

# Summary of Benefits

## UPMC Health Plan

### Exclusive Provider Organization Option 15

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  | \$1,000   |
| Family  | \$2,000   |
| <b>Annual out-of-pocket limit</b>   |   |
| Individual  | None  |
| Family  | None  |
| <b>Plan payment level</b>   | 100%  |
| <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>Preventive Care</b>  |   |
| <b>Adult</b>  |   |
| Routine physical exam   | 100% after \$5 copayment per visit  |
| <b>Pediatric</b>  |   |
| Routine physical exam   | 100% after \$5 copayment per visit  |
| Pediatric immunizations   | 100% - deductible does not apply  |
| Well-baby visits  | 100% after \$5 copayment per visit  |
| <b>Women's Care</b>   |   |
| Routine gynecological exam  | 100% after \$5 copayment per visit  |
| Routine Pap test and routine mammogram  | 100% - deductible does not apply  |
| <b>Physician Services</b>   |   |
| Physician office visit (for illness or injury)  | 100% after \$40 copayment per visit   |
| Specialist office visit   | 100% after \$40 copayment per visit   |
| Medical/Surgical services   | 100% after deductible   |
| <b>Hospital Services</b>  |   |
| Inpatient/outpatient care, medical/ surgical services, ancillary services, and supplies | 100% after deductible   |
| <b>Emergency Services</b>   |   |
| Emergency care coverage   | 100% after \$75 copayment per visit (waived if admitted)  |
| <b>Diagnostic Services</b>  |   |
| Advanced imaging (e.g. PET, MRI, etc.)  | 100% after deductible   |
| Other imaging (e.g. X-ray, sonogram, etc.)  | 100% after deductible   |
| Lab and other services  | 100% after deductible   |
| <b>Rehabilitation Therapy Services</b>  |   |
| Physical, speech, and occupational  | 100% after \$25 copayment per visit<br>Covered up to 60 visits per Benefit Period for all three therapies combined. |
| <b>Medical Therapy Services</b>   |   |
| Chemotherapy, radiation, infusion therapy, dialysis treatment                           | 100% after deductible   |

| Covered Services   | Benefit Level   |
|--|---|
| <b>Other Medical Services</b>  |   |
| Skilled nursing facility   | 100% after deductible (limit of 100 days per Benefit Period)  |
| Home health care   | 100% after deductible   |
| Hospice care   | 100% after deductible   |
| Therapeutic manipulation   | 100% after \$25 copayment per visit<br>Limit of 25 visits per Benefit Period.   |
| Podiatric care   | 100% after \$25 copayment per visit   |
| Allergy testing and serum  | 100% after deductible   |
| Durable medical equipment and corrective appliances  | 100% after deductible   |
| Fertility testing  | 100% after deductible   |
| <b>Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>   |   |
| Behavioral health  |   |
| Inpatient  | 100% after deductible   |
| Outpatient   | 100% after \$25 copayment per visit   |
| Substance abuse services   |   |
| Inpatient detoxification   | 100% after deductible   |
| Inpatient rehabilitation   | 100% after deductible   |
| Outpatient rehabilitation  | 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>1</sup><br>• Prescriptions must be dispensed by a participating pharmacy   | \$15 copayment for generic drugs<br>\$30 copayment for preferred brand drugs<br>\$50 copayment for non-preferred brand drugs<br><br>90-day maximum retail supply available for 3 copayments |
| Specialty prescription drug <sup>1</sup><br>• Specialty medications are limited to a 30-day supply<br>• Most specialty medications must be filled at our contracted specialty pharmacy provider (List available upon request). | \$50 copayment for specialty drugs<br><br>30-day maximum specialty supply   |
| Mail-order prescription drug <sup>1</sup><br>• A three month supply (up to 90 days) of medication may be dispensed through the contracted mail service pharmacy.   | \$30 copayment for generic drugs<br>\$60 copayment for preferred brand drugs<br>\$100 copayment for non-preferred brand drugs<br>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> 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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