

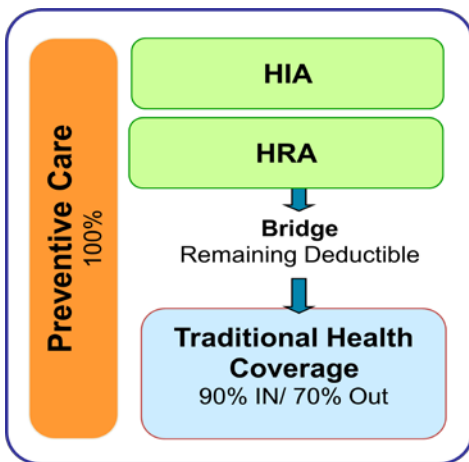
**UPMC Health Plan Health Reimbursement Account (HRA) PPO \$3,750
Summary of Benefits Rx: \$8-\$38-\$76**

Isn't it time you were rewarded for your good health?



UPMC **HealthyU** will incentivize you to *Understand* your health, *Improve* your health, and *Partner* with your doctor for ongoing maintenance.

Members will be able to earn up to \$500 for an individual, \$1000 for a family to pay deductibles, coinsurance, and copays by participating in healthy activities.



HRA/HIA Information

HRA Contributions from employer:
\$1,375 Individual/ \$2,750 Family

Funds can be used for plan deductible, coinsurance and copays

Members are able to roll in 2x the deductible from year to year

Earn Incentive Dollars

Members and their families have the opportunity to earn incentive dollars up to \$500 for an individual and \$1,000 for a family. These dollars can be earned in three easy steps. *Understand, Improve and Partner*

1. **Understand** - Learn more about yourself by completing a Health Risk Assessment or Biometric Screening.
2. **Improve** - Once you understand the area that you need to improve, take your next step. You can talk with our health coaches to get you started and track the progress in areas like quitting smoking, weight loss, understanding and maintaining your diabetes (or other disease management) or managing the stress in your busy life.
3. **Partner** - Take your activities to the next level by getting your annual physical, eye or dental exam. These providers can recommend additional programs available to you. Once completed, these programs can improve your health and you earn incentive dollars!

Covered Services	Participating Provider	Non-Participating Provider
Annual Health Incentives Dollars		
Individual Coverage		\$500
Family Coverage		\$1,000
Annual deductible ^{1,2}		
Individual Coverage		\$3,750
Family Coverage		\$7,500
Annual out-of-pocket limit		
Individual Coverage	\$3,750	\$10,000
Family Coverage	\$3,750 per person \$7,500 family	\$10,000 per person \$20,000 family
Plan payment level	You pay 10% after deductible	You pay 30% after deductible
Lifetime benefit limit	Unlimited	Unlimited
Pre-existing condition limitations	None	None
Precertification requirements	Provider responsibility	Member responsibility - \$500 penalty per incident for failure to pre-certify non emergency inpatient admissions
Provider Medical Services³		
Adult Care		
Preventive/health screening examination	Covered at 100%, You pay \$0	Not covered
Pediatric Care		
Preventive/health screening examination	Covered at 100%, You pay \$0	Not covered
Pediatric immunizations	Covered at 100%, You pay \$0	Not covered
Well-baby visits	Covered at 100%, You pay \$0	Not covered
Women's Care		
Screening gynecological exam	Covered at 100%, You pay \$0	Not covered
Screening Pap test and Mammogram	Covered at 100%, You pay \$0	Not covered
Provider office visit (for illness or injury)	You pay 10% after deductible	You pay 30% after deductible
Medical/Surgical services	You pay 10% after deductible	You pay 30% after deductible

¹ If care is out-of-network, benefits are paid at a lower level after your annual deductible is met. If you go to an out-of-network provider, you also may have to pay the difference between the provider's charge and the UPMC Health Network, Inc. payment (reasonable and customary amount). Deductible applies to all services except preventive services.

² The Family Deductible must be met by one or more Members of the family before benefits will be paid.

³UPMC 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.

⁴ 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 the 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.

Covered Services	Participating Provider	Non-Participating Provider
Hospital Services		
Inpatient/outpatient care, medical/ surgical services, ancillary services, and supplies	You pay 10% after deductible	You pay 30% after deductible
Emergency Services		
Emergency Care	You pay 10% after deductible	You pay 10% after deductible
Urgent Care	You pay 10% after deductible	You pay 30% after deductible
Diagnostic Services		
Imaging (Advanced and Other)	You pay 10% after deductible	You pay 30% after deductible
Lab and other services	You pay 10% after deductible	You pay 30% after deductible
Medical Therapy Services		
Chemotherapy, radiation, infusion therapy, dialysis treatment	You pay 10% after deductible	You pay 30% after deductible
Rehabilitation Therapy Services		
Physical, speech, and occupational	You pay 10% after deductible	You pay 30% after deductible
	Covered up to 60 visits per Benefit Period for all three therapies combined.	
Other Medical Services		
Skilled nursing facility	You pay 10% after deductible	You pay 30% after deductible
	Limit of 100 days per Benefit Period	
Home health care	You pay 10% after deductible	You pay 30% after deductible
Hospice care	You pay 10% after deductible	You pay 30% after deductible
Therapeutic manipulation	You pay 10% after deductible	You pay 30% after deductible
	Limit of 25 visits per Benefit Period	
Podiatric care	You pay 10% after deductible	You pay 30% after deductible
Allergy testing and serum	You pay 10% after deductible	You pay 30% after deductible
Durable medical equipment and corrective appliances	You pay 10% after deductible	You pay 30% after deductible
Fertility testing	You pay 10% after deductible	You pay 30% after deductible
Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083		
Behavioral health		
Inpatient / Outpatient	You pay 10% after deductible	You pay 30% after deductible
Substance abuse services		
Inpatient detoxification	You pay 10% after deductible	You pay 30% after deductible
Inpatient / Outpatient rehab	You pay 10% after deductible	You pay 30% after deductible

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

UPMC HEALTH PLAN

One Chatham Center
 112 Washington Place
 Pittsburgh, Pennsylvania 15219

www.upmchealthplan.com

Prescription Drug Coverage– The <i>Your Choice</i> pharmacy program will apply (Mandatory Generic).	Subject to Plan Deductible
Retail prescription drug ⁴ <ul style="list-style-type: none"> • Prescriptions must be dispensed by a participating pharmacy 	You pay \$8 for generic drugs You pay \$38 for preferred brand drugs You pay \$76 for non-preferred brand drugs 90-day maximum retail supply
Specialty prescription drug ⁴ <ul style="list-style-type: none"> • Specialty medications are limited to a 30-day supply • Most specialty medications must be filled at our contracted specialty pharmacy provider (List available upon request). 	You pay \$76 for specialty drugs 30-day maximum specialty supply
Mail-order prescription drug ⁴ <ul style="list-style-type: none"> • A three month supply (up to 90 days) of medication may be dispensed through the contracted mail service pharmacy. 	You pay \$16 for generic drugs You pay \$76 for preferred brand drugs You pay \$152 for non-preferred brand drugs 90-day maximum mail-order supply