

Thank you for applying for coverage from UPMC Health Plan. Until you receive a Confirmation of Enrollment letter from UPMC Health Plan, it is important that you do not cancel any other coverage. If accepted by UPMC Health Plan, you will receive a Confirmation of Enrollment letter with the policy effective date. **Canceling your existing coverage before your new policy goes into effect will result in your being uninsured for that time period.**

When completing this application:

- You must provide the complete home address, telephone number, and Social Security number for all applicants.
- You must complete all questions and sign this application.
- You must select a requested effective date.

Without this information, UPMC Health Plan will not be able to process your application.

If your coverage has been terminated within the last 12 calendar months and an outstanding premium balance remains on your account, you will be required to pay all current and past due premiums before you and any dependents can enroll in future UPMC *Advantage* coverage.

Easy steps to apply:

- In black ink carefully complete pages 2 through 15, in order.
- If you are not working with an insurance agent/producer, please return the completed application to the following address:
ATTN: Sales, UPMC Health Plan
U.S. Steel Tower
600 Grant Street
Floor 4
Pittsburgh, PA 15219
- Please retain a copy of this completed application.

UPMC *Advantage*

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., and/or UPMC Benefit Management Services Inc.

Eligibility status

Please check the box that applies to you.

Are you applying during the annual Open Enrollment Period? **If yes, choose a requested effective date at the bottom of this page. Then turn to page 3.**

Are you applying because of a qualifying life event? **If yes, complete the rest of this section.**

Typically, you may enroll in a UPMC *Advantage* plan only during the annual Open Enrollment Period, November 1, 2018, through December 15, 2018. However, some situations may qualify you to enroll in a plan outside this period.

Please read the following statements carefully and check the box that applies to you. When you check a box, you are certifying that, to the best of your knowledge, you are eligible for an exception to the standard Open Enrollment Period. If we later determine that the information you provided is incorrect, you could be disenrolled from this plan.

Qualifying Life Event

Did you or anyone in your household lose health coverage in the **last 60 days**, OR do you expect to lose it in the **next 60 days**? (Voluntarily giving up coverage or losing coverage because of failure to pay premiums does not qualify you for special enrollment.)

Yes No

Have any of these qualifying life events happened to you during the past 60 days?

- | | |
|---|--|
| Gained a dependent due to birth. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gained a dependent due to adoption or foster care. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gained a dependent due to marriage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lost a dependent due to death in the household. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lost a dependent due to divorce. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Permanently moved into UPMC Health Plan's service area. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Received a court order that affects insurance coverage.
This may be, for example, a divorce decree or custody order. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had a change in income that affects your eligibility for premium tax credits or cost-sharing reductions.
(For people already enrolled in Federally Facilitated Marketplace coverage, this affects eligibility for premium tax credits or cost-sharing reductions.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gained citizenship or lawful presence in the United States. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Released from incarceration. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lost or will lose in the next 60 days minimum essential coverage due to aging off a parent's coverage at 26 or losing eligibility for Medicaid, CHIP, etc. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Enrollment or plan error.* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gained status in a federally recognized tribe or Alaska Native Claims Settlement Act Corp.* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other qualifying changes,* such as domestic abuse or spousal abandonment, data matching issues or other exceptional circumstances. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you do not see your applicable qualifying event above and you are unsure if you are eligible, please contact the Federally Facilitated Marketplace at 1-800-318-2596.

You have 60 calendar days from these events to enroll in a new plan. You will be required to provide supporting documentation to prove eligibility. This application will not be considered complete and will not be processed unless acceptable documentation is provided to UPMC Health Plan within 60 days of your qualifying event.

Date of qualifying event _____

Requested effective date _____

**This event may only be available to you through the Federally Facilitated Marketplace. To see if you are eligible, please call the Federally Facilitated Marketplace at 1-800-318-2596.*

How to determine your effective date: If you accept coverage between the first and the last day of the month, you may select an effective date of the first day of the following month or the first day of the second following month. For example, if you accept on January 15, your coverage may be effective on February 1 or March 1. If you enroll through the Federally Facilitated Marketplace (FFM), your effective date is determined by the FFM.

