

UPMC Small Business *Advantage*



**BENEFIT  
PORTFOLIO**

**2012**



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## **UPMC HEALTH PLAN'S SMALL BUSINESS *ADVANTAGE***

is designed for today's unique challenges faced by businesses with 2 to 99 employees — increased price sensitivity, desire for health and wellness programs, and the need for dedicated customer service. It offers you a choice of medical, pharmacy, and vision coverage, as well as an employee assistance program and a variety of MyHealth wellness resources.

UPMC Health Plan brings stability, security, and local support for the access you and your employees demand.

Among the fastest growing health plans in the region, UPMC Health Plan is part of UPMC, one of the nation's leading academic medical centers and western Pennsylvania's largest employer.

Your employees will join the 1.6 million members we serve across the region. On average, 93 percent of members stay with UPMC Health Plan year after year. And UPMC Health Plan's top priority is to continually create better ways to improve the health of every member.

## **DEDICATED ACCOUNT MANAGEMENT**

Easy administration and accessibility to UPMC Health Plan are key components of our service excellence. Answers to client questions are only a phone call away. From initial enrollment to renewal assistance, your designated account manager will work closely with you or your producer (if applicable), using a consultative approach to administer your account and resolve any issues that may occur.

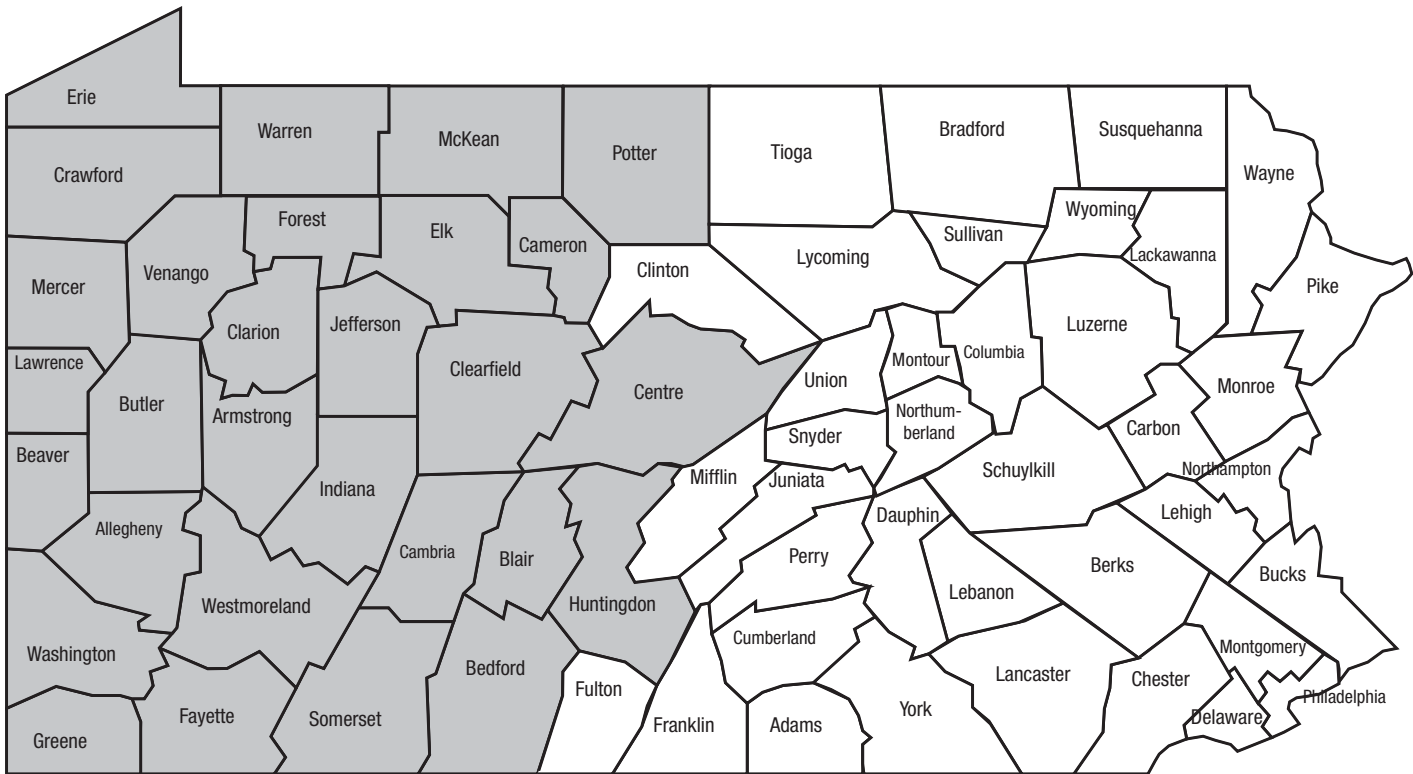


# HEALTHY PLANS FOR SMALL BUSINESSES

# 1



# 2012 UPMC HEALTH PLAN SERVICE AREA



■ 2012 UPMC Health Plan Commercial Service Area

## OUR NETWORK

Employers often have employees working in multiple regions or states, and they need a health plan with access to physicians, hospitals, and pharmacies no matter where their employees live, work, or travel. UPMC Health Plan provides this access. With nearly 5,000 facilities nationwide as well as more than half a million physicians from coast to coast, we cover your employees. And when they travel away from home, we have a service that helps them get medical care or arranges to bring them home for treatment.

### Local

Our comprehensive network includes the advanced-care, academic, and specialty hospitals of UPMC as well as community hospitals, cancer centers, physician practices, behavioral health programs, and long-term care facilities. UPMC Health Plan's local network includes more than 80 hospitals and more than 8,000 physicians — one of the largest and most diverse teams of health care professionals in the area.

### National

Are your employees working in other states? Traveling around the country? We're there for you and your employees. UPMC Health Plan's seamless national network extends across the country to include more than half a million physicians and nearly 5,000 facilities.

### Miles from Home

UPMC Health Plan's travel assistance program, provided by Assist America® at no additional charge for you or your employees, helps when you have a medical emergency more than 100 miles from home and are not sure where to turn.

A single call to Assist America connects you with experienced medical professionals and crisis response personnel who will make sure you receive appropriate medical care — literally, anywhere in the world. A few of the valuable services available to UPMC Health Plan members are medical consultation, evaluation, referral, emergency medical evacuation, medical monitoring, medical repatriation, and prescription assistance.

