

# Summary of Benefits

## UPMC Health Plan

### Exclusive Provider Organization Option

\$1500 \$20/\$40

15/30/50

The Exclusive Provider Organization (EPO) plan blends elements of a traditional HMO with elements of a preferred provider organization (PPO). Similar to a PPO, the EPO does not require you to select a primary care physician to act as a “gatekeeper.” But like an HMO, the EPO does require you to receive your care from network physicians and facilities in order for it to be covered.

While PCPs are not required, UPMC Health Plan still believes that PCPs play a vital role in managed care. We encourage EPO members to build long-term relationships with your physician, who can be a family or general practitioner, an internist, or a pediatrician. Your personal physician performs routine and preventive care, and can coordinate specialist care. Most important, your personal physician is in the best position to become familiar with your medical profile. Women (usually age 19 and older) also may select an ob-gyn to provide or coordinate all covered gynecological/obstetric care. However, women are not required to see the same ob-gyn on a regular basis.

As an EPO member, you must use network providers and facilities to receive covered benefits (except for emergency or urgent care, or very specialized care not available in our network; UPMC Health Plan must first authorize any services for specialized care not available in our network). If you choose to go to a provider or facility outside of the UPMC Health Plan network, you must pay for the services yourself.

Covered Services	Benefit Level
<b>Annual deductible</b>	
Individual	\$1500
Family	\$3000
<b>Annual out-of-pocket limit</b>	
Individual	None
Family	None
<b>Plan payment level</b>	Covered at 100% after deductible <sup>1</sup>
<b>Lifetime benefit limit</b>	Unlimited
<b>Primary care provider (PCP) required</b>	No
<b>Pre-existing condition limitations</b>	None
<b>Precertification requirements</b>	Provider responsibility
<b>Provider Medical Services<sup>2</sup></b>	
<b>Adult Care</b>	
Preventive/health screening examination	Covered at 100%, You pay \$0
<b>Pediatric Care</b>	
Preventive/health screening examination	Covered at 100%, You pay \$0
Pediatric immunizations	Covered at 100%, You pay \$0
Well-baby visits	Covered at 100%, You pay \$0
<b>Women's Care</b>	
Screening gynecological exam	Covered at 100%, You pay \$0
Screening Pap test and Screening Mammogram	Covered at 100%, You pay \$0
Provider office visit (for illness or injury)	Covered at 100% after \$20 copayment per visit
Specialist office visit	Covered at 100% after \$40 copayment per visit
Medical/Surgical services	Covered at 100% after deductible
<b>Hospital Services</b>	
Inpatient/outpatient care, medical/ surgical services, ancillary services, and supplies	Covered at 100% after deductible
<b>Emergency Services</b>	
Emergency care coverage	Covered at 100% after \$100 copayment per visit (waived if admitted)
Urgent care facility	Covered at 100% after \$40 copayment per visit
<b>Diagnostic Services</b>	
Advanced imaging (e.g. PET, MRI, etc.)	Covered at 100% after deductible
Other imaging (e.g. X-ray, sonogram, etc.)	Covered at 100% after deductible
Lab and other services	Covered at 100% after deductible
<b>Rehabilitation Therapy Services</b>	
Physical, speech, and occupational	Covered at 100% after \$20 copayment per visit
	Covered up to 60 visits per Benefit Period for all three therapies combined.

Covered Services	Benefit Level
<b>Medical Therapy Services</b>	
Chemotherapy, radiation, infusion therapy, dialysis treatment	Covered at 100% after deductible
<b>Other Medical Services</b>	
Skilled nursing facility	Covered at 100% after deductible (limit of 100 days per Benefit Period)
Home health care	Covered at 100% after deductible
Hospice care	Covered at 100% after deductible
Therapeutic manipulation	Covered at 100% after \$20 copayment per visit. (limit of 25 visits per Benefit Period)
Podiatric care	Covered at 100% after \$20 copayment per visit
Allergy testing and serum	Covered at 100% after deductible
Durable medical equipment and corrective appliances	Covered at 100% after deductible
Fertility testing	Covered at 100% after deductible
<b>Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>	
Behavioral health	
Inpatient	Covered at 100% after deductible
Outpatient	Covered at 100% after \$25 copayment per visit
Substance abuse services	
Inpatient detoxification	Covered at 100% after deductible
Inpatient rehabilitation	Covered at 100% after deductible
Outpatient rehabilitation	Covered at 100% after \$25 copayment per visit
<b>Prescription Drug Coverage— The <i>Your Choice</i> pharmacy program will apply (Mandatory Generic).</b>	
Retail prescription drug <sup>3</sup> <ul style="list-style-type: none"> <li>Prescriptions must be dispensed by a participating pharmacy</li> </ul>	You pay \$15 copayment for generic drugs You pay \$30 copayment for preferred brand drugs You pay \$50 copayment for non-preferred brand drugs  90-day maximum retail supply available for 3 copayments
Specialty prescription drug <sup>3</sup> <ul style="list-style-type: none"> <li>Specialty medications are limited to a 30-day supply</li> <li>Most specialty medications must be filled at our contracted specialty pharmacy provider (List available upon request).</li> </ul>	You pay \$50 copayment for specialty drugs  30-day maximum specialty supply
Mail-order prescription drug <sup>3</sup> <ul style="list-style-type: none"> <li>A three month supply (up to 90 days) of medication may be dispensed through the contracted mail service pharmacy.</li> </ul>	You pay \$30 copayment for generic drugs You pay \$60 copayment for preferred brand drugs You pay \$100 copayment for non-preferred brand drugs  90-day maximum mail-order supply

In this document, the term “UPMC Health Plan” refers to benefit plans offered by UPMC Health Network, Inc., as well as plans offered by UPMC Health Plan, 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.**

UPMC Health Plan Member  
Services: 1-888-876-2756.  
TTY service:1-800-361-2629.

<sup>1</sup> Copayments may apply to certain services.

<sup>2</sup> UPMC Health Plan maintains that the coverage described in this document is at all times administered in compliance with applicable laws and regulations, including but not limited to the Patient Protection and Affordable Care Act of 2010. If at any time any part or provision of this Statement of Benefits is in conflict with any applicable law, regulation or other controlling authority, the requirements of that authority shall prevail.

<sup>3</sup> If the brand-name drug is dispensed instead of the generic equivalent, you must pay the copayment associated with the brand-name drug as well as the retail price difference between the brand-name drug and the generic drug.

This summary is meant to assist in comparing the benefit plans. It is not a contract. If differences exist between this summary and a group’s contract or a member’s certificate of coverage, the contract or certificate of coverage prevails.

## UPMC HEALTH PLAN

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