Special cases: Newborn and newly adopted children are covered effective on the date of their birth or adoption. If you marry or if you lose minimum essential coverage, your coverage is effective on the first day of the month **after** the month in which you have accepted coverage. For example, if you accept coverage in January, your coverage will be effective February 1.

Applicant information

Name (Last, First, Middle Initial)	Social Security Number	Date of Birth	Age	Sex (M/F)
Primary Applicant:				
Parent/Guardian (if Primary Applicant is under 18):				
Spouse/Domestic Partner:				
Dependent Children Under 26				
a.				
b.				
c.				
d.				
e.				

Tobacco use

Tobacco use means that a person currently uses or has used tobacco an average of four or more times a week within the past six months. Tobacco includes all tobacco products. However, religious or ceremonial uses of tobacco (for example, by Native American Indians and Alaskans) are specifically exempt. **Do you or any dependents over the age of 18 use tobacco? If yes, please provide the following information.**

Name of Tobacco User	Date of Last Use	Would this tobacco user like to enroll in a tobacco cessation program with UPMC Health Plan?* Answer Yes or No.

*If you answer yes and you become a UPMC Health Plan member, a health coach may contact you to discuss our tobacco cessation program. You may also enroll by calling us at 1-800-807-0751 after your effective date.

Primary Applicant's Home Address (PO boxes are not accepted)		
Street Address 1:		
Street Address 2:		
City:	State:	ZIP Code:
Email Address:		
Primary Applicant's Mailing Address <input type="checkbox"/> Same as Home Address		
Street Address 1:		
Street Address 2:		
City:	State:	ZIP Code:
Spouse, Domestic Partner, or Dependent's Address (if living elsewhere)		
Name of Spouse, Domestic Partner, or Dependent:		
Street Address:		
City:	State:	ZIP Code:
<i>PO boxes are not accepted.</i>		
Primary Applicant's Phone Number		
Home:		
Other:		
Mobile:		

We want to make sure that all our members get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all members receive and make sure that everyone gets the highest quality of care. Please select one or more that apply.

<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African-American	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other, please specify: _____	<input type="checkbox"/> Declined

What language do you feel most comfortable speaking with your doctor or nurse? Please select one or more that apply.

<input type="checkbox"/> African languages	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Arabic	<input type="checkbox"/> Armenian	<input type="checkbox"/> Chinese	<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> French Creole
<input type="checkbox"/> German	<input type="checkbox"/> Greek	<input type="checkbox"/> Gujarati	<input type="checkbox"/> Hebrew	<input type="checkbox"/> Hindi	<input type="checkbox"/> Hungarian	<input type="checkbox"/> Italian	<input type="checkbox"/> Japanese
<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian	<input type="checkbox"/> Miao Hmong	<input type="checkbox"/> Mon-Khmer Cambodian	<input type="checkbox"/> Navajo	<input type="checkbox"/> Other American Indian Languages	<input type="checkbox"/> Farsi	<input type="checkbox"/> Polish
<input type="checkbox"/> Portuguese	<input type="checkbox"/> Portuguese Creole	<input type="checkbox"/> Russian	<input type="checkbox"/> Scandinavian languages	<input type="checkbox"/> Serbo-Croatian	<input type="checkbox"/> Spanish	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Thai
<input type="checkbox"/> Urdu	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Yiddish	<input type="checkbox"/> Pennsylvania Dutch	<input type="checkbox"/> Other, please specify: _____	<input type="checkbox"/> Do not know	<input type="checkbox"/> Unavailable	<input type="checkbox"/> Declined

In which language would you feel most comfortable reading medical or health care instructions? Please select one or more that apply.