### Partners Program

UPMC Health Plan's Partners Program for integrated health improvement is one of today's most forward-thinking approaches to managing medical costs. The program offers our network providers the tools and resources they need and want to manage their patients and creates stronger integration of member care between doctors and hospitals by:

- Pay-for-performance incentives for primary care physicians based on quality and efficiency metrics
- Incentives for high-performing hospitals
- Hospital performance comparison tools available to members and doctors

## OUR PHARMACY PROGRAM

Our pharmacy program offers innovative solutions to control pharmacy costs, as well as freedom of choice, by providing members with a variety of high-quality, effective generic and brand-name prescription drugs. Through Small Business *Advantage*, employers can choose from pharmacy plans with a variety of copayment levels. Our pharmacy networks include most national chains and hundreds of independent pharmacies throughout the region.

UPMC Health Plan's prescription drug plans are organized into tiers and provide access to today's full range of medications, while encouraging the use of generic drugs when available. Your pharmacy plan includes:

- **Tier 1** for generic drugs, which have the lowest copayment.
- **Tier 2** for preferred brand-name drugs, which have the middle-level copayment.
- **Tier 3** for non-preferred brand-name drugs, which have the high-level copayment.
- **Tier 4** for specialty drugs, which have the highest copayment level. Specialty drugs (biologicals) are often used to treat complex clinical conditions, have a higher cost, and usually require close management by a physician.

### Key strengths of UPMC Health Plan's pharmacy benefits

- Broad pharmacy network — National and regional retailers, including CVS/pharmacy, Giant Eagle, Kmart, Rite Aid, Sam's Club, Target, Walmart, and Wegmans (Erie locations only), as well as hundreds of independent pharmacies, can fill prescriptions for your employees.
- Choice — We inform and educate members about the cost-saving advantages of choosing the lower cost tier 1 generic

drugs, when available, over the higher cost tier 2 preferred brand-name drugs and tier 3 non-preferred brand-name drugs. And we provide members with easy website access to the most up-to-date pharmacy program information.

- Mail-order prescriptions — Offer convenience and cost savings. Maintenance drugs (up to a 90-day supply of drugs taken on a regular, long-term basis) can be sent directly to a member's home.
- Cost management through prior authorization and quantity limits — There is a short list of drugs that UPMC Health Plan must authorize before the program will cover them. Other drugs have quantity limits based on Food and Drug Administration guidelines.
- 24/7 access — Our enhanced online formulary includes a searchable database of medications. The database includes generic and brand alternatives and lists potential drug interactions. Members can:
  - Refill mail-order prescriptions.
  - Calculate medication copayments.
  - Search for participating pharmacies and other drug and health information.

