

# Summary of Benefits

## UPMC Health Plan

### Preferred Provider Organization Option

**\$250 \$20/\$20**

**15/30/50**

The Preferred Provider Organization (PPO) plan offers you the choice of two levels of health care benefits each time you need medical services. Members will have reduced cost-sharing if care is received from a participating provider. Coordination of service is not required.

| Covered Services   | Participating Provider  | Non-Participating Provider   |
|--|---|--|
| Annual deductible  |   |  |
| Individual   | \$250   | \$500  |
| Family   | \$500   | \$1,000  |
| Annual out-of-pocket limit   |   |  |
| Individual   | None  | \$10,000   |
| Family   | None  | \$20,000   |
| Plan payment level   | Covered at 100% after deductible <sup>1</sup>                                   | You pay 20% after deductible <sup>2</sup>  |
| Lifetime benefit limit   | Unlimited   | Unlimited  |
| Primary care provider (PCP) required   | No  | No   |
| 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 |
| <b>Provider Medical Services<sup>3</sup></b>   |   |  |
| <b>Adult Care</b>  |   |  |
| Preventive/health screening examination  | Covered at 100%, You pay \$0  | Not covered  |
| <b>Pediatric Care</b>  |   |  |
| Preventive/health screening examination  | Covered at 100%, You pay \$0  | Not covered  |
| Pediatric immunizations  | Covered at 100%, You pay \$0  | You pay 20% (deductible does not apply)  |
| Well-baby visits   | Covered at 100%, You pay \$0  | Not covered  |
| <b>Women's Care</b>  |   |  |
| Screening gynecological exam   | Covered at 100%, You pay \$0  | You pay 20% after deductible   |
| Screening Pap test and Screening Mammogram   | Covered at 100%, You pay \$0  | You pay 20% after deductible   |
| Provider office visit (for illness or injury)  | Covered at 100% after \$20 copayment per visit                                  | You pay 20% after deductible   |
| Medical/surgical services  | Covered at 100% after deductible  | You pay 20% after deductible   |
| <b>Hospital Services</b>   |   |  |
| Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies | Covered at 100% after deductible  | You pay 20% after deductible   |
| <b>Emergency Services</b>  |   |  |
| Emergency care coverage  | Covered at 100% after \$50 copayment per visit                                  | Covered at 100% after \$50 copayment per visit   |
|  | Deductible does not apply.<br>Copayment waived if member admitted as inpatient. |  |
| Urgent care facility   | Covered at 100% after \$20 copayment per visit                                  | You pay 20% after deductible   |
| <b>Diagnostic Services</b>   |   |  |
| Advanced imaging (e.g., PET, MRI, etc)   | Covered at 100% after deductible  | You pay 20% after deductible   |
| Other imaging (e.g., X-ray, sonogram, etc.)  | Covered at 100% after deductible  | You pay 20% after deductible   |
| Lab and other services   | Covered at 100% after deductible  | You pay 20% after deductible   |
| <b>Medical Therapy Services</b>  |   |  |
| Chemotherapy, radiation, infusion therapy, dialysis treatment                          | Covered at 100% after deductible  | You pay 20% after deductible   |

| Covered Services   | Participating Provider  | Non-Participating Provider   |
|--|---|------------------------------|
| <b>Rehabilitation Therapy Services</b>   |   |                              |
| Physical, speech, and occupational   | Covered at 100% after \$20 copayment per visit  | You pay 20% after deductible |
|  | Covered up to 60 visits per Benefit Period for all three therapies combined.  |                              |
| <b>Other Medical Services</b>  |   |                              |
| Skilled nursing facility   | Covered at 100% after deductible  | You pay 20% after deductible |
|  | Limit of 100 days per Benefit Period  |                              |
| Home health care   | Covered at 100% after deductible  | You pay 20% after deductible |
| Hospice care   | Covered at 100% after deductible  | You pay 20% after deductible |
| Therapeutic manipulation   | Covered at 100% after \$25 copayment for first visit, \$15 copayment per visit thereafter   | You pay 20% after deductible |
|  | Limit of 25 visits per Benefit Period   |                              |
| Podiatric care   | Covered at 100% after \$25 copayment per visit  | You pay 20% after deductible |
| Allergy testing and serum  | Covered at 100% after deductible  | You pay 20% after deductible |
| Durable medical equipment and corrective appliances  | Covered at 100% after deductible  | You pay 20% after deductible |
| Fertility testing  | Covered at 100% after deductible  | You pay 20% 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  | You pay 20% after deductible |
| Outpatient   | Covered at 100% after \$20 copayment per visit  | You pay 20% after deductible |
| Substance abuse services   |   |                              |
| Inpatient detoxification   | Covered at 100% after deductible  | You pay 20% after deductible |
| Inpatient rehabilitation   | Covered at 100% after deductible  | You pay 20% after deductible |
| Outpatient rehabilitation  | Covered at 100% after \$20 copayment per visit  | You pay 20% after deductible |
| <b>Prescription Drug Coverage— The <i>Your Choice</i> pharmacy program will apply (Mandatory Generic).</b>   |   |                              |
| Retail prescription drug <sup>4</sup><br>• Prescriptions must be dispensed by a participating pharmacy   | You pay \$15 copayment for generic drugs<br>You pay \$30 copayment for preferred brand drugs<br>You pay \$50 copayment for non-preferred brand drugs<br><br>90-day maximum retail supply available for 3 copayments |                              |
| Specialty prescription drug <sup>4</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). | You pay \$50 copayment for specialty drugs<br><br>30-day maximum specialty supply   |                              |
| Mail-order prescription drug <sup>4</sup><br>• A three month supply (up to 90 days) of medication may be dispensed through the contracted mail service pharmacy.   | You pay \$30 copayment for generic drugs<br>You pay \$60 copayment for preferred brand drugs<br>You pay \$100 copayment for non-preferred brand drugs<br><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> Copayments may apply to certain services.

<sup>2</sup> 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 Plan payment (reasonable and customary amount).

<sup>3</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>4</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.