. You can also choose to do a one-time visit by phone or connect via live chat. Participating in these programs also give you the opportunity to points toward your reward dollars. To get started, call a health coach at 800-807-0751.
***My*Health 24/7 Nurse Line**	For immediate access to free healthcare advice 24 hours a day, seven days a week call the *My*Health 24/7 Nurse Line at 866-918-1591. From general health information to help with a specific sickness or injury, an experienced registered nurse will provide you with prompt and efficient service.
UPMC AnywhereCare	When you're not feeling well, you can have a face-to-face conversation with a UPMC provider over live video straight from your smart phone, tablet or computer. See a UPMC provider in 30 minutes or less to discuss your symptoms and get a treatment plan. And if you need a prescription, the provider can call it in to your local pharmacy. Download the mobile app from the iTunes App Store or Google Play by searching for "AnywhereCare" or you can register at https://anywherecare.upmc.com/ from your computer.
UPMC Health Plan Mobile App	When you download this free app to your smartphone, you can: • Search for participating providers. • Chat with a Healthcare Concierge. • Access your member ID card. • Contact your providers. • Check the status of your claims. • Take the *My*Health Questionnaire.

Tobacco Cessation	UPMC Health Plan offers the *My*Health Ready to Quit™ health coaching program. The program will help you to quit using tobacco with a personal action plan that includes behavior modification strategies and tools based on the latest research. You will also earn points by participating in the program.
RxWell	Get prescription-strength health help with RxWell. Whether you're feeling anxious, stressed, or sad, RxWell has a path for you. This app is designed to help you become emotionally and physically healthy by combining health coaching support and proven techniques. You can also earn points by completing an RxWell program. • **Manage anxiety, stress, or** Choose from three effective programs based on your needs. • **Relax using helpful practices**. Learn calming techniques that can help you feel more centered in 10 minutes or less. • **Get support from a real health coach.** Receive a personalized plan, set up goals, and message your health coach to get help along the way. • **Track your progress.** Identify behavioral, mood, and emotional patterns over time.
Assist America	UPMC Health Plan offers a travel assistance plan through Assist America, a global emergency assistance program for members who are traveling more than 100 miles from home. Assist America can help locate qualified doctors and hospitals, replace forgotten prescriptions, provide emergency medical evacuation and arrange for transportation so family members can be with injured relatives. Support is accessible 24 hours a day, 365 days a year. For a complete list of Assist America services visit www.assistamerica.com. To receive services, contact Assist America at 800-872-1414 in the USA, or at 1-609-986-1234 outside of the USA. The Assist America reference number for UPMC Health Plan members is 01-AA-UP-156243. You may also download the Health Plan Mobile App for free to your smartphone.
Preventive Health	UPMC Health Plan offers Myhealthfinder tool @ https://www.upmchealthplan.com/members/learn/benefits-and-services/preventive-health.aspx. This tool will provide personalized recommendations to help you take charge of your health.
Services for Members who have a Hearing Impairment	UPMC Health Plan communicates by phone with our members who have a hearing impairment through TTY. If you have a hearing impairment, call our TTY number at 711.
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed- upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).

Medicare Part B Reimbursement Program	Standard Option Members enrolled in Medicare Part A and B are eligible for reimbursement of Medicare Part B premiums up to $800 per calendar year. See page 162. This applies to annuitants who chose to enroll in UPMC *for Life* PSHB Retirees Medicare Advantage plan as well.
Maternity Program	Baby Steps is a maternity program available to all UPMC Health Plan members. This program connects you with maternity health coaches who provide support, education, and resources. Some examples of what you can talk about include prenatal vitamins, a birthing plan, breastfeeding, and signs of postpartum depression. We want to help increase your chances of having a healthy pregnancy, baby, and postpartum recovery. This program is provided to you at no-cost as part of your benefits. How frequently you communicate with your coach is up to you, with both phone and in-person options available. Contact us to learn more about the Baby Steps program and get in touch with a health coach. Coaches are available Monday through Friday from 8 a.m. to 6 p.m. • **Phone:** 1-866-778-6073 (TTY:711) • **Chat via UPMC Health Plan member site:** Sign in to UPMC Health Plan member site | Register for UPMC Health Plan member site • **Email:** maternitycoaches@upmc.edu (Coaches will schedule a phone call based on your availability.) • UPMC Health Plan Maternity Program Any member who is identified as having active or a history of chronic hypertension or PIH is stratified as high risk and targeted for active Case Management outreach for program participation. If one of the Case Managers is working with a member that develops hypertension during pregnancy, they can help facilitate receipt of a blood pressure cuff and work with the member and her provider to ensure the member is comfortable with self- monitoring BP at home and notifying their provider with signs/ symptoms of worsening symptoms. Member can receive a blood pressure cuff from a DME provider with a physician's order. • Provider Directory | Find Care | UPMC Health Plan

High Deductible Health Plan Benefits

Section 5. High Deductible Health Plan Benefits Overview

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

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 833-288-6901 or on our website at www.upmchealthplan.com/PSHB.

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

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 99. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

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

- **Traditional medical coverage** — After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 85% for in-network and 60% for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other healthcare professionals
  - Surgical and anesthesia services provided by physicians and other healthcare professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance use disorder benefits
  - Prescription drug benefits
  - Dental benefits

- **Reward Dollars** — If you earn 250 points you will receive a $75 deposit into your HSA account debit card. See page 145 for more details on earning reward dollars. If you are not eligible for an HSA and earn 250 points you will receive $75 on a debit card that will be linked to your HRA to use toward deductible, copayments, and coinsurance that are incurred by anyone enrolled in your plan.

- **Savings** — Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see 88 for more details).

- **Health Savings Accounts (HSAs)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another High Deductible Health Plan. In 2025, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $75 per month for a Self Only enrollment or $150 per month for a Self Plus One enrollment or $150 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $4,300 for an individual and $8,550 for a family. See maximum contribution information on page 89. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

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

HSA features include:

- Your HSA is administered by UPMC Benefit Management Services
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Healthcare Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA healthcare flexible spending account, this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

- **Health Reimbursement Arrangements (HRA)**

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

In 2025, we will give you an HRA credit of $900 per year for a Self Only enrollment or $1,800 per month for a Self Plus One enrollment or $1,800 per year for a Self and Family enrollment. You can use the funds in your HRA debit card to help pay your health plan deductible, copayments and coinsurance incurred by anyone enrolled in your plan. Any reward dollars you earn will also be added to this debit card. If you disenroll, the funds on the card will be forfeited.

HRA features include:

- For our HDHP option, the HRA is administered by UPMC Health Plan
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year to year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in a Healthcare Flexible Spending Account (HCFSA). However, you must meet HCFSA eligibility requirements.

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

When you use participating providers, your annual limit for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $6,000 for Self Only or $12,000 for Self Plus One or Self and Family enrollment. When you use out-of-network providers, your annual limit for out-of-pocket expenses (deductibles and coinsurance) for covered services is limited to $8,000 for Self Only or $16,000 for Self Plus One or Self and Family enrollment. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Also, the family out-of-pocket maximum must be met by one or more members of the family before benefits are payable at 100%. Refer to Section 4, *Your catastrophic protection out-of-pocket maximum,* and HDHP Section 5, *Traditional medical coverage subject to the deductible,* for more details. If you are enrolled in our PDP EGWP, see page 137 for additional information about your out-of-pocket maximum.

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

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

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with WEX, Inc., this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	UPMC Health Plan is the HRA fiduciary for this Plan.
Fees	Set-up and monthly service fee is paid by the HDHP	None.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage, including an FSA (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits in the last three months • Complete and return all banking paperwork Eligibility for contributions is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.

	In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	
• **Self Only enrollment**	For 2025, a monthly premium pass through of $75 will be made by the HDHP directly into your HSA each month.	For 2025, your HRA annual credit is $900 (prorated for mid-year enrollment).
• **Self Plus One or Self and Family enrollment**	For 2025, a monthly premium pass through of $150 will be made by the HDHP directly into your HSA each month.	For 2025, your HRA annual credit is $1,800 (prorated for mid-year enrollment). This will be placed on your HRA debit card.
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $4,300 for an individual and $8,550 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.	The full HRA credit on the debit card will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Additional contribution discussed on page 92.	
• **Self Only enrollment**	You may make an annual maximum contribution of $3,250.	You cannot contribute to the HRA.
• **Self Plus One or Self and Family enrollment**	You may make an annual maximum contribution of $6,500.	You cannot contribute to the HRA.
Access funds	You can access your HSA by debit card.	You can access your HRA by debit card.
Distributions/withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 and 969 for information on eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses

Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	PSHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 88 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.
Reward Dollars	If you earn 250 points you will receive a $75 contribution to your HSA debit card. If you have a covered spouse and they earn 250 points you will earn an additional $75 contribution to your HSA debit card.	If you are not eligible for HSA and have HRA, you will receive a $75 contribution to your HRA debit card. If you have a covered spouse and they earn 250 points you will earn an additional $75 contribution to your HRA debit card.

If you have an HSA

Contributions

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

	If you newly enroll in an HDHP during Open Season your effective date is January 1st, or if you enroll at any other time and have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.
Over age 55 additional contributions	If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable additional contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS website at www.irs.gov or request a copy of IRS Publication 969 by calling 1-800-829-3676. www.ustreas.gov/offices/public-affairs/hsa/
If you die	If you have not named beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.
Qualified expenses	You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services. When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare. For detailed information of IRS-allowable expenses, request a copy of IRS Publication 502 and 969 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.
Non-qualified expenses	You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
Tracking your HSA balance	You will receive a periodic statement that shows the "premium pass through", withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA. Balances can also be viewed through UPMC UPMC Health Plan member site and the UPMC Consumer Advantage mobile app.
Minimum reimbursements from your HSA	You can request reimbursement in any amount.

If you have an HRA

Why an HRA is established	If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.
How an HRA differs	Please review the chart on page 88 which details the differences between an HRA and an HSA. The major differences are: • you cannot make contributions to an HRA • funds are forfeited if you leave the HDHP • an HRA does not earn interest

- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. PSHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Preventive care, adult	**HDHP Option**
Routine physical every 12 months by your PCP. **The following preventive services are covered at the time interval recommended at each of the links below:** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines	In-Network: Nothing Out-of-Network Colonoscopy screening: *All charges* Other Out-of-Network services: 40%
• Routine mammogram	In-Network: Nothing Out-of-Network: 40%
Tobacco cessation counseling	In-Network: Nothing Out-of-Network: 40%
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at Vaccines & Immunizations | CDC	In-Network: Nothing Out-of-Network routine physicals: *All charges* Other Out-of-Network services: 40%
Routine physicals which include: • One exam every 24 months up to age 65 • One exam every 12 months age 65 and older	In-Network: Nothing Out-of-Network routine physicals: *All charges* Other Out-of-Network services: 40%

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**HDHP Option**
Routine exams limited to: • One routine OB/GYN exam every 12 months, including 1 Pap smear and related services • One routine hearing exam every 24 months • One routine eye exam every 12 months Note: Any procedure, injection, diagnostic services, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance and deductible.	In-Network: Nothing Out-of-Network routine physicals: *All charges* Other Out-of-Network services: 40%
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy - Examination, referral, and Counseling: obesity prevention for midlife members (ages 40-60); annual counseling for those with normal or overweight body mass index (18-29.9 kg/m2) to main weight or limit weight gain, and screening/ referral for those with a BMI ≥ 30 for intense, multicomponent behavioral interventions. Counseling may include an individualized discussion of healthy eating and physical activity. - Obesity screening annually through 18 years • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. - Lifestyle health coaching: Through virtual (Anywhere Care), telephonic, and digital (RxWell mobile app) modalities, health coaches may address lifestyle health needs. - Support and care during pregnancy - maternity care management supporting members through pregnancy along with counseling for healthy weight gain in pregnancy - Condition management coaching: A medical-behavioral approach to help manage chronic conditions and improve your health.	In-Network: Nothing Out-of-Network: 40%