# BEHAVIORAL HEALTH BENEFITS

UPMC Health Plan Behavioral Health Services (BHS) assists Health Plan members in obtaining high-quality behavioral health care.

## Behavioral Health and Substance Abuse Coverage

Behavioral Health	EPO	PPO <sup>1</sup>
<b>Inpatient</b>	80% to 100% <sup>2</sup> (depending on plan)	80% to 100% <sup>2</sup> (depending on plan)
<b>Outpatient</b>	\$20 to \$25 copayment (depending on plan)	\$10 to \$25 copayment (depending on plan)
Substance Abuse	EPO	PPO <sup>1</sup>
<b>Inpatient Detoxification</b>	80% to 100% <sup>2</sup> (depending on plan)	80% to 100% <sup>2</sup> (depending on plan)
<b>Inpatient Rehabilitation</b>	80% to 100% <sup>2</sup> (depending on plan)	80% to 100% <sup>2</sup> (depending on plan)
<b>Outpatient Rehabilitation</b>	100% after deductible or copayment (depending on plan)	100% after deductible or copayment (depending on plan)

<sup>1</sup> In-network values are displayed for PPO plans. Different values will apply for out-of-network services in the PPO plans.

<sup>2</sup> Deductible may apply.

UPMC Health Plan members are served by the behavioral health clinicians of UPMC Health Plan Behavioral Health Services. UPMC Health Plan Behavioral Health Services is committed to providing high-quality, integrated behavioral health care services to our members. Many nationally recognized hospitals and facilities are integral parts of our comprehensive

network and are available to our clients and members. Behavioral health services include treatment for:

- Mental health conditions
- Alcohol problems
- Drug problems

# VISION BENEFITS

UPMC Health Plan offers a discount vision network through Small Business Advantage's arrangement with OptiCare Managed Vision at no extra charge. Discounts are available on exams, eyeglass frames and/or lenses, contact lenses, and sunglasses. For more information, visit OptiCare's website at <http://www.myvisionplan.com/upmc/discountvision/>.

UPMC Vision Advantage offers three plan options — Basic, Standard, and Premium — and a network of credentialed vision providers, within the regions where UPMC Vision Advantage is offered. There are many reasons to choose UPMC Vision Advantage, including:

- By calling one number, members receive outstanding customer service from UPMC Health Plan Member Advocates, who are able to answer questions about vision benefits, as well as medical, dental, and MyFlex Advantage benefits, if applicable.

- Members can chat online with a UPMC Vision Advantage Member Advocate regarding vision benefits, eligibility, and claim status.
- Members have access to vision benefits and information through MyHealth OnLine. If members are enrolled in our other products, UPMC Dental Advantage or MyFlex Advantage, for example, or any of our medical plans, they will be able to access information on those products as well.
- Members' eligibility for vision services will be instantly verified (auto-substantiated) when they use their MyFlex Advantage card, if applicable.

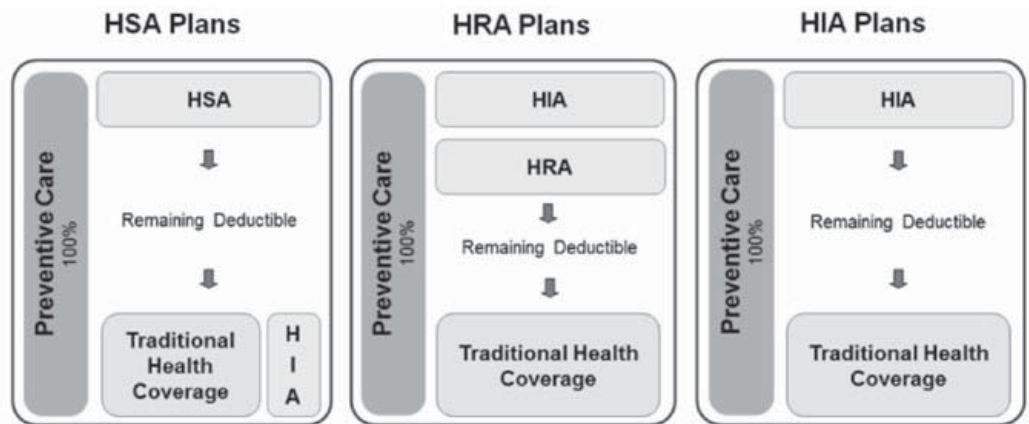
## DENTAL BENEFITS

UPMC Dental *Advantage* offers members a variety of plan options as well as a network of fully credentialed dentists. The plan is designed to encourage regular preventive care and foster open communication between patients and dentists regarding recommended treatment plans. There are many reasons to choose UPMC Dental *Advantage*, including:

- Members will receive outstanding customer service from UPMC Health Plan Member Advocates.
- Members are not required to select a primary care dentist, regardless of which plan they choose.