<input type="checkbox"/> African languages	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Arabic	<input type="checkbox"/> Armenian	<input type="checkbox"/> Chinese	<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> French Creole
<input type="checkbox"/> German	<input type="checkbox"/> Greek	<input type="checkbox"/> Gujarati	<input type="checkbox"/> Hebrew	<input type="checkbox"/> Hindi	<input type="checkbox"/> Hungarian	<input type="checkbox"/> Italian	<input type="checkbox"/> Japanese
<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian	<input type="checkbox"/> Miao Hmong	<input type="checkbox"/> Mon-Khmer Cambodian	<input type="checkbox"/> Navajo	<input type="checkbox"/> Other American Indian Languages	<input type="checkbox"/> Farsi	<input type="checkbox"/> Polish
<input type="checkbox"/> Portuguese	<input type="checkbox"/> Portuguese Creole	<input type="checkbox"/> Russian	<input type="checkbox"/> Scandinavian languages	<input type="checkbox"/> Serbo-Croatian	<input type="checkbox"/> Spanish	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Thai
<input type="checkbox"/> Urdu	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Yiddish	<input type="checkbox"/> Pennsylvania Dutch	<input type="checkbox"/> Other, please specify: _____	<input type="checkbox"/> Do not know	<input type="checkbox"/> Unavailable	<input type="checkbox"/> Declined

Plan selection

Instructions: On the next two pages, you will choose your network and medical plan. When you make your selection, it is important to consider the level of coverage you need, your budget, where you live, and if your provider is in the network.

1. Choose one network

UPMC Health Plan offers multiple network options. The network refers to where you have access to participating providers and hospitals for routine care. Participating providers in each network vary. Make one selection for your network. You must choose a network that is offered in the county where you live. All networks offer you full in-network access to all UPMC-owned hospitals and providers.

To find out if your doctor or specialist is part of a UPMC Advantage network, visit www.upmchealthplan.com/find, call 1-877-563-0292, or contact your provider.

UPMC Partner Network

Network offered to individuals living in these counties:

Allegheny	Blair	Erie	Lycoming	Tioga
Bedford	Clinton	Lawrence	Mercer	Venango

UPMC Select Network

Network offered to individuals living in these counties:

Allegheny	Fayette
Beaver	Washington
Butler	Westmoreland

UPMC Premium Network

Network offered to individuals living in these counties:

Adams	Clinton	Indiana	Potter
Allegheny	Clearfield	Jefferson	Snyder
Armstrong	Cumberland	Lackawanna	Somerset
Beaver	Columbia	Lancaster	Sullivan
Bedford	Crawford	Lawrence	Tioga
Blair	Dauphin	Lebanon	Union
Bradford	Elk	Luzerne	Venango
Butler	Erie	Lycoming	Warren
Cambria	Fayette	McKean	Washington
Cameron	Forest	Mercer	Westmoreland
Centre	Greene	Northumberland	Wyoming
Clarion	Huntingdon	Perry	York

2. Choose one plan

Make one selection for your medical plan. The cost of your coverage will be influenced by deductibles, coinsurance, copayments, and out-of-pocket maximums. All medical plans include Essential Health Benefits coverage for pediatric dental and vision. Optional adult dental coverage is available.

For residents of Western PA Choose one plan	Deductible Amount	
	Individual	Family
Plans available to residents of 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		
Bronze		
<input type="checkbox"/> UPMC Advantage Bronze \$6,950/\$35	\$6,950	\$13,900
Silver		
<input type="checkbox"/> UPMC Advantage Silver \$3,500/\$25	\$3,500	\$7,000
<input type="checkbox"/> UPMC Advantage Silver \$1,750/\$50	\$1,750	\$3,500
<input type="checkbox"/> UPMC Advantage Silver \$0/\$50	\$0	\$0
<input type="checkbox"/> UPMC Advantage Silver HSA \$2,700/20%* (Off-marketplace only)	\$2,700	\$5,400
<input type="checkbox"/> UPMC Advantage Silver \$2,000/\$60 (Off-marketplace only)	\$2,000	\$4,000
Gold		
<input type="checkbox"/> UPMC Advantage Gold \$800/\$20	\$800	\$1,600
Platinum		
<input type="checkbox"/> UPMC Advantage Platinum \$250/\$20	\$250	\$500
†Catastrophic		
<input type="checkbox"/> UPMC Advantage Catastrophic \$7,900/\$0	\$7,900	\$15,800

*If you choose to enroll in the UPMC Advantage Silver HSA \$2,700/20% plan, you may be eligible to open a health savings account (HSA) and begin saving money for health care expenses. Would you like to be contacted by UPMC Health Plan's HSA partner to learn more about how to open a health savings account? (Please note, if you are claimed as a dependent on someone else's tax return, you will not be eligible to open an HSA.)