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**HDHP Option**
- Case management: Case management coaches are licensed nurses, social workers, and other clinical professionals who help you manage your health by coordinating with your providers and providing access to resources. See also Section 5(h) for Wellness and Special Features.	In-Network: Nothing Out-of-Network: 40%
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a) for cost share requirements for anti-obesity medications.	
• When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**HDHP Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to www.brightfutures.aap.org/Pages/default.aspx • Immunizations such as DtaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and For a complete list of immunizations go to the Centers for Disease Control (CDC) website at Vaccines & Immunizations | CDC • Note: You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at: www.uspreventiveservicestaskforce.org • To build your personalized list of preventive services go to https://health.gov/myhealthfinder. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-Network: Nothing Out-of-Network well child visits: *All charges* Other Out-of-Network services: 40%

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**HDHP Option**
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy - Examination, referral, and Counseling: obesity prevention for midlife members (ages 40-60); annual counseling for those with normal or overweight body mass index (18-29.9 kg/m2) to main weight or limit weight gain, and screening/ referral for those with a BMI ≥ 30 for intense, multicomponent behavioral interventions. Counseling may include an individualized discussion of healthy eating and physical activity. - Obesity screening annually through 18 years • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. - Lifestyle health coaching: Through virtual (Anywhere Care), telephonic, and digital (RxWell mobile app) modalities, health coaches may address lifestyle health needs. - Support and care during pregnancy - maternity care management supporting members through pregnancy along with counseling for healthy weight gain in pregnancy - Condition management coaching: A medical-behavioral approach to help manage chronic conditions and improve your health. - Case management: Case management coaches are licensed nurses, social workers, and other clinical professionals who help you manage your health by coordinating with your providers and providing access to resources. See also Section 5(h) for Wellness and Special Features.	In-network: Nothing Out-of-network: 40%
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a) for cost share requirements for anti-obesity medications.	
• When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**HDHP Option**
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.* • *Well-child visits for routine examinations by an out-of-network provider*	*All charges*

Section 5. Traditional Medical Coverage Subject to the Deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 94) and is not subject to the calendar year deductible.
- The deductible is $2,000 for Self Only enrollment or $4,000 Self Plus One or Self and Family enrollment. The family deductible can be satisfied by one or more members of the The deductible applies to almost all benefits under the Traditional medical coverage.
- You must pay your annual deductible before your Traditional medical coverage
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. After your coinsurance, prescription copayments and deductibles total $6,000 for Self Only enrollment or $12,000 for Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. After your coinsurance and deductibles total $8,000 for Self Only enrollment or $16,000 for Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from out-of-network providers. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, and amounts in excess of the Plan allowance). Note that the family out-of-pocket maximum must be met by one or more members of the family before benefits will be paid at 100%. See page 137 if you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.

Benefit Description	You Pay
Deductible before Traditional medical coverage begins	**HDHP**
The deductible applies to almost all benefits in this Section. In the You pay column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible. You are permitted to use the HSA or HRA debit card to cover the deductible.	100% of allowable charges until you meet the deductible of $2,000 for Self Only enrollment or $4,000 for Self Plus One or Self and Family enrollment In-network: After you meet the deductible, you pay only the coinsurance or pharmacy copayment for covered services. You may choose to pay the coinsurance or pharmacy copayment from your HSA or HRA debit card. If you have earned 250 points then $75 will be deposited into your HSA debit card. If you have a covered spouse and they earn 250 points you will receive an additional $75 deposit into your HSA debit card. If you are not eligible for HSA and have an HRA and earned 250 points $75 will be deposited onto your HRA debit card.

Deductible before Traditional medical coverage begins - continued on next page

Benefit Description	You Pay
Deductible before Traditional medical coverage begins (cont.)	**HDHP**
	Out-of-network: After you meet the deductible, you pay pharmacy copayments or coinsurance on our Plan allowance and any difference between our allowance and the billed amount., you may choose to pay the coinsurance or pharmacy copayment from your HSA. If you have earned 250 points then $75 will be deposited into your HSA debit card. If you have a covered spouse and they earn 250 points an additional $75 will be deposited into your HSA debit card. If you are not eligible for HSA and have an HRA and earned 250 points you will earn $75 on a HRA debit card to use toward out-of-pocket costs. If you have a covered spouse and they earn 250 points an additional $75 will be added to the HRA debit card.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay only the coinsurance or pharmacy copayment for covered services. You may choose to pay the coinsurance or pharmacy copayment from your HSA or HRA debit card. If you have earned 250 points then $75 will be deposited into your HSA debit card. If you have a covered spouse and they earn 250 points you will receive an additional $75 deposit into your HSA debit card. If you are not eligible for HSA and have an HRA and earned 250 points $75 will be deposited onto your HRA debit card. Out-of-network: After you meet the deductible, you pay pharmacy copayments or coinsurance on our Plan allowance and any difference between our allowance and the billed amount., you may choose to pay the coinsurance or pharmacy copayment from your HSA. If you have earned 250 points then $75 will be deposited into your HSA debit card. If you have a covered spouse and they earn 250 points an additional $75 will be deposited into your HSA debit card. If you are not eligible for HSA and have an HRA and earned 250 points you will earn $75 on a HRA debit card to use toward out-of-pocket costs. If you have a covered spouse and they earn 250 points an additional $75 will be added to the HRA debit card.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- A facility charge applies to services that appear in this section if the services are performed in an ambulatory surgical center, outpatient department of a hospital, or an outpatient clinic owned by a hospital.
- The deductible is $2,000 for a Self Only enrollment only or $4,000 for a Self Plus One or Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible must be satisfied by one or more family members.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- The deductible applies to all benefits in this section unless we indicate
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You Pay
Diagnostic and treatment services	**HDHP Option**
Professional services of physicians • In physician's office • In a convenience care clinic • During a hospital stay • In a skilled nursing facility. Limited to 100 days per calendar year combined with Extended care facility admissions • Office medical consultations • Second surgical opinion • Advance care planning	In-Network: 15% Out-of-Network: 40%
Telehealth Services	**HDHP Option**
• Physician services for a Virtual Visit • Professional interpretation of diagnostic testing results	In-Network: 15% Out-of-Network: 40%

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests	**HDHP Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT (CAT) Scans/MRI • Ultrasound • Electrocardiogram and EEG	In-Network: 15% Out-of-Network: 40%
Maternity care	**HDHP Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Professional interpretation of diagnostic testing results • Screening and counseling for prenatal and postpartum depression	In-Network: 15% Out-of-Network: 40%
Breastfeeding and lactation support, supplies and counseling for each birth	In-Network: 15% Out-of-Network: 40%
Note: Here are some things to keep in mind: • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • You do not need to precertify your vaginal delivery; see page 103 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or a Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	In-Network: 15% Out-of-Network: 40%

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	**HDHP Option**
• Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits. Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	In-Network: 15% Out-of-Network: 40%
Baby Steps is a maternity program available to all UPMC Health Plan members. This program connects you with maternity health coaches who provide support, education, and resources. Some examples of what you can talk about include prenatal vitamins, a birthing plan, breastfeeding, and signs of postpartum depression. We want to help increase your chances of having a healthy pregnancy, baby, and postpartum recovery. This program is provided to you at no-cost as part of your benefits. How frequently you communicate with your coach is up to you, with both phone and in-person options available. Contact us to learn more about the Baby Steps program and get in touch with a health coach. Coaches are available Monday through Friday from 8 a.m. to 6 p.m. • **Phone:** 1-866-778-6073 (TTY:711) • **Chat via UPMC Health Plan member site:** Sign in to UPMC Health Plan member site | Register for UPMC Health Plan member site • **Email:** maternitycoaches@upmc.edu (Coaches will schedule a phone call based on your) • **UPMC Health Plan Maternity Program**	In-Network: 15% Out-of-Network: 40%

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	**HDHP Option**
Any member who is identified as having active or a history of chronic hypertension or PIH is stratified as high risk and targeted for active Case Management outreach for program participation. If one of the Case Managers is working with a member that develops hypertension during pregnancy, they can help facilitate receipt of a blood pressure cuff and work with the member and her provider to ensure the member is comfortable with self-monitoring BP at home and notifying their provider with signs/ symptoms of worsening symptoms. Member can receive a blood pressure cuff from a DME provider with a physician's order. • Provider Directory | Find Care | UPMC Health Plan	In-Network: 15% Out-of-Network: 40%
Family planning	**HDHP Option**
Contraceptive counseling as prescribed	In-Network: Nothing (No deductible) Out-of-Network: 40%
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f) or 5(f)(a). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	In-Network: Nothing (No deductible) Out-of-Network: 40%
Voluntary family planning services, limited to: • Voluntary male sterilization	In-Network: 15% coinsurance after deductible is met Out-of-Network: 40%
Not covered:	*All charges*

Family planning - continued on next page

Benefit Description	You Pay
Family planning (cont.)	**HDHP Option**
• *Reversal of voluntary surgical sterilization* • *Genetic testing counseling*	*All charges*
Infertility services	**HDHP Option**
Infertility is the documented inability of a person under the age of 35 years to conceive a child within a 12 month period or a person 35 years or older to conceive a child within a six month period: (a) of unprotected coitus (sexual intercourse); or (b) egg-sperm contact through artificial insemination. Infertility may also be established through evidence of medical history and diagnostic testing. **Medical Description** Refer to MP.017 – Infertility – Treatment policy. Note that treatment of the causes of infertility is not addressed in this policy. **Specific Indications for Diagnosis** • Member must fit the definition for infertility (as indicated in Section I0 Definitions) • Members must be pre-menopausal and reasonably expect fertility as a natural state; or if menopausal, should have experienced it at an early age **Diagnosis and treatment of Infertility** Depending on the member's unique medical situation, the following diagnostic tests to diagnose fertility in males and females may be considered medically necessary: • History & Physical • Sperm function tests • Hysterosalpingogram • Hysteroscopy • Sonohysterogram • Prediction of Ovarian Reserve Hormone Evaluation • Evaluation of folliculogenesis • Endometrial biopsy • Diagnostic laparoscopy • Follow-up Conference • Artificial insemination: - Intravaginal insemination (IVI) - Intrauterine insemination (IUI) - Intracervical insemination (ICI) • Artificial reproduction:	In-Network: 15% Out-of-Network: 40%

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	**HDHP Option**
- Assisted Reproductive Technologies (ART)- all clinical and laboratory treatments in which both human oocytes and sperm, or embryos, are manipulated outside of the body with the intent of establishing pregnancy. - In vitro fertilization, embryo transfer, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), services, IVF drugs and supplies related to covered ART procedures, cost of donor sperm and cost of donor egg. All included within the lifetime maximum of $25,000 per member. • Iatrogenic infertility (Fertility Preservation) - Coverage includes cryopreservation of embryos, eggs, sperm, and ovarian and testicular tissues in the case of medically necessary chemotherapy, radiation or pharmacological treatment with a likely side effect • Infertility prescription drugs - subject to cost sharing shown in Section 5(f) Prescription Drug Benefits in UPMC Health Plan 2025 Postal Brochure RI 73-933 and included in the Lifetime maximum benefit per member. • Lifetime maximum benefit per member is $25,000 and includes all of the above except artificial insemination which is exempt from the lifetime maximum of $25,000. Coverage of member's preserved specimen is only available while the member is enrolled in UPMC Health Member is responsible for the cost once the member's enrollment terminates or reaches the $25,000 maximum lifetime benefit. There are no annual cycle limits. **Limitations/Contraindications** Normal physiological causes of infertility such as menopause • Infertility resulting from voluntary sterilization • The following diagnostic tests are considered investigational: - Tests to assess/improve sperm movement, or computer-assisted sperm analysis (CASA) - Analysis of adenosine triphosphate (ATP) in ejaculation - Tubaloscopy - Anti-zona pellucida antibodies - Hyaluronan binding assay (HBA) - Sperm washing and swim-up when performed as part of insemination	In-Network: 15% Out-of-Network: 40%