- There is no waiting period, and members can't be denied coverage or benefits if they have a pre-existing dental condition.
- UPMC Dental *Advantage* does not require prior authorization for major services.
- No ID card is required. Members will provide their dentist's office with some basic demographic information and the name of their employer.
- Members have access to their dental, medical, and *MyFlex Advantage* (if applicable) information as well as access to health tools through *MyHealth OnLine*.

## UPMC HEALTHYU



Employers are increasingly focused on the health and productivity of their employees as an essential business investment. Healthy employees = increased productivity. Employers also need a cost-effective solution to the rising cost of health care.

UPMC *HealthyU*, UPMC Health Plan's next-generation consumer-directed health plan, is your solution to both. *HealthyU* can help you better control costs while offering a rich benefit package to your employees. It is a unique combination of the following:

- A Health Incentive Account (HIA) that gives employees an opportunity to earn funds to pay for health care expenses
- A healthy living rewards program that includes personalized health coaching support
- A robust online resource center with tools and information on how to stay healthy and make better health care decisions on pharmacy costs, medical procedures, and more

- Lower premium plans with various options and deductible levels to meet employer needs
- The Health Incentive Account, funded by UPMC Health Plan, allows your employees to earn money for healthy behavior, such as getting a preventive screening or a flu shot. The money employees earn in their HIA is used to pay their out-of-pocket health care expenses. Our online resources and tools will help employees stay healthy — creating a more productive workforce for you.

For more information, visit [www.upmchealthyu.com](http://www.upmchealthyu.com), contact your insurance producer, or call 1-888-383-UPMC (8762).

## PERSONAL ASSISTANCE

### **Member Advocate Program**

Members have telephone access to a personal Member Advocate, who will call to welcome them to the program, help them understand their coverage, provide preventive care reminders, and notify them of special events related to their health benefits.

Member Advocates serve as advisors to help members make important decisions regarding their benefits. Members can also chat online with a Member Advocate by simply logging in to the member portal, MyHealth OnLine, and selecting Chat Online. Through MyHealth OnLine, we also offer our members an online Message Center where members can securely post a message to a Member Advocate 24 hours a day, 7 days a week.

### **Advice Line**

UPMC Health Plan's MyHealth Advice Line is available 24/7 to provide members with health care advice. When a member calls to discuss a specific health issue, experienced registered nurses provide prompt and efficient service over the phone.

### **Employee Assistance Program**

*LifeSolutions*, our employee assistance program, provides employers with an array

of valuable resources to enhance workplace productivity and employee health and wellness. Services include:

- Manager/Supervisor consultation available 24/7 to assist in addressing difficult employee situations and deteriorating performance.
- Critical incident management by telephone, providing guidance and support when people are facing a significant negative event in the workplace.

*LifeSolutions* also offers employees and their household members an easily accessed benefit to address everyday concerns before those concerns become problematic or impact work and well-being. For family and relationship issues, child or elder care, career challenges, stress management, anxiety or depression, and drug and alcohol concerns, *LifeSolutions* offers:

- Telephone coaching and counseling (1-3 sessions) to provide a listening ear, help with problem-solving concerns, and help with action plan development
- Referrals to local community resources 24/7 phone support
- Online WorkLife portal that includes thousands of articles, tip sheets, ready documents, and resource links

## COMPREHENSIVE CARE

### **Benefit Options for Employees**

UPMC Health Plan offers you a variety of coverage options for your employees. You can choose from a wide range of plans that offer the flexibility, benefits, and premiums you desire (see Benefit Summary). Options include preferred provider organizations, exclusive provider organizations, and high-deductible health plans. These medical plan options are packaged with a suite of value-added benefits at no additional charge. These options help provide comprehensive care to your employees.

### **Coverage for Dependents**

At UPMC Health Plan, dependent coverage is available. If employer groups choose to offer dependent coverage to their employees, UPMC Health Plan will administer such coverage in accordance with all relevant state and federal laws and regulations.

### **Emergency Services**

Emergency services provided at participating and nonparticipating facilities are covered.