Yes No

†Catastrophic plans are offered to eligible individuals under 30 living throughout Pennsylvania. People 30 and older with a "hardship exemption" may buy a catastrophic plan. Financial hardship exemptions are determined by the Federally Facilitated Marketplace.

If you have questions or want to learn more about each plan, visit www.upmchealthplan.com/coverage, call 1-877-563-0292, or contact your producer/insurance agent.

For Residents of Eastern PA Choose one plan	Deductible Amount	
	Individual	Family
Plans available to residents of Clinton, Lycoming and Tioga counties		
Partner Network Plans		
Bronze		
<input type="checkbox"/> UPMC Advantage Bronze \$6,950/\$35	\$6,950	\$13,900
Silver		
<input type="checkbox"/> UPMC Advantage Silver \$3,500/\$25	\$3,500	\$7,000
<input type="checkbox"/> UPMC Advantage Silver \$1,750/\$50	\$1,750	\$3,500
<input type="checkbox"/> UPMC Advantage Silver \$0/\$50	\$0	\$0
<input type="checkbox"/> UPMC Advantage Silver HSA \$2,700/20%* (Off-marketplace only)	\$2,700	\$5,400
<input type="checkbox"/> UPMC Advantage Silver \$2,000/\$60 (Off-marketplace only)	\$2,000	\$4,000
Gold		
<input type="checkbox"/> UPMC Advantage Gold \$800/\$20	\$800	\$1,600
Platinum		
<input type="checkbox"/> UPMC Advantage Platinum \$250/\$20	\$250	\$500
†Catastrophic		
<input type="checkbox"/> UPMC Advantage Catastrophic \$7,900/\$0	\$7,900	\$15,800

Plans available to residents of Clinton, Lycoming and Tioga counties	Individual	Family
Premium Network Plans		
Bronze		
<input type="checkbox"/> UPMC Advantage Bronze \$6,950/\$35	\$6,950	\$13,900
Silver		
<input type="checkbox"/> UPMC Advantage Silver \$3,500/\$25	\$3,500	\$7,000
<input type="checkbox"/> UPMC Advantage Silver \$2,000/\$60 (Off-marketplace only)	\$2,000	\$4,000
Gold		
<input type="checkbox"/> UPMC Advantage Gold \$800/\$20	\$800	\$1,600

Plans available to residents of Adams, Bradford, Columbia, Cumberland, Dauphin, Lackawanna, Lancaster, Lebanon, Luzerne, Northumberland, Perry, Snyder, Sullivan, Union, Wyoming, and York counties	Individual	Family
Bronze		
<input type="checkbox"/> UPMC Advantage Bronze \$6,950/\$35	\$6,950	\$13,900
Silver		
<input type="checkbox"/> UPMC Advantage Silver \$3,500/\$25	\$3,500	\$7,000
<input type="checkbox"/> UPMC Advantage Silver \$2,000/\$60 (Off-marketplace only)	\$2,000	\$4,000
Gold		
<input type="checkbox"/> UPMC Advantage Gold \$800/\$20	\$800	\$1,600

*If you choose to enroll in the UPMC Advantage Silver HSA \$2,700/20% plan, you may be eligible to open a health savings account (HSA) and begin saving money for health care expenses. Would you like to be contacted by UPMC Health Plan's HSA partner to learn more about how to open a health savings account? (Please note, if you are claimed as a dependent on someone else's tax return, you will not be eligible to open an HSA.)