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	**HDHP Option**
In order to assess medical necessity for infertility services, adequate information must be furnished by the treating physician. Necessary documentation includes, but is not limited to the following: • Member's age, clinical history, physical and functional status; • Documentation of infertility, testing if done, and treatment history • Documentation of any history of substance abuse, including smoking; • Social Service evaluation • Lab results: HIV antibody Diagnostic tests for infertility may be ordered by a participating provider. However, most anti-retroviral therapy drugs and procedures should only be ordered or performed by credentialed Reproductive Endocrinologists. If a member lives in an out-of-network area, then the credentials of the nearest Reproductive Endocrinologist or OB/Gynecologist must be reviewed by the Credentials Specialist prior to approval for coverage. Refer to plan-specific infertility riders. The procedure regarding a member acting as a surrogate mother is only covered if the couple has a relationship under which the PSHB Program recognizes each partner as a spouse of the other.	In-Network: 15% Out-of-Network: 40%
• Fertility drugs (See Section 5f or 5(f)(a) and page 131 or 139) Note: We cover Injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	
Not covered: • *Member acting as a surrogate mother and all services and supplies associated with surrogate motherhood are not covered by the UPMC Insurance Services Division, nor are supplies and services related to the following:* - *Pre-pregnancyevaluations* - *Prenatalcare* - *Perinatalcare* - *Postnatal care*	*All charges*

Benefit Description	You Pay
Allergy care	**HDHP Option**
• Testing and treatment • Allergy injections	In-Network: 15% Out-of-Network: 40%
Allergy serum	In-Network: 15% Out-of-Network: 40%
Treatment therapies	**HDHP Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 117. • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/ condition is provided for up to 12 sessions. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder • Medical nutrition therapy to treat a chronic illness or condition; includes nutrition assessment and nutritional counseling by a dietitian or facility-based program which is ordered by a physician. • Chronic Renal Disease, Diabetes Mellitus, and High Risk Obstetrical Symptomatic Conditions: unlimited number of visits when medically necessary • Morbid Obesity: limited to an initial assessment and five follow-up visits for a total of six visits per calendar year • Heart Disease, Symptomatic HIV/AIDS, and Celiac Disease: limited to two visits per calendar year • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page x. • Pain management	In-Network: 15% Out-of-Network: 40%

Treatment therapies - continued on next page

Benefit Description	You Pay
Treatment therapies (cont.)	**HDHP Option**
Note: Pain management is covered if you are diagnosed with refractory chronic pain of at least six months duration. The provider must demonstrate that they anticipates these services to result in substantial improvement to your medical condition.	In-Network: 15% Out-of-Network: 40%
Nutritional products	**HDHP Option**
Nutritional products that are specialty food products are covered when Medically Necessary and when under the direction of a physician on an outpatient basis, for the treatment of inborn errors of metabolism and some hereditary metabolic disorders in accordance with state law. Coverage is independent of whether the product is administered orally or enterally. These disorders include: • Phenylketonuria (PKU) • Branch-chain ketonuria • Galactosemia • Homocystinuria • Allergic reaction or malabsorption syndromes, specifically hemorrhagic colitis	In-Network: 15% (no deductible) Out-of-Network: 40% (no deductible)
Physical and occupational therapies	**HDHP Option**
Rehabilitation services are limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year. Habilitation services are also limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year. • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a physician: • Orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed.	In-Network: 15% Out-of-Network: 40%
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*

Benefit Description	You Pay
Speech therapy	**HDHP Option**
Limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year for Rehabilitation. Limited to the greater of 60 consecutive days of coverage or 25 visits per condition, per calendar year for Habilitation.	In-Network: 15% Out-of-Network: 40%
Not covered: • *Speech therapy for developmental delays*	*All charges*
Hearing services (testing, treatment, and supplies)	**HDHP Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	In-Network: 15% Out-of-Network: 40%
• External hearing aids (see Section 5(a) *Orthopedic and prosthetic devices,* page 111.) • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	In-Network: 15% Out-of-Network: 40%
Not covered: • *Hearingaid batteries* • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**HDHP Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	In-Network: 15% Out-of-Network: 40%
• Annual eye examination once every 24 months for adults and children To use your eye examination benefit, call us at 833-288-6901 or visit www.upmchealthplan.com/PSHB/ to locate a vision care provider.	In-Network: 15% Out-of-Network: 40%
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You Pay
Foot care	**HDHP Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-Network: 15% Out-of-Network: 40%
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**HDHP Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Hearing aids are covered at the applicable coinsurance level after the calendar year deductible is met for adults age 21 and over. The benefit limit is $1,500 per ear in each 36 month period. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services*.	In-Network: 15% Out-of-Network: 40%
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups (covered only with a diagnosis of diabetes or peripheral vascular disease)* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices (gradient compression stockings may be covered for certain diagnoses)*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay
Orthopedic and prosthetic devices (cont.)	**HDHP Option**
• *Prosthetic replacements when it is determined by us that a repair costs less than 50% of a replacement* • *Hearing aids for children up to age 21* • *Hearing aid batteries*	*All charges*
Durable medical equipment (DME)	**HDHP Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Insulin pumps Note: Call us at 833-288-6901 as soon as your as soon as your physician prescribes this equipment. We can assist you in locating a participating supplier.	In-Network: 15% Out-of-Network: 40%
Not covered: • *Audible prescription reading devices* • *Replacement or duplication except when necessitated due to a change in the patient's medical condition or the cost to repair the item exceeds 50% of the price of a new item* • *Comfort or convenience items, for your comfort or convenience or the comfort or convenience of your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, phones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty services, guest service or similar items, even if recommended by a professional provider.* • *Medical equipment and supplies that are:* - *expendable in nature (i.e. disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and* - *primarily used for non-medical purposes, regardless of whether recommended by a professional provider*	*All charges*

Benefit Description	You Pay
Home health services	**HDHP Option**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	In-Network: 15% Out-of-Network: 40%
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	**HDHP Option**
• Manipulation of the spine and extremities limited to 25 visits per calendar year • Must be medically necessary • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Children under the age of 13 must receive prior authorization for chiropractic care.	In-Network: 15% Out-of-Network: 40%
Not covered:	*All charges*
Alternative treatments	**HDHP Option**
Acupuncture – by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner Dry Needling – by a licensed or certified practitioner	In-Network: 15% Out-of-Network: 40%
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture, other than listed above*	*All charges*
Educational classes and programs	**HDHP Option**
Diabetic Self-Management Education (DSME) - Outpatient diabetes self-management training and education program is a program of self-management, training, and education, for the treatment of diabetes. You do not need a physician prescription and no referral is required. You must have a chronic condition and your care must be medically necessary. There is no visit limit for this service.	Nothing (No deductible)

Educational classes and programs - continued on next page

Benefit Description	You Pay
Educational classes and programs (cont.)	**HDHP Option**
Nutritional Counseling - the assessment of a person's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or nutrition therapies to treat a chronic illness or condition. Services must be delivered by a dietitian or facility-based program, ordered by a participating physician and offered by a participating provider. Coverage is limited to two visits per calendar year. Also see *Medical nutrition therapy* under *Treatment therapies* on page 108.	In-Network: 15% Out-of-Network: 40%
Tobacco Cessation- individual, group, phone counseling provided by UPMC Health Plan, call 800-807-0751, and over-the-counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence. You must have a written prescription from your doctor for all medications, including OTC, in order to obtain coverage. See *Prescription drug benefits*.	Nothing (No deductible)

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $2,000 for a Self Only or $4,000 for a Self Plus One or Self and Family enrollment. The family deductible can be met by one or more members of the deductible applies to all benefits in this section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**HDHP Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of severe obesity (bariatric surgery) See criteria: MP.PA.040 • Insertion of internal prosthetic devices. See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a)	In-Network: 15% Out-of-Network: 40%

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**HDHP Option**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges*
Reconstructive surgery	**HDHP Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • Gender Affirming Surgery - All medically necessary gender-affirming care surgeries are covered, including facial surgeries with prior authorization. - For female to male surgery: mastectomy, oophorectomy, salpingoophorectomy, hysterectomy, vaginectomy, metoidioplasty, phalloplasty, and scrotoplasty. - For male to female surgery: orchiectomy, penectomy, penile inversion vaginoplasty, breast augmentation, and labiaplasty and facial feminization surgeries. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • All stages of breast reconstruction surgery following a mastectomy, such as: surgery to produce a symmetrical appearance of breasts treatment of any physical complications, such as lymphedemas breast prostheses and surgical bras and replacements (see Prosthetic devices)	In-Network: 15% Out-of-Network: 40%
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**HDHP Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Surgery for TMJ Note: In order for surgery to be covered, documentation in the medical record must support that treatment of TMJ disorder with conventional non-surgical therapy has not resulted in adequate improvement. • Other surgical procedures that do not involve the teeth or their supporting structures.	In-Network: 15% Out-of-Network: 40%
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**HDHP Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver Lung: single/bilateral/lobar • Pancreas	In-Network: 15% Out-of-Network: 40%

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**HDHP Option**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer)	In-Network: 15% Out-of-Network: 40%
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis Chronic lymphocytic leukemia/ small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	In-Network: 15% Out-of-Network: 40%

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**HDHP Option**
- Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Aggressive non-Hodgkin's lymphoma - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	In-Network: 15% Out-of-Network: 40%
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	In-Network: 15% Out-of-Network: 40%

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**HDHP Option**
- Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis Chronic lymphocytic leukemia/ small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-Network: 15% Out-of-Network: 40%
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia	In-Network: 15% Out-of-Network: 40%

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**HDHP Option**
- Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus	In-Network: 15% Out-of-Network: 40%

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**HDHP Option**
- Systemic sclerosis • Hematopoietic Stem Cell Transplant (HSCT) UPMC Health Plan utilizes the top transplant centers in Pennsylvania. Should care not be available in Pennsylvania, UPMC Health Plan will arrange for services out of the area.	In-Network: 15% Out-of-Network: 40%
National Transplant Program (NTP) – Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	In-Network: 15% Out-of-Network: 40%
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**HDHP Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility. Limited to 100 days per calendar year combined with Extended care facility • Ambulatory surgical center • Office	In-Network: 15% Out-of-Network: 40%

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.

The deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family The family deductible can be satisfied by one or more members of the family. The deductible applies to all benefits in this section.

After you have satisfied your deductible, your Traditional medical coverage begins.

Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.

- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require precertification

Benefit Description	You Pay
Inpatient hospital	**HDHP Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	In-Network: 15% Out-of-Network: 40%

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	**HDHP Option**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**HDHP Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Observation level of care Note: Observation is a level of care in an acute care hospital setting that is appropriate when a patient is receiving ongoing short-term treatment and assessments and it is not clear if inpatient level of care is needed. Reassessments are made during this time to determine if the patient requires inpatient admission, or may be discharged and receive follow-up in the outpatient setting. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	In-Network: 15% Out-of-Network: 40%
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**HDHP Option**
Extended care benefit: Limited to 100 days per calendar year combined with skilled nursing facility admissions.	In-Network: 15% Out-of-Network: 40%
Skilled nursing facility (SNF): Limited to 100 days per calendar year combined with skilled nursing facility admissions.	In-Network: 15% Out-of-Network: 40%
Not covered: Custodial care	*All charges*

Benefit Description	You Pay
Hospice care	**HDHP Option**
Supportive and palliative care is covered for terminally ill patients, either in the home or in a hospice facility. Services include inpatient and outpatient care and family counseling. These services are provided under the direction of a physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	In-Network: 15% Out-of-Network: 40%
Not covered: Independent nursing, homemaker services	*All charges*
End of life care	**HDHP Option**
Advance directive information and forms are available to all members upon request. End of life care also includes face-to-face services with a patient, family member or surrogate in counseling and discussing advance directives.	In-Network: 15% Out-of-Network: 40%
Ambulance	**HDHP Option**
Local professional ambulance service when medically appropriate	In-Network: 15% Out-of-Network: 40%

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

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Emergencies within our service area

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

- Your doctor tells you to
- You cannot reach your personal physician and you believe that your health is in jeopardy

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

After your receive emergency room treatment or are admitted to the hospital, contact your personal physician as soon as possible.