## WELLNESS PROGRAMS

### UPMC MyHealth

Small businesses have access to a variety of wellness assessments and programs through UPMC Health Plan's UPMC MyHealth program. MyHealth, our award-winning employee wellness and health management program, provides members with tools and resources to better manage their health. MyHealth received the highest honor — *Platinum* — from the National Business Group on Health. As a member, you will have access to MyHealth OnLine, which provides personalized online programs, tools, and services that include:

- MyHealth Questionnaire (health risk assessment), employee needs assessments, and several health assessments (coronary artery disease, women's health, high blood pressure, etc.)
- Online programs for:
  - Weight management
  - Stress management
  - Smoking cessation
  - Nutrition
  - Physical activity
- My Activity Tracker: Online tool used to track physical activity. Members can track the number of steps they walk per day by using a pedometer or by converting activities into the equivalent number of steps.

- Nutrition Tracker: Logs daily food intake with regard to calories, fat, serving size, etc.
- Weight Tracker: Logs weight
- Condition Centers/Health Topics: Centers for all medical conditions, assessments, and library reference materials, etc.

### MyHealth Coach on Call

Members can place inbound calls to a health coach to discuss their MyHealth Questionnaire, biometric screening results, or any other health topics they are interested in.

### MyHealth Community

MyHealth Community is an online tool that helps our members find health and wellness resources in their own communities. Members enter their ZIP code to see nearby health and wellness resources and vendors that offer discounts. A special icon indicates vendors that offer a discount to UPMC Health Plan members only. Members can browse a map and narrow or modify their search.

## e AND EMPLOYER ONLINE

### e, UPMC Health Plan's All-Electronic Solution

UPMC Health Plan is always looking for ways to use technology to make health care delivery more efficient and affordable. Our all-electronic solution, **e**, does just that. This new option streamlines communication between employers, their employees, and the Health Plan. **e** can be incorporated into most benefit plan packages to reduce paper usage and print materials, facilitate administrative requirements, and reduce costs. **Groups choosing e will have lower monthly premiums than those that don't.**

Which processes can be accessed electronically with **e**?

- **Quoting** — **e** begins with an online company application that sets the tone for efficiency and timeliness. Turnaround times are quicker for both quotes and final rates, though getting started differs for small, mid- and large-sized companies.
- **Employee Status Updates** — Employers perform online membership changes and account upkeep to submit to the Health Plan, where the database is immediately updated.
- **Billing** — Employers can review bills and bill history as well as pay through UPay, UPMC Health Plan's exclusive electronic bill payment system.

- **Member Welcome Materials** — Employees can securely access plan- and member-specific documents 24/7 when they log in to MyHealth OnLine.
- **Explanation of Benefits (EOB)** — EOBs show payments the member and UPMC Health Plan made to health care providers. Employees receive e-mail alerts when their EOBs are available at MyHealth OnLine.

For more information, visit [www.upmchealthplan.com/e](http://www.upmchealthplan.com/e), contact your insurance producer, or call 1-888-383-UPMC (8762).

### Employer OnLine

Employer groups can securely access resources and update their account information 24/7 at the Employer OnLine service center.

Without having to call the Health Plan, Employer OnLine allows you to:

- Verify benefit information.
- Process new enrollments.
- Add or subtract dependents for coverage.
- Create temporary member ID cards.
- Access tools and resources for health promotion and wellness activities.



# CHOOSE YOUR BENEFIT PLAN

# 2



# BENEFIT SUMMARY

## Medical Plan Options Effective January 1, 2012

EPO										
					In-Network			Out-of-Network		
Plan	Specialist Copay	Preventive Care Copay	Office Visit Copay	ER Copay	Coinsurance %	Deductible \$ Individual/Family	Out-of-Pocket Maximum \$ Individual/Family	Coinsurance	Deductible	Out-of-Pocket Maximum
EPO \$500 \$20/\$20	\$20	\$0	\$20	\$50	100%	500/1,000	N/A	N/A	N/A	N/A
EPO \$1,500 \$20/\$40	\$40	\$0	\$20	\$100	100%	1,500/3,000	N/A	N/A	N/A	N/A
EPO \$10/\$30	\$30	\$0	\$10	\$50	100%	N/A	N/A	N/A	N/A	N/A
EPO \$15/\$35	\$35	\$0	\$15	\$50	100%	N/A	N/A	N/A	N/A	N/A
EPO \$20/\$40	\$40	\$0	\$20	\$50	100%	N/A	N/A	N/A	N/A	N/A
EPO \$250/80% \$20/\$20	\$20	\$0	\$20	\$50	80%	250/500	500/1,000	N/A	N/A	N/A
EPO \$250 \$40/\$40	\$40	\$0	\$40	\$75	100%	250/500	N/A	N/A	N/A	N/A
EPO \$500 \$40/\$40	\$40	\$0	\$40	\$75	100%	500/1,000	N/A	N/A	N/A	N/A
EPO \$750 \$40/\$40	\$40	\$0	\$40	\$75	100%	750/1,500	N/A	N/A	N/A	N/A
EPO \$1,000 \$40/\$40	\$40	\$0	\$40	\$75	100%	1,000/2,000	N/A	N/A	N/A	N/A