Yes No

†Catastrophic plans are offered to eligible individuals under 30 living throughout Pennsylvania. People 30 and older with a "hardship exemption" may buy a catastrophic plan. Financial hardship exemptions are determined by the Federally Facilitated Marketplace.

If you have questions or want to learn more about each plan, visit www.upmchealthplan.com/coverage, call 1-877-563-0292, or contact your producer/insurance agent.

3. Dental coverage

UPMC Health Plan adult dental coverage is administered by Dominion Dental Inc. Adult dental coverage is optional. If multiple family members apply for coverage on this application, only one dental plan option can be chosen. Coverage applies to all family members on the application who are age 19 and older. Please refer to the Dominion Dental Services policies for more information.

(Access PPO Plan Policy, Form# PA16PICOC; \$30 Preventive Plan Policy, Form# PA 16UPMC-COC-2).

To find out if a dentist participates in the Dominion Dental network, please visit www.DominionDental.com/upmcdentists and select your desired dental plan in the Plan dropdown menu.

Dental coverage must be paired with a medical plan.

Choose a Dominion Dental Services plan:

\$30 Preventive Plan

- Fixed member copayment of \$30 per general dentist office visit when diagnostic and preventive services are performed. Members must receive services from a participating network dentist.

Access PPO Plan

- Twice-a-year preventive services, including routine exams, cleaning, and bitewing x-rays. \$50 per insured person (\$150 family) deductible applies to all services. Member may receive services from any licensed dentist.

Statement of understanding

Review the completed application and read the section below carefully before signing.

I have read this application or had it read to me. I represent that the answers and statements on this application are true, complete, and correctly recorded.

Fraud Statement

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I understand and agree that: (1) this application and the payment of the initial premium do not give me immediate coverage; (2) incorrect or incomplete information on this application may result in avoidance of coverage or claim denial; (3) this completed application, and any supplements or amendments, will be made a part of any policy or certificate which may be issued; (4) the insurance producer may not change or waive any right or requirement, and is authorized to submit the application, to submit the initial premium or payment information, and to receive acceptance/denial information; and (5) providing false information or omitting relevant information in this application may result in the denial of claims or cancellation of coverage.

A request for new insurance coverage will require me to submit a completed application. I understand that my application will be void after 60 days if it has not been completed and submitted for review.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UPMC Health Plan, as explained in UPMC Health Plan's Notice of Privacy Practices. UPMC Health Plan may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I understand I have the right to retain a copy of this authorization. UPMC Health Plan's Notice of Privacy Practices may be reviewed at www.upmchealthplan.com or requested from Member Services at 1-855-489-3494.

If my coverage has been terminated within the past 12 calendar months and an outstanding premium balance remains on my account, I will be required to pay all current and past due premiums before I can enroll myself and my dependents in future UPMC Advantage Coverage.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

Do you have current insurance coverage this policy will replace? Yes No

If yes, please read this section and mark the checkbox below.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by UPMC Health Plan.* Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. Omissions or misstatements in the application could cause an otherwise valid claim to be denied.

Please note: if you have current coverage with UPMC Health Plan, it will not automatically terminate upon submission of this application for coverage. You must contact UPMC Health Plan separately to terminate your current coverage.

I have read and completely understand the Statement of Understanding.

I have read and completely understand the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance.

*UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., and/or UPMC Benefit Management Services Inc.

Insurance producer statement

If you worked with a producer to complete this application, please ask the producer to complete this section.

Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has read the completed application, or it has been read to him or her. The applicant is fully aware that any false statement or misrepresentation may result in voidance of coverage under the policy.

Signature of Insurance Producer: _____

Print Full Name: _____

Optional

The information gathered in this optional section will be used in a collaborative manner, with the focus on you, to help UPMC Health Plan provide the highest quality plan of care to you and your family. Our goal is to work together to improve your overall health. **This information will not be used to set premium rates or determine eligibility for coverage.**

Select your Primary Care Physician (PCP)

It's important you choose a PCP that participates in the network within your plan. Visit www.upmchealthplan.com/find to locate a PCP within your network.