Emergencies outside our service area

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

If you are admitted to the hospital, contact our Member Services Department at 833-288-6901 within 48 hours.

Benefit Description	You pay
Emergency within our service area	**HDHP Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	15%
Not covered: Elective care or non-emergency care	*All charges*
Emergencies outside our service area	**HDHP Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	15%
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Accidental injury	**HDHP Option**
Accidental injury	15%
Ambulance	**HDHP Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	15%
Not covered: Air ambulance	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to all benefits in this The calendar year deductible is $2,000 per person ($2,000 per Self Only enrollment or $4,000 for Self Plus One or Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefits Description	You pay
Professional services	**HDHP Option**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. In order to ensure compliance with the Mental Health Parity and Addiction Equity Act, member cost-sharing may be reduced for certain services when received for the diagnosis or treatment of a mental health or substance use disorder or condition. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug use, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-Network: 15% Out-of-Network: 40%

Benefits Description	You pay
Diagnostics	**HDHP Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-Network: 15% Out-of-Network: 40%
Inpatient hospital or other covered facility	**HDHP Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	In-Network: 15% Out-of-Network: 40%
Outpatient hospital or other covered facility	**HDHP Option**
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-Network: 15% Out-of-Network: 40%
Not covered	**HDHP Option**
• *Services related to disorders that are not diagnoses listed in the most recent edition of the diagnostic and Statistical manual of Mental Disorders* • *Treatment for organic disorders, including, but not limited, to organic brain disease* • *Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder* • *Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies such as art or psychodrama, and hyperbaric or other therapy* • *Sex therapy, listed in the most recent edition of the diagnostic and Statistical manual of Mental Disorders and treatment for sexual addiction* • *Sedative action electrostimulation therapy* • *Sensitivity training* • *Twelve-step model programs as sole therapy for conditions, including, but not limited to, addictive gambling*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about thin mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- The deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. The family deductible can be satisfied by one or more members of the family. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Your covered prescription expense can be applied toward satisfaction of the deductible.
- You are responsible for copayments for eligible prescriptions after the deductible is met.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Some drugs may require prior authorization. Your doctor must consult with the Plan before prescribing it. Prior authorizations are set on a drug-by-drug basis and require specific criteria for approval based upon FDA and manufacturer guidelines, medical literature, safety concerns, and appropriate use.
- Some drugs may require step therapy. This means that you must try specific medications first before we will cover the drug that requires step therapy. Step therapy is built into the electronic system that checks your medication history. A drug with step therapy will be automatically approved if there is a record that you have already tried the preferred drug(s). If there is no record that you tried the preferred drug(s) in your medication history, your physician must submit relevant clinical information to the UPMC Health Plan Pharmacy Services Department before it may be covered.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a participating retail pharmacy, or by mail for maintenance and specialty drugs. Participating retail pharmacies include most national chains as well as many independent pharmacies. Call Member Services at 833-288-6901 or visit www.upmchealthplan.com/PSHB for assistance in locating a participating pharmacy near you.
- **We have a managed formulary.** If your provider believes a name brand product is necessary or there is no generic available, your provider may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 833-288-6901. You can also visit www.upmchealthplan.com/PSHB. UPMC Health Plan makes changes to it's formulary each January 1 and July 1. You will be notified by a separate letter if the prescription drug you are taking is affected by a negative formulary change. To order a prescription drug brochure, call 833-288-6901.

- **These are the dispensing limitations.** Covered prescription drugs obtained at a participating retail pharmacy will be dispensed for a 30-day supply for one copayment or a 90-day supply for three copayments. Controlled substance medications are limited to a 30-day supply. Specialty prescription drugs obtained through the Plan's specialty pharmacy will be dispensed for up to a 30-day supply. Prescriptions for maintenance drugs obtained through the Plan's mail order pharmacy will be dispensed up to a 90-day supply. The copay for mail order equals two times the 30 day retail copay for Preferred Generic Medications, Preferred Brand and Generic Medications and Non-Preferred Medication tiers. Medications will be dispensed based on FDA guidelines. If you travel away from home for an extended period of time, or if you will be traveling outside of the country, consider using mail-order so that you receive a 90-day supply prior to traveling. If you need an emergency supply of medication, call Member Services at 833-288-6901.

Prescription drugs are subject to the deductible for the PSHB HDHP plan sponsored by UPMC Health Plan. This means members will pay the full discounted rate for prescriptions until the member has met the deductible. However, the IRS provides an exception for preventive care benefits, which is known as a "safe harbor." This safe harbor provision permits an HDHP to provide certain preventive medications before members meet their deductibles for that plan year. See page 134.

- **Specialty medications.** Specialty medications usually treat complex and rare conditions. These drugs are created because of advancements in drug Many specialty drugs require close management by a physician. Physicians need to monitor these drugs due to potential side effects and the need for frequent dosage adjustments. Most specialty medications must be obtained through our designated specialty pharmacy providers, Accredo or Chartwell.
- Your plan has a Preventive Drug list of select medications that are covered at the applicable copayment before the deductible is met as a part of the "safe harbor" These medications are used to treat certain health conditions.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs.** A generic drug is the chemical equivalent of a corresponding brand-name drug. Generic drugs are less expensive than brand-name drugs, so the cost is lower. You can lower your out-of-pocket expense by using generic drugs, when available.
- **When you do have to file a claim.** If you are enrolled in an HRA, you will need to file an HRA reimbursement form until you meet your deductible. Once your deductible is met, you will pay your copayment at the point of purchase. If you are enrolled in an HSA, you can use your debit card to pay for your prescription or copayment. Once your deductible is met, if there is a circumstance in which you pay the full cost out-of-pocket, you can be reimbursed by completing a prescription drug reimbursement form. You will be reimbursed 100% of the covered prescription cost less the applicable copayment as long as you used a participating pharmacy. Call Member Services at 833-288-6901 to obtain a prescription drug reimbursement form.

Benefits Description	You pay
Covered medications and supplies	**HDHP Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to disposable needles and syringes for the administration of covered medications • Drugs for the treatment of infertility including IVF, Artificial Insemination and cryopreservation - We cover injectable fertility drugs under the prescription drug and medical benefits and oral fertility drugs under the prescription drug benefit	**In-Network:** **Retail (up to a 30-day supply)** $0 copayment for select generic medications $20 copayment for preferred generic drugs $50 copayment for preferred brand medications and generic medications $100 copayment for non-preferred brand-name drugs 90-day maximum supply available at certain retail outlets for three copayments. **Specialty Prescription Drugs (up to a 30-day supply)** 50% coinsurance up to a maximum of $250

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**HDHP Option**
• Drugs for sexual dysfunction • Tobacco cessation drugs including over-the-counter (OTC) drugs approved by the FDA to treat tobacco dependence. (See page 114). • Drugs to treat gender dysphoria • Medications prescribed to treat obesity	**In-Network:** **Retail (up to a 30-day supply)** $0 copayment for select generic medications $20 copayment for preferred generic drugs $50 copayment for preferred brand medications and generic medications $100 copayment for non-preferred brand-name drugs 90-day maximum supply available at certain retail outlets for three copayments. **Specialty Prescription Drugs (up to a 30-day supply)** 50% coinsurance up to a maximum of $250 **Mail-Order (up to a 90-day supply)** $0 copayment for select generic medications $40 copayment for preferred generic drugs $100 copayment for preferred brand medications and generic medications $200 copayment for non-preferred brand-name drugs Specialty drugs are not covered through Mail-Order Notes: • If there is no generic equivalent available, you will pay the brand-name copayment. • Copayments are waived for tobacco cessation (No deductible) **Out-of-Network:** *All charges*
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Generic and brand name drugs covered on the formulary are available at no copayments.

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**HDHP Option**
• Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • UPMC Health Plan offers the full range of contraceptive methods. At this time, the only products that are not readily available without cost share are multi-source brand drugs. In order to get a multi-source brand contraceptive covered at $0, your provider will need to complete and submit a Cost Sharing Exception request form. This form is included with the Preventive Services Resource Guide as part of your plan documents, or may be downloaded from the Pharmacy Prior Authorization section of our website (upmchealthplan.com). Your provider can also directly submit an electronic version of the exception request through UPMC's PromptPA Portal. In order to be approved for a cost-sharing exception, your provider must attest that the prescribed medication is medically necessary, and explain why it is a necessary form of contraception for you. Reimbursement for covered over-the-counter contraceptives can be submitted using the process outlined below. • If you paid out-of-pocket for an OTC contraceptive product with a prescription from your provider and were not assessed $0 cost share, you can request a Pharmacy Direct Reimbursement Claim Form by calling our Health Care Concierge team at the phone number listed on the back of your member ID card or by logging into UPMC Health Plan member site. You must submit the completed form and your pharmacy label to UPMC Health Plan for review. Please note, a prescription is not required for reimbursement for Opill. Note: For additional Family Planning benefits see Section 5(a)	Generic and brand name drugs covered on the formulary are available at no copayments.
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	

Benefits Description	You pay
Safe Harbor Medications	**HDHP Option**
Medications to promote better health as recommended by the ACA. The following medications are covered with the applicable copay prior to the deductible being met. Please see www.upmchealthplan.com/PSHB for the list of qualifying medications.	(No deductible) Applicable copay applies **Retail (up to a 30-day supply)** $20 copayment for generic drugs **Mail-Order (up to a 90-day supply)** $40 copayment for generic drugs **Out-of-Network:** *All charges*
Preventive medications	**HDHP Option**
Preventive Medications with USPSTF A and B recommendations are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy, with the exception of Opill. These may include some over the counter vitamins, nicotine replacement medications, and low dose aspirin. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations The pharmacy benefit plan includes coverage for some preventive medications at no cost share when certain criteria in accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA) are met. The following drugs are eligible for ACA coverage. Generic products are required when available. • Bowel preps for members age 45-75. Coverage is for generic products limited to 2 prescriptions per year. • Smoking cessation products for all members age 18 and older. Coverage is limited to 24 weeks of therapy per year. • Aspirin (81 mg) for members of child- bearing potential • Contraceptives coverage includes a full range of generic and single-source brand Food and Drug Administration (FDA) approved classes. • Breast cancer medications (generic tamoxifen, raloxifene, aromatase inhibitors) used for prevention in members age 35 and older who are at increased risk for breast cancer and at low risk for adverse medication effects. • Statins for members age 40-75. Statin must be low to moderate intensity and the member must have no history of cardiovascular disease, with at least one cardiovascular risk factor. • Pre-Exposure Prophylaxis (PrEP) for members who are not infected with HIV who are at high risk for HIV infection.	Nothing (No deductible)

Preventive medications - continued on next page

Benefits Description	You pay
Preventive medications (cont.)	**HDHP Option**
• Folic acid supplements (400 and 800 mcg) for members of childbearing age. • Fluoride tablets, solution (not toothpaste, rinses) for children age 6 months through 16 years. Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations Note: To receive this benefit a prescription from a prescriber must be presented to the pharmacy, with the exception of Opill.	Nothing (No deductible)
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a participating pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www.findtreatment.samhsa.gov/	Nothing (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugsobtainedatanon-Planpharmacy(afterthe plan deductible is met)* • *Vitamins, nutrients, and food supplements not listed as a covered benefit even if a physician prescribes or administers them are not covered except medically necessary formulas that are equivalent to a prescription drug for the treatment of phenylketonuris (PKU) branched-chain ketonuris, galactosemia, and homocystinuria as administered under the direction of a physician or listed as a covered benefit.* • *Non-prescription medications, except those listed on the Your Choice formulary* • *Medications prescribed for foreign travel*	*All charges*

Important phone numbers:

For questions about your pharmacy benefits and participating retail locations, call UPMC Health Plan at: **833-288-6901**

For specialty drug orders, call Accredo at **888-773-7376 (TTY:711)** or Chartwell at **800-366-6020 (TTY:711)**. For mail-order maintenance drug orders, call Express Scripts at **877-787-6279 (TTY:711).**

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at (833)-288-6901.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network where members can fill prescriptions at any in-network pharmacy of their choice and can have low copays when filling at one of our preferred retail or mail-order pharmacies. Some preferred retail pharmacy locations include Giant, Giant Eagle, Rite Aid, Sam's Club, Walgreens, Walmart, and Weis. To find a preferred pharmacy, go to www.upmchealthplan.com/pshb
- You also have prescription drug benefits under your HDHP PPO plan that may reduce your cost share or cover medications that are not included in the UPMC *for Life* drug formulary.