PPO										
					In-Network			Out-of-Network		
Plan	Specialist Copay	Preventive Care Copay	Office Visit Copay	ER Copay	Coinsurance %	Deductible \$ Individual/Family	Out-of-Pocket Maximum \$ Individual/Family	Coinsurance	Deductible \$ Individual/Family	Out-of-Pocket Maximum \$ Individual/Family
PPO \$300/80% \$20/\$20	\$20	\$0	\$20	\$50	80%	300/600	2,000/4,000	60%	500/1,000	10,000/20,000
PPO \$10/\$10	\$10	\$0	\$10	\$50	100%	N/A	N/A	60%	250/500	10,000/20,000
PPO \$300 \$15/\$15	\$15	\$0	\$15	\$50	100%	300/600	N/A	60%	500/1,000	10,000/20,000
PPO \$1,250 \$20/\$20	\$20	\$0	\$20	\$50	100%	1,250/2,500	N/A	60%	2,500/5,000	10,000/20,000
PPO \$20/\$20	\$20	\$0	\$20	\$50	100%	N/A	N/A	80%	500/1,000	10,000/20,000
PPO \$250 \$20/\$20	\$20	\$0	\$20	\$50	100%	250/500	N/A	80%	500/1,000	10,000/20,000
PPO \$500 \$15/\$25	\$25	\$0	\$15	\$50	100%	500/1,000	N/A	60%	1,000/2,000	10,000/20,000
PPO \$2,500/90% \$25/\$40	\$40	\$0	\$25	\$100	90%	2,500/5,000 combined	1,500/3,000	70%	N/A	10,000/20,000

# HealthyU HSA Plans

Preventive Care: Covered at 100%; not subject to deductible and will not use HIA funds.

Physician Office Visit: Subject to deductible; then follows standard coinsurance reimbursement.

HSA Plans						
Plan	HIA Incentive Limit <sup>1</sup> \$ Individual/ Family	ER Coverage After Deductible	Coinsurance % In-Network/ Out-of-Network	Deductible <sup>2</sup> (Single Individual or Family Deductible) \$ Individual/Family	In-Network Out-of-Pocket Maximum \$ Individual/Family	Out-of-Network Out-of-Pocket Maximum \$ Individual/Family
HSA PPO 1250	500/1000	90%/90%	90%/70%	1,250/2,500	1,250/2,500	10,000/20,000
HSA PPO 2500	500/1000	90%/90%	90%/70%	2,500/5,000	2,500/5,000	10,000/20,000
HSA PPO 3750	500/1000	90%/90%	90%/70%	3,750/7,500	2,300/4,600	10,000/20,000
HSA EPO 1250	500/1000	90%/90%	90%/N/A	1,250/2,500	1,250/2,500	N/A
HSA EPO 2500	500/1000	90%/90%	90%/N/A	2,500/5,000	2,500/5,000	N/A
HSA EPO 3750	500/1000	90%/90%	90%/N/A	3,750/7,500	2,300/4,600	N/A

<sup>1</sup>Incentives funded by UPMC Health Plan. Funds will pay coinsurance and Rx Copays/coinsurance once deductible is satisfied in compliance with IRS regulations.

<sup>2</sup>The Family Deductible must be met by one or more members of the family before benefits subject to deductible will be paid. Deductible does not apply to Out-of-Pocket Maximum.

# HealthyU HIA Plans

Preventive Care: Covered at 100%; not subject to deductible and will not use HIA funds.

Physician Office Visit: Subject to deductible; then follows standard coinsurance reimbursement.

