

# Summary of Benefits

## UPMC Health Plan

### Preferred Provider Organization Option

\$500 \$15/\$25

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	\$500	\$1,000
Family	\$1,000	\$2,000
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 40% 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>		
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	You pay 40% (deductible does not apply)
Well-baby visits	Covered at 100%, You pay \$0	Not covered
Women's Care		
Screening gynecological exam	Covered at 100%, You pay \$0	You pay 40% (deductible does not apply)
Screening Pap test and Screening Mammogram	Covered at 100%, You pay \$0	You pay 40% (deductible does not apply)
Provider office visit (for illness or injury)	Covered at 100% after \$15 copayment per visit	You pay 40% after deductible
Specialist office visit	Covered at 100% after \$25 copayment per visit	You pay 40% after deductible
Medical/surgical services	Covered at 100% after deductible	You pay 40% after deductible
<b>Hospital Services</b>		
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	Covered at 100% after deductible	You pay 40% 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. Copayment waived if member admitted as inpatient.	
Urgent care facility	Covered at 100% after \$25 copayment per visit	You pay 40% after deductible
<b>Diagnostic Services</b>		
Advanced imaging (e.g., PET, MRI, etc.)	Covered at 100% after deductible	You pay 40% after deductible
Other imaging (e.g., X-ray, sonogram, etc.)	Covered at 100% after deductible	You pay 40% after deductible
Lab and other services	Covered at 100% after deductible	You pay 40% after deductible

Covered Services	Participating Provider	Non-Participating Provider
<b>Medical Therapy Services</b>		
Chemotherapy, radiation, infusion therapy, dialysis treatment	Covered at 100% after deductible	You pay 40% after deductible
<b>Rehabilitation Therapy Services</b>		
Physical, speech, and occupational	Covered at 100% after \$15 copayment per visit	You pay 40% 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 40% after deductible
	Limit of 100 days per Benefit Period	
Home health care	Covered at 100% after deductible	You pay 40% after deductible
Hospice care	Covered at 100% after deductible	You pay 40% after deductible
Therapeutic manipulation	Covered at 100% after \$25 copayment for first visit, \$15 copayment per visit thereafter	You pay 40% after deductible
	Limit of 25 visits per Benefit Period	
Podiatric care	Covered at 100% after \$25 copayment per visit	You pay 40% after deductible
Allergy testing and serum	Covered at 100% after deductible	You pay 40% after deductible
Durable medical equipment and corrective appliances	Covered at 100% after deductible	You pay 40% after deductible
Fertility testing	Covered at 100% after deductible	You pay 40% 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 40% after deductible
Outpatient	Covered at 100% after \$25 copayment per visit	You pay 40% after deductible
Substance abuse services		
Inpatient detoxification	Covered at 100% after deductible	You pay 40% after deductible
Inpatient rehabilitation	Covered at 100% after deductible	You pay 40% after deductible
Outpatient rehabilitation	Covered at 100% after \$25 copayment per visit	You pay 40% after deductible
<b>Prescription Drug Coverage The <i>Your Choice</i> pharmacy program will apply (Mandatory Generic).</b>		
Retail prescription drug <sup>4</sup> • Prescriptions must be dispensed by a participating pharmacy		You pay \$15 copayment for generic drugs You pay \$30 copayment for preferred brand drugs You pay \$100 copayment for non-preferred brand drugs  90-day maximum retail supply available for 3 copayments
Specialty prescription drug <sup>4</sup> • 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 \$100 copayment for specialty drugs  30-day maximum specialty supply
Mail-order prescription drug <sup>4</sup> • 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 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> 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.