We cover drugs, medications, and supplies as described below and on the following pages.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- Starting Jan. 1, 2025, Medicare members with high prescription drug costs can get help with their payments through the Medicare Prescription Payment Plan. This new payment option allows you to spread your prescription drug costs across monthly payments throughout the year instead of paying them up front at the pharmacy. Contact 833-869-6924 or to go to our website to learn more about the program https://www.upmchealthplan.com/medicare/prescription-payment-plan
- There is no Medicare Part D calendar year deductible. This deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at 844-761-0083

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

However, you can enroll in our MAPD and receive PSHB Program Prescription Drug Coverage.

In order to enroll in the UPMC *for Life* PSHB Retirees HMO Custom plan, you must be enrolled in the UPMC Health Plan Standard Option PSHB plan. To enroll in UPMC Health Plan's Standard Option HMO, please use your PSHB System.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance, 844-761-0083**.**

Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope.

Please note that this UPMC *for Life* PDP identification card is separate from your PSHB UPMC Health Plan identification card. You will need to present both cards when you receive prescription drugs.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You may fill prescriptions at any network pharmacy. For assistance locating a PDP EGWP network pharmacy, visit our website at www.upmchealthplan.com/pshb, or call us at 833-869-6924 TTY
- **We have a managed formulary.** Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. You may view our formulary on our website at www.upmchealthplan.com/pshb or call us at 833-869-6924
- **You also have prescription drug benefits under your commercial plan that may reduce your cost share or cover medications that are not included in the UPMC *For Life* drug formulary**. Your out-of-pocket drug costs can also change as you move through your prescription drug coverage stages, the pharmacy you use and the tier of your drug. Refer to Section 5(f) for information on your commercial plan prescription drug benefits.
- **These are the dispensing limitations.** For certain prescription drugs, our plan limits the amount of the drug that we will cover. Prescription drugs with quantity limits are listed in your plan's comprehensive formulary (list of covered drugs). To see if any of your prescription drugs have a quantity limit, check your plan's comprehensive formulary for Requirements/ Limits.
- **We may require Utilization Management strategies.** For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan. For certain drugs, you are required to try another drug before we will cover the drug for you. This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called step therapy.
- **You may request a Formulary Exception.** The forms linked below can be used to request prior authorization, coverage determination and redetermination, or an exception for prescription drugs.

1. Select and open the appropriate form:
   - **Use this link to submit a request for a drug not currently covered under your plan:** UPMC for Life Prescription Drug Coverage Determination/Exception Request Form (PDF)
   - **Use this link to submit a request or redetermination of a drug coverage request denied within the past 60 days:** UPMC for Life Medicare Prescription Drug Coverage Redetermination Request Form (PDF)

3. Fill out the form and save it to your computer's hard drive.

4. Submit your request form using our online submission tool

- **A generic equivalent will be dispensed if it is available** unless your physician specifically requires a brand name drug. If you receive a brand name drug when an FDA approved generic drug is available, and your physician has not specified Dispense as Written for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- **Why use generic drugs?** A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs, so the cost is lower. You can lower your out-of-pocket expense by using generic drugs when available.
- **When you do have to file a claim.** If you are a UPMC *for Life* member, and recently paid cash for a covered medication, complete the form below to apply for reimbursement for Part D prescription drugs. Please follow these steps to submit a prescription drug claim reimbursement form to us.

1. Open this form:
   - UPMC for Life Prescription Drug Claim Reimbursement Form
   - UPMC for Life Complete Care (HMO D-SNP) Prescription Drug Claim Reimbursement Form

3. Print the form. Follow the instructions on the form and fill out as completely as possible.

4. For your claim to be processed, you will need to get your prescription receipts or patient history printout from your pharmacy.

5. Mail the form and your receipts to us at the address below. Please do not staple or attach your receipts to another piece of paper.

UPMC *for Life*/UPMC *for Life* Complete Care Pharmacy Services Department

U.S. Steel Tower, 12th Floor

600 Grant Street

Pittsburgh, PA 15219

- **If we deny your claim and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). Medicare PDP EGWP Disputed Claims Process. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

UPMC *for Life* members may ask for a coverage determination or redetermination (appeal) for a Part D prescription drug. Members can request a coverage determination/exception by completing and signing the form below. It can be mailed or faxed to UPMC Health Plan. You may also call our Member Services Department to file an appeal, get information about this process, check on the status of a request, or obtain an aggregate number of appeals, grievances, and exceptions for our plan. Please contact us by:

- **Phone**: UPMC *for Life* HMO/PPO members can call our Member Services Department at 833-869-6924 **(TTY: 711)**. From Oct. 1 – March 31, we are available seven days a week from 8 a.m. to 8 p.m. From April 1 – Sept. 30, we are available Monday through Friday from 8 a.m. to 8 p.m.
- **Fax**: 412-454-7722
- **Mail**: UPMC Health Plan Pharmacy Department
  U.S. Steel Tower, 12th Floor
  600 Grant Street
  Pittsburgh, PA 15219

UPMC for Life Prescription Drug Coverage Determination/Exception Request Form

Redetermination (Appeal) Request

Members can request a redetermination (appeal) by completing and signing one of the forms below. It can be mailed or faxed to UPMC Health Plan. You may also call our Member Services Department to file an appeal, get information about this process, check on the status of a request, or obtain an aggregate number of appeals, grievances, and exceptions for our plan. Please contact us by:

- **Phone:** UPMC *for Life* HMO/PPO members can call our Member Services Department at 833-869-6924 **(TTY: 711).** From Oct. 1 – March 31, we are available seven days a week from 8 a.m. to 8 p.m. From April 1 – Sept. 30, we are available Monday through Friday from 8 a.m. to 8 p.m.
- **Fax:** 412-454-7920
- **Mail:** UPMC Health Plan
  ATTN: Appeals and Grievances
  PO BOX 2939
  Pittsburgh, PA 15230-2939

UPMC for Life Medicare Prescription Drug Coverage Redetermination Request Form

PDP EGWP Catastrophic Maximum

Your total yearly drug costs will be capped at $2,000. Once the costs paid by you and your plan reach $2,000, you will move into the catastrophic coverage stage. In this stage, you won't pay anything for your covered drugs. You will stay in this stage through the end of the year.

Benefits Description	You pay
Covered medications and supplies	**HDHP Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for the treatment of infertility including IVF, Artificial Insemination and cryopreservation - We cover injectable fertility drugs under the prescription drug and medical benefits and oral fertility drugs under the prescription drug benefit • Drugs for sexual dysfunction • Tobacco cessation drugs including over-the-counter (OTC) drugs approved by the FDA to treat tobacco dependence. (See page 114).	**Retail (up to a 30-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $15 at a standard pharmacy Generic medications: $10 copayment at a preferred pharmacy; $20 at a standard pharmacy Preferred brand medications: $47 copayment at both preferred and standard pharmacies Non-Preferred brand medications: $100 copayment at both preferred and standard pharmacies Covered Insulins: $35 copayment at both preferred and standard pharmacies **Specialty Prescription Drugs (up to a 30-day supply)** 33% coinsurance **Retail (up to a 100-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $30 at a standard pharmacy Generic medications: $20 copayment at a preferred pharmacy; $40 at a standard pharmacy Preferred brand medications: $129.50 copayment at a preferred pharmacy; $141 at a standard pharmacy Non-preferred medications: $300 copayment at both preferred and standard pharmacies

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**HDHP Option**
• Drugs to treat gender dysphoria for gender-affirming services are covered under your prescription benefit plan and include testosterone, estrogen, and Luteinizing Hormone Releasing Hormone (LHRH) agents. Some of these medications may require prior authorization prior to approval. • Medications prescribed to treat obesity • Medical Foods	**Retail (up to a 30-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $15 at a standard pharmacy Generic medications: $10 copayment at a preferred pharmacy; $20 at a standard pharmacy Preferred brand medications: $47 copayment at both preferred and standard pharmacies Non-Preferred brand medications: $100 copayment at both preferred and standard pharmacies Covered Insulins: $35 copayment at both preferred and standard pharmacies **Specialty Prescription Drugs (up to a 30-day supply)** 33% coinsurance **Retail (up to a 100-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $30 at a standard pharmacy Generic medications: $20 copayment at a preferred pharmacy; $40 at a standard pharmacy Preferred brand medications: $129.50 copayment at a preferred pharmacy; $141 at a standard pharmacy Non-preferred medications: $300 copayment at both preferred and standard pharmacies Covered insulins: $96.25 copayment at a preferred pharmacy, $105 at a standard pharmacy **Mail Order (up to a 100-day supply)** Preferred generic medications: $0 copayment at a preferred pharmacy; $30 at a standard pharmacy Generic medications: $20 copayment at a preferred pharmacy; $40 at a standard pharmacy Preferred brand medications: $117.50 copayment at a preferred pharmacy; $141 at a standard pharmacy Non-preferred medications: $300 copayment at both preferred and standard pharmacies Covered insulins: $87.50 copayment at a preferred pharmacy, $105 at a standard pharmacy

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**HDHP Option**
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • UPMC Health Plan offers the full range of contraceptive methods. At this time, the only products that are not readily available without cost share are multi-source brand drugs. In order to get a multi-source brand contraceptive covered at $0, your provider will need to complete and submit a Cost Sharing Exception request form. This form is included with the Preventive Services Resource Guide as part of your plan documents, or may be downloaded from the Pharmacy Prior Authorization section of our website (upmchealthplan.com). Your provider can also directly submit an electronic version of the exception request through UPMC's PromptPA Portal. In order to be approved for a cost-sharing exception, your provider must attest that the prescribed medication is medically necessary, and explain why it is a necessary form of contraception for you. Reimbursement for covered over-the-counter contraceptives can be submitted using the process outlined below. • If you paid out-of-pocket for an OTC contraceptive product with a prescription from your provider and were not assessed $0 cost share, you can request a Pharmacy Direct Reimbursement Claim Form by calling our Health Care Concierge team at the phone number listed on the back of your member ID card or by logging into UPMC Health Plan member site. You must submit the completed form and your pharmacy label to UPMC Health Plan for review. Please note, a prescription is not required for reimbursement for Opill.	Generic and brand name drugs covered on the formulary are available at no copayments.