Name of PCP (Last, First):
Street Address:
City, State, ZIP:

Who was your previous insurance carrier?

- Aetna/Coventry/HealthAmerica
- Capital BlueCross
- Geisinger
- Highmark
- UPMC

Policyholder Name: _____

Member ID Number: _____

- Other _____

Payment Reminder Texts

Now you can receive text reminders from UPMC Health Plan!

Text JOIN to 876247 to receive monthly payment reminders and other important plan benefit information from UPMC Health Plan. You can expect to receive approximately five text messages per month. Message and data rates may apply. No purchase required. Text STOP to end messages at any time. Text HELP for help.

Healthy Texts on the Go

Are you trying to create a new healthy habit? Or support your work with a health coach? A daily or weekly text message offering support, advice, and tips can be just the reminder you need to stay on track.

To sign up for this FREE service from UPMC Health Plan:

- Choose a topic that interests you (you can select more than one) and text the corresponding keyword to 876247.
 - Eat better: eatright
 - Manage stress: relax
 - Manage weight: lose
 - Be more active: befit
 - Stop smoking: breathe
 - Manage diabetes: regulate
- You'll get a response asking if you'd like to receive daily or weekly texts.
- Text back "1" or "STOP" at any time if you want to stop receiving texts.
- To contact a health coach, call 1-800-807-0751.

Note: Although UPMC Health Plan does not charge for the text messages, data and message rates from your carrier may apply

I authorize on behalf of myself and eligible dependents and spouse, if any, UPMC Health Plan to obtain health information to evaluate and manage care. This information cannot and will not be used to medically underwrite, set premium rates, or determine coverage eligibility. This information will be used by UPMC Insurance Services Division for all lawful purposes including, but not limited to, medical management and implementation of health/wellness initiatives.

Any health care provider, pharmacy benefit manager, or pharmacy-related service organization having any health information about my family or me is authorized to give it to UPMC Health Plan.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

This authorization shall remain valid for 30 months from the date of signature on this application. I (we) understand the following:

- A photocopy of this authorization is as valid as the original.
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UPMC Health Plan.
- I (we) may request revocation of this authorization as described in UPMC Health Plan's Notice of Privacy Practices.
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.
- UPMC Health Plan cannot condition purchase of its health plan or eligibility for benefits on my (our) refusal to sign this authorization.
- I understand I have the right to retain a copy of this authorization.

Once you become a UPMC Health Plan member, would you like to receive initial plan documents electronically **by accessing our member website?** (This gives you convenient 24/7 online access to your policy, schedules of benefits, and other important information about where you can access services.)

Yes No

Would you like to receive electronic marketing communications from UPMC Health Plan and its business units or affiliates? (If you decide you no longer wish to receive electronic communications, you may opt-out anytime by clicking the unsubscribe feature in the bottom of our emails.)

Yes No

Your signature below completes your application and indicates your agreement with the checkboxes you marked in this application. By signing below, you acknowledge and agree that you are signing on behalf of yourself and all dependents included in this application and agree that the information you have provided on behalf of yourself and your dependents is true and correct to the best of your knowledge and belief.

Signature of Primary Applicant: _____

Signature of Parent/Guardian
(if Primary Applicant is a minor): _____

Date

Relationship

Payment election

You must choose one of the payment methods below to make your first monthly payment. Once you are enrolled and you receive your first invoice, you can log in to *MyHealth OnLine* to enroll in autopay for your future monthly premium payments.

Card or Account Information:		
Name on Account:		
Billing Address:		
City:	State:	ZIP Code:
Country:		

Select Card Type:																					
<input type="checkbox"/> Visa	Card Number:																				
<input type="checkbox"/> MasterCard	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																				
<input type="checkbox"/> Discover	Expiration Date (MM/YY):																				

Or

Select Account Type:	
<input type="checkbox"/> Checking Account	ABA Routing Number:
<input type="checkbox"/> Savings Account	Account Number:

Payment Election Terms and Conditions

I hereby authorize UPMC Health Plan, its affiliates, and its subsidiaries to deduct insurance payments from my account at the financial institution named herein. The information herein is for the first month's premium payment. By providing payment information and submitting the application, I accept the rate for this plan. Online payments are subject to the terms and conditions of the online payment system, which can be found at https://pay.upmchp.com/MarketPlace/Files/OnlinePayment_TermsandConditions.pdf.

