Freedom now Home Care

UPMC rates

Effective 3/1/2019

UPMC EPO

2500/5000

Single	78.46
Employee + Spouse	454.84
Employee + Child (ren)	306.36
Family	481.19

UPMC PPO

2500/5000

Single	78.46
Employee + Spouse	546.34
Employee +Child(ren)	562.70
Family	578.89

All Rates are per pay

UPMC HEALTH PLAN

Employee Benefit Election & Change Form

For employer use only:

Employee Name: ____________________
Employer Group Name: ____________________
Producer Name: ____________________
Quote ID: ____________________

Medical Plan Details
Group #: ____________________
Subgroup #: ____________________
Effective Date: ____________________

Dental and/or Vision Plans
Group #: ____________________
Subgroup #: ____________________
Effective Date: ____________________

1. Reason for Application

☐ Open Enrollment ☐ COBRA ☐ Qualifying Event
☐ New Hire ☐ Mini-COBRA

2. Plan Description Name

Medical: ____________________
UPMC Dental *Advantage*: ____________________
UPMC Vision Care: ____________________
UPMC Vision *Advantage*: ____________________

3. Change of Status/Coverage

☐ Select/Change PCP
☐ Change Address
☐ Change Name
Former Name: ____________________

☐ COBRA
☐ Add Dependent
☐ Drop Dependent
☐ Birth

☐ Marriage
☐ Other: ____________________
☐ Date of Qualifying Event: ____________________

4. Employee Information

Employee Name: ____________________
Street Address: ____________________
City: ____________________ State: ________ ZIP Code: ________ Home Phone Number: ____________________
Work Phone Number: ____________________ First Day of Employment: ____________________ Retiree: ☐ Yes ☐ No

5. Covered Family Members and Benefit Enrollment Selection

Name (Last, First, MI)	SSN (Required)	Sex (M or F)	Birth Date (Month/Day/Year)	Dependent Code*	Email Address	PCP & Practice #**
Primary (Self)						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving:	
Spouse ☐ Domestic Partner†						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving:	

Dependent Children

	Name (Last, First, MI)	SSN (Required)	Sex (M or F)	Birth Date (Month/Day/Year)	Dependent Code*	Email Address	PCP & Practice #**
1							
Medical: ☐ Enroll ☐ Waive		Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving:	
2							
Medical: ☐ Enroll ☐ Waive		Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving:	
3							
Medical: ☐ Enroll ☐ Waive		Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving:	
4							
Medical: ☐ Enroll ☐ Waive		Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving:	
5							
Medical: ☐ Enroll ☐ Waive		Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving:	

**FTS = Full-Time Student; DD = Disabled Dependent (certification required) **Required for HMO plans only.*
†Not all employer groups offer domestic partner coverage. Please contact your employer group if you have questions.

Employee Name: ____________________

Detatch before submission

5. Covered Family Members and Benefit Enrollment Selection (continued)

Pediatric dental and vision services will be covered for individuals under age 19 in compliance with requirements under the Affordable Care Act for members of group plans with 50 or fewer employees. However, dependents under age 19 enrolled in a UPMC Health Plan medical plan may still enroll in select Standard commercial dental plan or Premium commercial dental plan — or in another carrier's employer-sponsored dental or vision plan. In cases of dual coverage, the essential health benefits (EHB) pediatric dental coverage will act as the primary coverage; Standard or Premium commercial dental plan will act as secondary coverage for EHB-eligible dependents.

The subscriber should make one selection for medical, dental, and vision coverage. If the subscriber waives medical, dental, or vision coverage, such coverage will not be available for his or her dependent(s). The dependent(s) must be enrolled in the same plan as the subscriber, unless the dependent(s) waives coverage. If the dependent(s) waives coverage, he or she must mark a reason.

Please sign here only if you are declining coverage for yourself and/or dependent(s).
I acknowledge I have been given the right to apply for this coverage; however, I, and/or my dependent(s), am/are electing not to enroll. I acknowledge that I, and/or my dependent(s), may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Signature of Employee: ______________________ Date: ____________

6. Other Group Health Insurance

Name of Covered Member: ______________________ Name of Health Insurance Company: ______________________

Policy Number: ______________________ Effective Date: ______________________

If you need additional space, attach a separate sheet of paper.

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

Disclosure of Personal Health Information

By acceptance of coverage and upon signing this application, for so long as I am enrolled in UPMC Health Plan, I understand, on behalf of myself and my eligible dependents and spouse, if any, that all of my/our health care, dental, and/or vision providers will release to UPMC Health Plan or its authorized agents all information related to my/our medical, dental, and vision history and treatment, including mental health, substance abuse treatment/conditions, and AIDS-related information, if any, for all lawful purposes relating to the administration of my health/dental/vision benefits, including determining or reviewing coverage claims, quality assurance, clinical resource management, and utilization review for services that I/we request or receive. I further understand that UPMC Health Plan will release such information to health care, dental, and/or vision entities for such purposes. My right to revoke this consent in writing at any time will not apply to the extent that UPMC Health Plan or any other provider already has acted in reliance on this statement. The term "UPMC Health Plan" collectively refer0s to UPMC Health Plan Inc., UPMC Health Coverage Inc., UPMC Health Options, Inc., and UPMC Health Benefits Inc.

I further understand that information will be released by, to, or among the various UPMC Insurance Services Division entities for all lawful purposes, including administration of workers' compensation and short-term disability, medical management, and implementation of health/wellness initiatives.

Authorization/Signature

I have read and agree with the terms as stated on this Employee Benefit Election & Change Form. Subject to revocation by me by written notice to my employer, I authorize the required deduction (if any) of applicable contributions from my wages.

I agree that all information on this Employee Benefit Election & Change Form is true and correct to the best of my knowledge and belief. I understand that this Election Form is the basis upon which coverage may be issued under the plan.

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 THAT PROVIDING FALSE INFORMATION OR OMITTING RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

UPMC Health Plan administers benefit plans underwritten by UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC Health Coverage Inc., and UPMC Health Options Inc. This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

Signature of Employee ______________________ Date ____________

Signature of Spouse/Domestic Partner (if to be covered) ______________________ Date ____________

Signature of Employer or Employer's Agent/Authorized Representative ______________________ Title ____________ Date ____________

Detatch before submission