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**HDHP Option**
Note: For additional Family Planning benefits see Section 5(a)	Generic and brand name drugs covered on the formulary are available at no copayments.
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	
Preventive medications	**HDHP Option**
Preventive Medications with USPSTF A and B recommendations are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy, with the exception of Opill. These may include some over the counter vitamins, nicotine replacement medications, and low dose aspirin. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations The pharmacy benefit plan includes coverage for some preventive medications at no cost share when certain criteria in accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA) are met. The following drugs are eligible for ACA coverage. Generic products are required when available. • Bowel preps for members age 45-75. Coverage is for generic products limited to 2 prescriptions per year • Smoking cessation products for all members age 18 and older. Coverage is limited to 24 weeks of therapy per year. • Aspirin (81 mg) for members of child- bearing potential • Contraceptives coverage includes a full range of generic and single-source brand Food and Drug Administration (FDA) approved classes. • Breast cancer medications (generic tamoxifen, raloxifene, aromatase inhibitors) used for prevention in members age 35 and older who are at increased risk for breast cancer and at low risk for adverse medication effects. • Statins for members age 40-75. Statin must be low to moderate intensity and the member must have no history of cardiovascular disease, with at least one cardiovascular risk factor. • Pre-Exposure Prophylaxis (PrEP) for members who are not infected with HIV who are at high risk for HIV infection. • Folic acid supplements (400 and 800 mcg) for members of childbearing age.	Nothing (No deductible)

Preventive medications - continued on next page

Benefits Description	You pay
Preventive medications (cont.)	**HDHP Option**
• Fluoride tablets, solution (not toothpaste, rinses) for children age 6 months through 16 years.	Nothing (No deductible)
• Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations Note: To receive this benefit a prescription from a prescriber must be presented to the pharmacy, with the exception of Opill.	Nothing (No deductible)
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at: https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	Nothing (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugsobtainedatanon-Planpharmacy(afterthe plan deductible is met)* • *Vitamins, nutrients, and food supplements not listed as a covered benefit even if a physician prescribes or administers them are not covered except medically necessary formulas that are equivalent to a prescription drug for the treatment of phenylketonuris (PKU) branched-chain ketonuris, galactosemia, and homocystinuria as administered under the direction of a physician or listed as a covered benefit.* • *Non-prescription medications, except those listed on the Your Choice formulary* • *Medications prescribed for foreign travel*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family The family deductible can be met by one or more members of the family. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefits Description	You pay
Accidental injury benefit	**HDHP Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-Network: 15% Out-of-Network: 40%
Dental benefits	**HDHP Option**
Dental benefits	We have no other dental benefits

Section 5(h). Wellness and Other Special Features

Healthcare Concierge Team	You and your family members can call Member Services with questions or concerns. Our Healthcare Concierge team delivers fast, personal service, and strives to answer your question on the first call. To speak with a Healthcare Concierge, call 833-288-6901. Our Healthcare Concierge team is available Monday through Friday from 8 a.m. to 6 p.m. TTY/TDD users should call 711.
Reward Dollars	You and your covered spouse, if applicable, can earn points by completing healthy activities throughout the year. These activities have been specially designed by our team of doctors, nurses, nutritionists, exercise physiologists, and behavioral health experts. They will alert you to potential health issues and provide tools to help you address the issues. Activities include: • *My*Health Questionnaire: The confidential well-being assessment, is a 10-12-minute online survey you take once a year. The results can help you understand your health status and suggest ways to make improvements. You can earn 50 points by completing the MyHealth Questionnaire. • Biometric Screening: This health screening measures your total cholesterol level and glucose Your doctor will also check your blood pressure, height, weight, and body mass index (BMI). It is a simple assessment that can be done at your doctor's office, a lab, or some convenience care clinics. Biometric screenings are recommended once every three years. You will earn 50 points for completing biometric screening. • Condition or Lifestyle Management Coaching: A health coach for condition management will help you manage a chronic condition so you can live your healthiest life possible. Health coaches can help with heart disease, diabetes, asthma, COPD, depression, and much more. Lifestyle programs include smoking cessation, stress management, physician activity, weight management, and nutrition. You can earn 25 points per coaching session • You will also receive reward dollars for completing activities uniquely customized just for you. You will find a full list of eligible activities by logging in to UPMC Health Plan member site, the website that powers *Take a Healthy Step*, UPMC Health Plan's member website. The reward dollars you earn apply to your pharmacy copayments and coinsurance after your deductible is met. In one plan year, you can earn up to $75 for Self Only coverage or $150 for Self Plus One or Self and Family coverage to your HSA/HRA. If you are eligible for HSA the funds can be used for any 213d medical expense prior to the deductible being met. If you are not HSA eligible it will be placed in an HRA and will be used after the deductible is met for coinsurance and pharmacy copayments via claim submission. Any unused reward dollars — at a value up to two times your annual deductible — automatically roll over to the next year. To learn more about *Take a Healthy Step,* visit www.upmchealthplan.com/PSHB or call a Healthcare Concierge at 833-288-6901. *Take a Healthy Step* is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary well-being assessment or "health questionnaire" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).You are not required to complete the health questionnaire or other medical examinations.

	However, employees who choose to participate in the wellness program can receive an HSA contribution of $75 for self, $150 for self plus one, and $150 for self plus family for completing healthy activities that are customized. Although you are not required to complete the health questionnaire only employees who do so will receive the selected reward. Additional incentives as noted above may be available for employees who participate in certain health-related customized activities If you are unable to participate in any of the health- related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting UPMC Health Plan at 833-288-6901. The information from your health questionnaire will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as recommended healthy activities. You also are encouraged to share your results or concerns with your own doctor.
***My*Health Health and Wellness**	You and your family members have access to *My*Health, A nationally acclaimed health and wellness program. *My*Health guides and motivates you to live your healthiest life possible through online programs, tools, and over-the-phone advice. *My*Health was developed by UPMC, one of the nation's top hospital systems. This gives us in-house expertise in condition management and lifestyle behavior change that no other health plan can match. *My*Health includes: • UPMC Health Plan member site • *My*Health Questionnaire • *My*Health Community • Health Coaching • *My*Health Advice Line For detailed descriptions, see below.
UPMC Health Plan member site	UPMC Health Plan member site is where you can go every day for practical tips, tools, and strategies for better health. You can also find a doctor, view your medical history, and get information on your health plan benefits. The site keeps all your health information, all in one place. At UPMC Health Plan member site, you can: *Earn and track your reward dollars*, so you know exactly how much you have in your account to spend on healthcare. (Remember, with Take a Healthy Step, you earn reward dollars when you do healthy activities throughout the year.) *Enjoy discounts and savings*: Health and Wellness Discounts focuses on great discounts at health- and wellness- related retailers such as gyms, spas, salons, health food stores, sporting goods stores, and more. *Manage your healthcare information*: Access your doctor’s contact information, plan benefits, research prescription and treatment options, savings information, and view your spending summary and claims. You can even order a new member ID card if you lose it. You can also chat online with a Healthcare Concierge or Health Coach, read blogs from health experts, get advice on medical screenings and healthy activities, and set personal goals for managing your health.

	To get the most out of your benefits, log in to UPMC Health Plan member site at www.upmchealthplan.com/PSHB. To create an account click on Sign Up and use the number on your member ID card to register.
***My*Health Questionnaire**	Once you log in to UPMC Health Plan member site, complete your *My*Health Questionnaire. Not only will you earn points, but your answers generate a simple summary of your current health status and customize UPMC Health Plan member site with activities that benefit you the most.
Health and Wellness Discounts	You and your family can receive discounts through Health and Wellness Discounts. Visit UPMC Health Plan member site and log in or register to find great discounts near you, including Active&Fit. The Active&Fit Direct program allows you to choose from 16,000+ participating fitness centers nationwide for $28 a month (plus a $28 enrollment fee and applicable taxes). Learn more: https://www.activeandfitnow.com/. The Active&Fit Direct program is offered through American Specialty Health Fitness, Inc., one of the nation's leading fitness networks serving millions of members. Plus, you'll have access to your health information and tools that can help you get or stay healthy! Log in to UPMC Health Plan member site, click on **Better Health and Wellness** in the left-hand navigation, and then click on **Health and Wellness Discounts** to find great discounts near you.
Health Coaching	A UPMC Health Plan health coach can get you started on a healthy living plan today. Enroll in one of our proven lifestyle or chronic condition coaching programs and earn reward dollars in your Health Incentive Account. A health coach can help you manage a variety of conditions, including asthma, diabetes, hypertension and low back pain. They can also help you lose weight, quit smoking, eat healthier, reduce stress, and make other lifestyle changes to improve your health. You can also choose to do a one-time visit by phone or connect via live chat. Participating in these programs also give you the opportunity to earn points toward reward dollars. To get started, call a health coach at 800-807-0751.
***My*Health 24/7 Nurse Line**	For immediate access to free healthcare advice 24 hours a day, seven days a week call the *My*Health 24/7 Nurse Line at 866-918-1591. From general health information to help with a specific sickness or injury, an experienced registered nurse will provide you with prompt and efficient service.
UPMC AnywhereCare	When you're not feeling well, you can have a face-to-face conversation with a UPMC provider over live video straight from your smart phone, tablet or computer. See a UPMC provider in 30 minutes or less to discuss your symptoms and get a treatment plan. And if you need a prescription, the provider can call it in to your local pharmacy. Download the mobile app from the iTunes App Store or Google Play by searching for "AnywhereCare" or you can register at https://anywherecare.upmc.com/ from your computer.
UPMC Health Plan Mobile App	When you download this free app to your smartphone, you can: • Search for participating providers. • Chat with a Healthcare Concierge. • Access your member ID card. • Contact your providers. • Check the status of your claims. • Take the *My*Health Questionnaire.

RxWell	Get prescription-strength health help with RxWell. Whether you're feeling anxious, stressed, or sad, RxWell has a path for you. This app is designed to help you become emotionally and physically healthy by combining health coaching support and proven techniques. You can also earn points by completing an RxWell program. • **Manage anxiety, stress, or** Choose from three effective programs based on your needs. • **Relax using helpful practices**. Learn calming techniques that can help you feel more centered in 10 minutes or less • **Get support from a real health coach.** Receive a personalized plan, set up goals, and message your health coach to get help along the way. • **Track your progress.** Identify behavioral, mood, and emotional patterns over time.
Assist America	UPMC Health Plan offers a travel assistance plan through Assist America, a global emergency assistance program for members who are traveling more than 100 miles from home. Assist America can help locate qualified doctors and hospitals, replace forgotten prescriptions, provide emergency medical evacuation and arrange for transportation so family members can be with injured relatives. Support is accessible 24 hours a day, 365 days a year. For a complete list of Assist America services visit www.assistamerica.com. To receive services, contact Assist America at 800-872-1414 in the USA, or at 1-609-986-1234 outside of the USA. The Assist America reference number for UPMC Health Plan members is 01-AA-UP-156243. You may also download the Health Plan Mobile App for free to your smartphone.
Preventive Health	UPMC Health Plan offers Myhealthfinder tool @ https://www.upmchealthplan.com/members/learn/benefits-and-services/preventive-health.aspx. This tool will provide personalized recommendations to help you take charge of your health.
Services for Members who have a Hearing Impairment	UPMC Health Plan communicates by phone with our members who have a hearing impairment through TTY. If you have a hearing impairment, call our TTY number at 711.
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed- upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).