Timing of Payments

One-Time Payment

Payments made by deduction from your bank account will be withdrawn from your bank account within three business days. Business days are Monday through Friday, except for banking holidays.

Payments made by credit card will be charged to your card on the day the payment is made.

You are solely responsible for making payments prior to the due date, and you are solely responsible for any late fees charged by UPMC Health Plan for payments not made by the due date.

Your Account

Should you choose to pay by deduction from your bank account, it is your responsibility to ensure that there are sufficient funds in your bank account to cover the payment. If there is not enough money in your account, UPMC Health Plan will charge you a fee of \$20, in addition to any interest that you would otherwise owe UPMC Health Plan if the payment was late. You are also solely responsible for paying any fees and/or interest charged by your financial institution.

You are responsible for paying all reasonable collection charges and costs, including attorney's fees and expenses of collection, if your payment is dishonored, refused, or not paid on time.

You should print a copy of this authorization/receipt for your records. You should also check your bank account statement or credit card statement to verify that the amounts deducted from your account are correct. The payments made will appear on your statement as charges from UPMC HP Portal Online.

Cancellation

Once you submit a one-time payment, the payment cannot be cancelled.

Unauthorized or Disputed Payments

If you believe that someone has made an unauthorized payment through the website, you should contact your financial institution immediately. You are solely responsible for any unauthorized payments, although your financial institution may provide fraud protection.

In case of disputes or questions about your bill or payments that you have made, please contact UPMC Health Plan by phone at 1-855-489-3494. Customer Service is available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m.

After you have completed the application and before you sign it, review it carefully to be certain that all information has been properly recorded.

Your signature on page 13 completes your application and indicates your agreement with the checkboxes you marked in this application. By signing, you acknowledge and agree that you are signing on behalf of yourself and all dependents included in this application and agree that the information you have provided on behalf of yourself and your dependents is true and correct to the best of your knowledge and belief.

I have read and completely understand the Payment Election Terms and Conditions.

Nondiscrimination Notice

UPMC Health Plan¹ complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression. UPMC Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression.

UPMC Health Plan:

- Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:
 - Qualified sign language interpreters.
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters.
 - Information written in other languages.

If you need these services, contact the Member Services phone number listed on the back of your member ID card.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression, you can file a complaint with:

Complaints and Grievances
PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-888-876-2756 (TTY: 1-800-361-2629)
Fax: 1-412-454-7920
Email: HealthPlanCompliance@upmc.edu

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

¹UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-489-3494 (TTY: 1-800-361-2629).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-489-3494 (TTY: 1-800-361-2629)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-489-3494 (TTY: 1-800-361-2629).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-489-3494 (телетайп: 1-800-361-2629).

Wann du Deitsch (Pennsylvania German / Dutch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-489-3494 (TTY: 1-800-361-2629).

주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-855-489-3494 (TTY: 1-800-361-2629) 번으로 전화해 주십시오 .

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-489-3494 (TTY: 1-800-361-2629).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-489-3494 (رقم هاتف الصم والبكم: 1-800-361-2629).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-489-3494 (ATS: 1-800-361-2629).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-489-3494 (TTY: 1-800-361-2629).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-489-3494 (TTY: 1-800-361-2629).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-489-3494 (TTY: 1-800-361-2629).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-489-3494 (TTY: 1-800-361-2629).

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ យើងមានផ្តល់សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ ។ សូមទូរស័ព្ទទៅលេខ 1-855-489-3494 (TTY: 1-800-361-2629) ។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-489-3494 (TTY: 1-800-361-2629).

UPMC HEALTH PLAN

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

www.upmchealthplan.com