Maternity Program	Baby Steps is a maternity program available to all UPMC Health Plan members. This program connects you with maternity health coaches who provide support, education, and resources. Some examples of what you can talk about include prenatal vitamins, a birthing plan, breastfeeding, and signs of postpartum depression. We want to help increase your chances of having a healthy pregnancy, baby, and postpartum recovery. This program is provided to you at no-cost as part of your benefits. How frequently you communicate with your coach is up to you, with both phone and in-person options available. Contact us to learn more about the Baby Steps program and get in touch with a health coach. Coaches are available Monday through Friday from 8 a.m. to 6 p.m. • **Phone:** 1-866-778-6073 (TTY:711) • **Chat via UPMC Health Plan member site:** Sign in to UPMC Health Plan member site | Register for UPMC Health Plan member site • **Email:** maternitycoaches@upmc.edu (Coaches will schedule a phone call based on your availability.) • UPMC Health Plan Maternity Program Any member who is identified as having active or a history of chronic hypertension or PIH is stratified as high risk and targeted for active Case Management outreach for program participation. If one of the Case Managers is working with a member that develops hypertension during pregnancy, they can help facilitate receipt of a blood pressure cuff and work with the member and her provider to ensure the member is comfortable with self- monitoring BP at home and notifying their provider with signs/ symptoms of worsening symptoms. Member can receive a blood pressure cuff from a DME provider with a physician's order. • Provider Directory | Find Care | UPMC Health Plan

Section 5(i). Health Education Resources and Account Management Tools

Special features	Description
Health education resources	*Take a Healthy Step* makes it easy to get information, knowledge, and resources to help you guide your healthcare needs and healthcare costs. You can earn reward dollars and save more money by picking the best healthcare options for you. Educate yourself on your health by: • Asking your doctor for generic drugs • Reviewing treatment options for your condition on UPMC Health Plan member site, and possibly avoid costly procedures • Working with a health coach to assist with your health decisions • Calling the Nurse Advice Line if you have questions on any health issue Our secure member portal, UPMC Health Plan member site, gives you instant access to tools and support. You can earn and track reward dollars, search for a doctor, review claims and spending account balances, chat with a Member Services Healthcare Concierge, and more. Once you log in to UPMC Health Plan member site, complete your *My*Health Questionnaire and earn 50 points. Your answers generate a simple summary of your current health status and customize UPMC Health Plan member site with activities that benefit you the most. UPMC Health Plan provides health education, decision-making, and price and quality comparison tools. You are able to access more than 200 health topics covering many common conditions, procedures, and alternative treatments. You'll also find online health coaching, helpful videos, and downloadable educational materials. Join our health discussion online. Visit the UPMC MyHealth Facebook page or follow @UPMCMyHealth on Twitter for health and wellness information. Or read the UPMC *My*Health Matters blog from our health and nutrition experts that cover a variety of topics that will inspire you to take an active role in your health. To get the most out of your benefits, log in to UPMC Health Plan member site at www.upmchealthplan.com/PSHB. To create an account click on Sign Up and use the number on your member ID card to register.
Account management tools	If you have an HSA, • You will receive a monthly statement outlining your account balance and activity. • Your HSA balance will be available through UPMC Health Plan member site. Visit www.upmchealthplan.com/PSHB and login to UPMC Health Plan member site using the member identification number on your member ID card. If you have an HRA, • Your HRA balance will be available through UPMC Health Plan member site. Visit www.upmchealthplan.com/PSHB and login to UPMC Health Plan member site using the member identification number on your member ID card. Your balance will also be shown on your EOB form.
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.upmchealthplan.com/PSHB.

	Pricing information for medical care is available at www.upmchealthplan.com/PSHB. Pricing information for prescription drugs is available at www.upmchealthplan.com/PSHB. Link to online pharmacy through www.upmchealthplan.com/PSHB. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.upmchealthplan.com/PSHB.
Care support	Patient safety information is available online at www.upmchealthplan.com/PSHB. Case Managers

Non-PSHB Benefits Available to Plan Members

The benefits on this page are not part of the PSHB contract or premium, and you cannot file an PSHB disputed claim about them. Fees you pay for these services do not count toward PSHB deductibles or catastrophic protection (out-of-pocket maximums). These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines.

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

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

You can present your UPMC Health Plan identification card at the time of service. There is no additional enrollment form or ID card needed. To find a participating dentist or if you have questions visit our website at https://www.upmchealthplan.com/pshb/additional-benefits/dental-vision-hearing.aspx or contact UPMC Health Plan by phone at 833-288-6901 for information. Representatives are available Monday through Friday from 8 a.m. to 6 p.m.

UPMC Vision *Care*: Limited vision coverage for examinations only is included with your enrollment in either the UPMC Health Plan HMO or HDHP plan option through UPMC Vision Care. View your coverage benefit on the UPMC Health Plan PSHB website. UPMC Vision *Care* participants are eligible for discounts on LASIK surgery when received by one of the following preferred providers: UPMC Eye Center, TLC Vision, or QualSight.

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

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

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

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Breast augmentation is not covered as a part of gender affirmation from male to female.
- Services or supplies we are prohibited from covering under the Federal law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 833-288-6901, or at our website at www.upmchealthplan.com/PSHB.

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

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

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

Submit your claims to:

UPMC Health Plan

Claims Department

P.O. Box 2999

Pittsburgh, PA 15230-2999

Prescription drugs

Submit your claims to:

UPMC Health Plan

Claims Department

P.O. Box 2999

Pittsburgh, PA 15230-2999

PDP EGWP- How to file a claim

If you recently paid cash for a covered medication, complete the form below to apply for reimbursement for Part D prescription drugs. Please follow these steps to submit a prescription drug claim reimbursement form to us.

1. Open this form:
   - UPMC for Life Prescription Drug Claim Reimbursement Form
   - UPMC for Life Complete Care (HMO D-SNP) Prescription Drug Claim Reimbursement Form
3. Print the form. Follow the instructions on the form and fill out as completely as possible.
4. For your claim to be processed, you will need to get your prescription receipts or patient history printout from your pharmacy.
5. Mail the form and your receipts to us at the address below. Please do not staple or attach your receipts to another piece of paper.

UPMC *for Life*/UPMC *for Life* Complete Care Pharmacy Services Department
U.S. Steel Tower, 12th Floor
600 Grant Street
Pittsburgh, PA 15219

Other supplies or services

Submit your claims to:

UPMC Health Plan

Claims Department

P.O. Box 2999

Pittsburgh, PA 15230-2999

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

Authorized Representative

You may designate a representative of your choice, such as family member, friend, advocate, or attorney, to act on your behalf at any point during the Complaint or Grievance process. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

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

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

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.upmchealthplan.com/PSHB, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8a. Medicare PDP EGWP Disputed Claims Process.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Complaints & Grievances Department by writing to UPMC Health Plan, Complaints/ Grievances/Appeals, P.O. Box 2939, Pittsburgh, PA 15230-2939 or calling 1-833-288-6901 (TTY:711).

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

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

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

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

Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: **UPMC Health Plan** **Complaints/Grievances/Appeals Department** **P.O. Box 2939** **Pittsburgh,PA 15230-2939** c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

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

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

2

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

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

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

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

3

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

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, room 3443, NW, Washington, DC 20415

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

Step	Description
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute. Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 833-288-6901. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at202-936-0002 between 8 a.m. and 5 p.m. Eastern Time. Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8a.

Section 8(a). Medicare PDP EGWP Disputed Claims Process

When a claim is denied in whole or in part, you may appeal the denial. When a request is denied in whole or in part, you may appeal the denial.

Our Plan follows the Medicare Part D appeals process.

How to make a Level 1 appeal

An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination**.

A fast appeal is also called an **expedited redetermination**.

Step 1: **Decide if you need a standard appeal or a fast appeal.**

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72hours. If your health requires it, ask for a fast appeal.

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision.
  - ***If your health requires it, ask us to give you a fast coverage decision.***

Step 2: **You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.**

For standard appeals, submit a written request or call us.

Fax: 412-454-7920

Write:

UPMC for Life Attn

Appeals and Grievances

P.O. Box 2939

Pittsburgh, PA 15230-2939

- For fast appeals either submit your appeal in writing or call us at 1-833-869-6924 (TTY users should call 711).
- **We must accept any written request**, including a request submitted on the CMS Model Coverage

Determination Request Form, which is available on our website www.upmchealthplan.com/medicare/documents-and-forms. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.

- **You must make your appeal request within 65 calendar days** from the date on the written notice

we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.** You and

your doctor may add more information to support your appeal.

Step 3: **We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your

coverage request. We check to see if we were following all the rules when we said no to your request.

We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer within 72 hours after we receive your appeal. We

will give you our answer sooner if your health requires us to. If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have

agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that

explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your

appeal. We will give you our decision sooner if you have not received the drug yet and your health

condition requires us to do so.

- If we do not give you a decision within 7 calendar days, we are required to send your request on to

Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly

as your health requires, but no later than **7 calendar days** after we receive your appeal.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that

explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer within **14 calendar days** after we receive your request.

o If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals

process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to

you within **30 calendar days** after we receive your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that

explains why we said no. We will also tell you how you can appeal.

Step 4: **If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals

process.

How to make a Level 2 appeal

The formal name for the independent review organization is the **Independent Review Entity**. It is sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

***Step 1*: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.**

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your case file. **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

***Step 2:* The independent review organization reviews your appeal.**

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

***Step 3:* The independent review organization gives you their answer.**

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must

provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must provide the drug coverage that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no **to part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **turning down your appeal**). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

***Step 4*: If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.upmchealthplan.com/PSHB.

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

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

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

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

Suspended PSHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these programs, eliminating your PSHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

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

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

• **Medicaid**	When you have this Plan and Medicaid, we pay first. **Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance:** If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.
When other Government agencies are responsible for your care	We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.
When others are responsible for injuries	Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage. If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise. We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received. Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed. We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights. If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage	Some PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.
Clinical trials	Your benefit plan covers routine clinical services that are part of a clinical trial or research study approved by an Institutional Review Board as well as medically necessary services to treat complications arising from participation in the clinical trials and studies. These services must be prior authorized by UPMC Health Plan and all plan limitations apply.
When you have Medicare	For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

You can find more information about how our plan coordinates benefits with Medicare in UPMC Health Plan at upmchealthplan.com/PSHB

The Original Medicare Plan (Part A or Part B)

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

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.
When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 833-288-6901 or see our website at www.upmchealthplan.com/PSHB.

Medicare Part B Premium Reimbursement

We offer two options designed to help retired Standard Option HMO members who are enrolled in Medicare Parts A and B with their Medicare Part B premium. The first option you may choose is to enroll in "UPMC *for Life* PSHB Retirees HMO" Medicare Advantage plan; if you choose this option the benefits of the new plan will apply. In addition to partial reimbursement of your Medicare Part B premium, we will cover additional benefits, including several $0 cost services and hearing aids. The second option is to be covered by the Standard Option HMO and Original Medicare (Parts A and B), and you choose not to enroll in the UPMC *for Life* PSHB Retirees, then your coinsurance will be reduced to 0% after the calendar year deductible is met. Whichever option you choose you will be eligible for up to a $800 Medicare Part B premium reimbursement. UPMC Health Plan will reimburse enrolled members up to $66.67 per month up to a maximum of $800 per year for Medicare Part B premium through a health reimbursement arrangement (HRA). This reimbursement is available once per year and must be requested through our portal with proof of payment

You may enroll in this program if:

- You enroll in the Plan's Standard Option HMO
- You have Medicare Parts A and B
- The PSHB subscriber completes an additional application for enrollment in UPMC *for Life* PSHB Retirees

If, for any reason, you do not meet the enrollment requirements for UPMC for Life PSHB Retirees you will no longer be eligible to participate in the program. Your reimbursements will end and your regular PSHB Standard Option HMO will resume.

To learn more about "UPMC *for Life* PSHB Retirees" and how to enroll, call us at 1-844-761-0083. Our hours of operation are Oct. 1 – March 31 seven days a week from 8 a.m. to 8 p.m. and April 1 – Sept. 30 Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 9 a.m. to 3 p.m. or visit our website at Postal Employee Health Benefits (PSHB) | UPMC Health Plan TTY users should call 711.

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227) (TTY:877-486-2048) or at www.medicare.gov. If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: We offer a Medicare Advantage plan known as "UPMC *for Life* PSHB Retirees HMO". UPMC *for Life* PSHB Retirees HMO enhances your PSHB coverage by lowering cost-sharing for many services and/or adding benefits. If you have Medicare Parts A and B, and you reside in our Medicare Advantage plan area, you are able to enroll in UPMC *for Life* PSHB Retirees. Enrolling in UPMC *for Life* PSHB Retirees does not change your PSHB premium. Your enrollment is in addition to your PSHB Standard Option enrollment: however, your benefits will be provided under the UPMC *for Life* PSHB Retirees and are subject to Medicare rules. If you are considering enrolling in UPMC *for Life* PSHB Retirees , please call us at 1-844-761-0083. Our hours of operation are Oct. 1 – March 31 seven days a week from 8 a.m. to 8 p.m. and April 1 – Sept. 30 Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 9 a.m. to 3 p.m. or visit our website at Postal Service Health Benefits (PSHB) | UPMC Health Plan TTY users should call 711.

PSHB annuitants that are enrolled in the PSHB Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan receive additional benefits and cost savings.

Annual Deductible

Standard Option HMO You pay without Medicare Part B: $850 per individual

Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan: You pay $0 per individual

Standard Option You pay with Medicare Part B: $700 per individual

Annual Out of Pocket Maximum

Standard Option You pay with or without Medicare Part B: $6,000 per individual

Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan: You pay $3,400 per individual

Medicare Part B Premium Reimbursement Offered

Standard Option You receive without Medicare Part B: None

Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan with Medicare Part B:

You receive up to $800 per calendar year submitted once per year with a proof of premium payment and reimbursement form

Primary Care Provider

Standard Option You pay with or without Medicare Part B: $20

Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan: You pay $0

Specialist Physician

Standard Option You pay with or without Medicare Part B: $50

Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan: You pay $25

Inpatient Hospital

Standard Option You pay without Medicare Part B: You pay 20% after deductible

Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan: You pay $0

Outpatient Hospital

Standard Option You pay without Medicare Part B: You pay 20% after deductible

Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan: You pay $0

Standard Option HMO with Medicare Part B: Deductible then 0%

Prescription Drugs

Retail (up to 30-day maximum supply) Standard Option You pay with or without Medicare Part B: $20 generic, $50 preferred brand, $100 non-preferred brand

Retail (up to 30-day maximum supply) Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan : $0/$15 generic, $10/$20 preferred brand, $47 non-preferred brand

Mail Order (90-day supply) Standard Option You pay with or without Medicare Part B: 2x retail copayment

Mail Order (90-day supply) Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan : $0/$30 generic, $20/$40 preferred brand, $117.50 -$141 non-preferred brand

Specialty Drugs (up to 30-day maximum supply) Standard Option You pay with or without Medicare Part B: 50% coinsurance with a maximum of $250

Specialty Drugs (up to 30-day maximum supply) Standard Option HMO and UPMC *for Life* PSHB Retirees Medicare Advantage Plan : $300

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (1-800-633-4227), (TTY:877-486-2048) or at www.medicare.gov.

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

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

- **Medicare Part D Prescription Drugs Plans**

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

- **Medicare Prescription Drug Plan (PDP) Drug Plan Employer Group Waiver Plan (EGWP)**

If you are enrolled in Medicare Part A and/or Part B, and are not enrolled in our Medicare Advantage Prescription Drug Plan (MAPD), you will be automatically group enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note:You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

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

The PDP EGWP opt out process:

If you were automatically group enrolled into our PDP EGWP and choose to opt out

Contact us at 844-761-0083. Our hours of operation are Oct. 1 – March 31 seven days a week from 8 a.m. to 8 p.m. and April 1 – Sept. 30 Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 9 a.m. to 3 p.m. TTY users should call 711.

The PDP EGWP disenrollment process:

When you are enrolled in our PDP EGWP, you may choose to disenroll at any time.

Contact us at 844-761-0083

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our MAPD during Open Season or for a QLE and receive PSHB Program Prescription Drug Coverage.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance, 844-761-0083

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation		✓*
8) Are a Postal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30-month coordination period)**		✓
• Medicare based on ESRD **(after the 30-month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Calendar year deductible

If you enroll for family coverage, the family deductible must be met by one or more members of the family before any benefits will be paid.

Catastrophic Limits

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

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

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

Clinical trials cost categories

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

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance See Section 4, page 26

Copayment See Section 4, page 26

Cost-sharing See Section 4, page 26

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

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

Deductible See Section 4, page 26

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

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

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

1. The intervention does not have FDA approval to market for the specific relevant indication(s); or
2. Available scientific evidence and/or prevailing peer review medical literature do not indicate that the treatment is safe and effective for treating or diagnosing the relevant medical condition or illness; or
3. The intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or
4. The intervention does not improve health outcomes; or
5. The intervention is not proven to be able to be replicated outside the research setting.

If an intervention as defined above is determined to be Experimental/Investigative at the time of service, it will not receive retroactive coverage even if it is found to be in accordance with the above criteria at a later date.

Group health coverage Group health coverage is coverage offered through an employment relationship to employees or former employees of that organization and their eligible dependents or Medicare.

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

Medicare Part A Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

Medicare Part B Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.

Medicare Part D Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Prescription Drug Plan (MAPD).

Medicare Part D EGWP A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.

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

1. Commonly recognized throughout the physician's specialty as appropriate for the diagnosis and/or treatment of the member's condition, illness, disease or injury
2. Provided in accordance with standards of good medical practice and consistent with scientifically based guidelines of medical, research, or healthcare coverage organizations or governmental agencies that are accepted by UPMC Health Plan
3. Can reasonably be expected to improve an individual's condition or level of functioning; and
4. Is in conformity, at the time of treatment, with medical management criteria/guidelines adopted by UPMC Health Plan or its designee
5. Not provided only as a convenience or comfort measure or to improve physical appearance; and
6. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

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

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

Plan allowance Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Participating providers accept our plan allowance, so you will be billed no more than the applicable cost-sharing amount when you utilize participating providers.

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

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

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

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

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

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

Surprise bill An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Us/We Us and We refer to UPMC Health Plan

You You refers to the enrollee and each covered family member.

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

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

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Member Service Department at 833-288-6901. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	If you enroll for family coverage, the family deductible must be met by one or more members of the family before any benefits will be paid. The deductible is combined for services received from both network and out-of-network providers.
Catastrophic limit	When you use participating providers, you are protected by an annual catastrophic limit for out-of-pocket expenses for covered services. After your coinsurance, prescription copayments, and deductibles total the out-of-pocket limit, you do not have to pay any more for covered services. There are separate out-of-pocket limits for Self Only, Self Plus One or Self and Family coverage, as well as network and out-of-network expenses. Certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, or amounts in excess of the Plan allowance). The family out-of-pocket maximum must be met by one or more members of the family before benefits will be paid at 100%.
Copayment (prescription drugs)	See Section 4, page 26
Deductible	See Section 4, page 26
Coinsurance	See Section 4, page 26
Cost-sharing	See Section 4, page 26
Health Reimbursement Arrangement (HRA)	Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses. If you enroll in the HDHP option and you are not eligible for a Health Savings Account (HSA), an HRA will be provided instead. You can use funds in your HRA to help pay your health plan deductible, and/or for certain expenses that don't count toward the deductible. **HRA features include:** 1. Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment 2. Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP 3. Unused credits carryover from year to year 4. HRA credit does not earn interest 5. HRA credit is forfeited if you leave Federal employment or switch health insurance plans
Health Savings Account (HSA)	Health Savings Accounts provide a means to help you pay out-of-pocket expenses. By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA benefits within the last three months, or do not have other health insurance coverage other than another high deductible health plan. In addition to the monthly contribution the HDHP will make to your HSA, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

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

HSA features include:

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

Premium contribution to HSA/HRA

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

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits for the Standard Option 2025

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.upmchealthplan.com/PSHB. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $850 Self Only/$1,700 Self Plus One or Self and Family calendar year deductible.

Standard Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $50 specialist	34
Services provided by a hospital: • Inpatient	20% of the Plan allowance	59
Services provided by a hospital: • Outpatient	20% of the Plan allowance	60
Emergency benefits: • In-area	$150 copay per emergency room visit	63
Emergency benefits: • Out-of-area	$150 copay per emergency room visit	63
Mental health and substance use disorder treatment: Inpatient*	20% of the Plan allowance	65
Mental health and substance use disorder treatment: Outpatient	$20 copay per outpatient visit	65
Prescription drugs: • Retail Pharmacy — up to a 30-day supply (or up to a 90-day supply for three copayments)	$20 generic $50 preferred brand-name $100 non-preferred brand-name	67
Prescription Drugs: • Specialty prescription drugs — up to 30-day supply	50% coinsurance up to a maximum of $250	67
Prescription drugs: • Mail order — up to a 90-day supply	$40 generic $100 preferred brand-name $200 non-preferred brand-name Specialty prescription drugs are not covered through mail-order	68
Prescription Drugs: • Medicare PDP EGWP		75
Dental care:		81

	Limited Dental benefits and discounts under a non-PSHB benefit program	
Vision care:	Nothing for routine eye exam. Once every 24 months for adults and children.	46
Special features:	• HealthCare Concierge Team • Health Incentive Account • *My*Health Health and Wellness • UPMC Health Plan member site • *My*Health Questionnaire • *My*Health Community • Health Coaching • *My*Health Advice Line • UPMC Anywhere Care • Health Plan Mobile App • Tobacco Cessation • RXWell • Assist America • Services for Members who have a Hearing Impairment • Flexible Benefits Option	82
Protection against catastrophic costs (out-of-pocket maximum):	$6,000 Self Only or $12,000 Self Plus One or Self and Family per year.	29

Summary of Benefits for the HDHP 2025

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.upmchealthplan.com/PSHB. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2025 for each month you are eligible for the Health Savings Account (HSA), we will deposit $75 per month for Self Only enrollment or $150 per month for Self Plus One or Self and Family enrollment to your For the HSA, you must use your HSA or pay out of pocket to satisfy your calendar year deductible of $2,000 for Self Only and $4,000 for Self Plus One or Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $900 for Self Only and $1,800 for Self Plus One or Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the $2,000 Self Only/$4,000 Self Plus One or Self and Family calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other healthcare professional.

HDHP Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	In-Network: 15% Out-of-Network: 40%	104
Services provided by a hospital: • Inpatient	In-Network: 15% Out-of-Network: 40%	127
Services provided by a hospital: • Outpatient	In-Network: 15% Out-of-Network: 40%	127
Emergency benefits: • In-area	In-Network: 15% Out-of-Network: 15%	130
Emergency benefits: • Out-of-area	In-Network: 15% Out-of-Network: 15%	130
Mental health and substance use disorder treatment:	In-Network: 15% Out-of-Network: 40%	132
Prescription drugs: • Retail pharmacy — up to a 30-day supply (or up to a 90-day supply for three copayments)	$20 generic drugs $50 preferred brand-name drugs $100 non-preferred brand-name drugs	134
Prescription drugs: Specialty prescription drugs — up to a 30-day supply	50% of the cost up to a maximum of $250	134
Prescription drugs: • Mail order — up to a 90-day supply	$40 generic drugs $100 preferred brand-name drugs $200 non-preferred brand-name drugs Specialty prescription drugs are not covered through mail-order	135

HDHP Benefits	You pay	Page
Prescription drugs: • Medicare PDP EGWP		141
Dental care:	Limited Dental benefits and discounts under a non-PSHB benefit program.	149
Vision care:	Nothing for routine eye exam. Once every 24 months for adults and children.	113
Special features:	• HealthCare Concierge Team • Health Incentive Account • *My*Health Health and Wellness • UPMC Health Plan member site • *My*Health Questionnaire • *My*Health Community • Health Coaching • *My*Health Advice Line • UPMC Anywhere Care • Health Plan Mobile App • Tobacco Cessation • RXWell • Assist America • Services for Members who have a Hearing Impairment • Flexible Benefits Option	150
Protection against catastrophic costs (out-of-pocket maximum):	In-Network: $6,000 Self Only or $12,000 Self Plus One or Self and Family Out-of-Network: $8,000 Self Only or $16,000 Self Plus One or Self and Family	91

2025 Rate Information for UPMC Health Plan

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/

To review premium rates for all PSHB health plan options please go to **https://www.opm.gov/healthcare-insurance/pshb/premiums/**

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
HDHP Option Self Only	G9A	$165.98	$55.33	$359.63	$119.88
HDHP Option Self Plus One	G9C	$391.46	$130.48	$848.15	$282.72
HDHP Option Self and Family	G9B	$433.49	$144.50	$939.23	$313.08
Standard Option Self Only	G9D	$227.94	$75.98	$493.87	$164.62
Standard Option Self Plus One	G9F	$555.50	$185.16	$1,203.57	$401.19
Standard Option Self and Family	G9E	$621.77	$207.26	$1,347.17	$449.06