HIA Plans						
Plan	HIA Incentive Limit <sup>1</sup> \$ Individual/ Family	ER Coverage After Deductible	Coinsurance % In-Network/ Out-of-Network	Deductible <sup>2</sup> (Single Individual or Family Deductible) \$ Individual/Family	In-Network Out-of-Pocket Maximum \$ Individual/Family	Out-of-Network Out-of-Pocket Maximum \$ Individual/Family
HIA PPO 750	500/1000	80%/80%	80%/70%	750/1,500	2,000/4,000	10,000/20,000
HIA PPO 1250	500/1000	90%/90%	90%/70%	1,250/2,500	1,250/2,500	10,000/20,000
HIA PPO 2500	500/1000	90%/90%	90%/70%	2,500/5,000	2,500/5,000	10,000/20,000
HIA PPO 3750	500/1000	90%/90%	90%/70%	3,750/7,500	3,750/7,500	10,000/20,000
HIA EPO 750	500/1000	80%/80%	80%/N/A	750/1,500	2,000/4,000	N/A
HIA EPO 1250	500/1000	90%/90%	90%/N/A	1,250/2,500	1,250/2,500	N/A
HIA EPO 2500	500/1000	90%/90%	90%/N/A	2,500/5,000	2,500/5,000	N/A
HIA EPO 3750	500/1000	90%/90%	90%/N/A	3,750/7,500	3,750/7,500	N/A

<sup>1</sup>Incentives funded by UPMC Health Plan. Funds will pay deductible, coinsurance and Rx Copays/coinsurance.

<sup>2</sup>The Family Deductible must be met by one or more members of the family before benefits subject to deductible will be paid. Deductible does not apply to Out-of-Pocket Maximum.

# HealthyU HRA Plans

Preventive Care: Covered at 100%; not subject to deductible and will not use HIA/HRA funds.

Physician Office Visit: Subject to deductible; then follows standard coinsurance reimbursement.

HRA Plans							
Plan	HIA Incentive Limit <sup>1</sup> \$ Individual/ Family	Employer HRA Contribution \$ Individual/ Family	ER Coverage After Deductible	Coinsurance % In-Network/ Out-of-Network	Deductible <sup>2</sup> (Single Individual or Family Deductible) \$ Individual/Family	In-Network Out-of-Pocket Maximum \$ Individual/Family	Out-of-Network Out-of-Pocket Maximum \$ Individual/ Family
HRA PPO 750	500/1000	125/250	80%/80%	80%/70%	750/1,500	2,000/4,000	10,000/20,000
HRA PPO 1250	500/1000	125/250	90%/90%	90%/70%	1,250/2,500	1,250/2,500	10,000/20,000
HRA PPO 2500	500/1000	750/1,500	90%/90%	90%/70%	2,500/5,000	2,500/5,000	10,000/20,000
HRA PPO 3750	500/1000	1,375/2,750	90%/90%	90%/70%	3,750/7,500	3,750/7,500	10,000/20,000
HRA EPO 750	500/1000	125/250	80%/80%	80%/N/A	750/1,500	2,000/4,000	N/A
HRA EPO 1250	500/1000	125/250	90%/90%	90%/N/A	1,250/2,500	1,250/2,500	N/A
HRA EPO 2500	500/1000	750/1500	90%/90%	90%/N/A	2,500/5,000	2,500/5,000	N/A
HRA EPO 3750	500/1000	1,375/2,750	90%/90%	90%/N/A	3,750/7,500	3,750/7,500	N/A

<sup>1</sup>Incentives Funded by UPMC Health Plan. Funds will pay deductible, coinsurance and Rx Copays/coinsurance.

<sup>2</sup>The Family Deductible must be met by one or more members of the family before benefits subject to deductible will be paid. Deductible does not apply to Out-of-Pocket Maximum.

## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$500 \$20/\$20**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	\$500
Family	\$1,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>	
Individual	None
Family	None
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No
<b>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100% (deductible does not apply)
Screening Gynecological Exam	100% (deductible does not apply)
Screening Mammograms	100% (deductible does not apply)
Well-Child Exam	100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Provider Office Visit (for illness or injury)	\$20 copayment per visit
Specialist Office Visit	\$20 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	\$50 copayment (copayment waived if admitted)
Urgent Care Facility	\$20 copayment per visit
<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>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100% (after deductible)
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$20 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	100% (after deductible) (limit of 100 days/benefit period)
Home Health Care	100% (after deductible)
Hospice Care	100% (after deductible)
Therapeutic Manipulation	\$25 copayment (first visit); \$20 copayment thereafter (limit of 25 visits/benefit period)
Podiatric Care	\$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>	
<b>Behavioral Health</b>	
Inpatient	100% (after deductible)
Outpatient	\$20 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	100% (after deductible)
Inpatient Rehabilitation	100% (after deductible)
Outpatient Rehabilitation	\$20 copayment per visit
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## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$1,500 \$20/\$40**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	\$1,500
Family	\$3,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>	
Individual	None
Family	None
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No
<b>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100% (deductible does not apply)
Screening Gynecological Exam	100% (deductible does not apply)
Screening Mammograms	100% (deductible does not apply)
Well-Child Exam	100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Provider Office Visit (for illness or injury)	\$20 copayment per visit
Specialist Office Visit	\$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 copayment (copayment waived if admitted)
Urgent Care Facility	\$40 copayment per visit
<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>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100% (after deductible)
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$20 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	100% (after deductible) (limit of 100 days/benefit period)
Home Health Care	100% (after deductible)
Hospice Care	100% (after deductible)
Therapeutic Manipulation	\$20 copayment per visit (limit of 25 visits/benefit period)
Podiatric Care	\$20 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>	
<b>Behavioral Health</b>	
Inpatient	100% (after deductible)
Outpatient	\$25 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	100% (after deductible)
Inpatient Rehabilitation	100% (after deductible)
Outpatient Rehabilitation	\$25 copayment per visit
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## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$10/\$30**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	None
Family	None
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</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>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100%
Screening Gynecological Exam	100%
Screening Mammograms	100%
Well-Child Exam	100%
Pediatric Immunizations	100%
Provider Office Visit (for illness or injury)	\$10 copayment per visit
Specialist Office Visit	\$30 copayment per visit
Medical/Surgical Services	100%
<b>HOSPITAL SERVICES</b>	
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	100%
<b>EMERGENCY SERVICES</b>	
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)
Urgent Care Facility	\$30 copayment per visit
<b>DIAGNOSTIC SERVICES</b>	
Advanced Imaging (e.g. PET, MRI, etc.)	100%
Other Imaging (e.g. x-ray, sonogram, etc.)	100%
Lab and Other Services	100%
<b>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100%
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$10 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	100% (limit of 100 days/benefit period)
Home Health Care	100%
Hospice Care	100%
Therapeutic Manipulation	\$25 copayment (first visit); \$10 copayment thereafter (limit of 25 visits/benefit period)
Podiatric Care	\$25 copayment per visit
Allergy Testing and Serum	100%
Durable Medical Equipment and Corrective Appliances	100%
Fertility Testing	100%
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>	
<b>Behavioral Health</b>	
Inpatient	100%
Outpatient	\$25 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	100%
Inpatient Rehabilitation	100%
Outpatient Rehabilitation	\$25 copayment per visit
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## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$15/\$35**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	None
Family	None
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</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>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100%
Screening Gynecological Exam	100%
Screening Mammograms	100%
Well-Child Exam	100%
Pediatric Immunizations	100%
Provider Office Visit (for illness or injury)	\$15 copayment per visit
Specialist Office Visit	\$35 copayment per visit
Medical/Surgical Services	100%
<b>HOSPITAL SERVICES</b>	
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	100%
<b>EMERGENCY SERVICES</b>	
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)
Urgent Care Facility	\$35 copayment per visit
<b>DIAGNOSTIC SERVICES</b>	
Advanced Imaging (e.g. PET, MRI, etc.)	100%
Other Imaging (e.g. x-ray, sonogram, etc.)	100%
Lab and Other Services	100%
<b>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100%
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$15 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	100% (limit of 100 days per benefit period)
Home Health Care	100%
Hospice Care	100%
Therapeutic Manipulation	\$20 copayment per visit (limit of 25 visits per benefit period)
Podiatric Care	\$20 copayment per visit
Allergy Testing and Serum	100%
Durable Medical Equipment and Corrective Appliances	100%
Fertility Testing	100%
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>	
<b>Behavioral Health</b>	
Inpatient	100%
Outpatient	\$25 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	100%
Inpatient Rehabilitation	100%
Outpatient Rehabilitation	\$25 copayment per visit
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## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$20/\$40**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	None
Family	None
<b>ANNUAL OUT-OF-POCKET MAXIMUM (excludes deductibles and copayments)</b>	
Individual	None
Family	None
<b>COINSURANCE</b>	
	100%
<b>LIFETIME MAXIMUM</b>	
	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	
	No
<b>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100%
Screening Gynecological Exam	100%
Screening Mammograms	100%
Well-Child Exam	100%
Pediatric Immunizations	100%
Provider Office Visit (for illness or injury)	\$20 copayment per visit
Specialist Office Visit	\$40 copayment per visit
Medical/Surgical Services	100%
<b>HOSPITAL SERVICES</b>	
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	100%
<b>EMERGENCY DEPARTMENT SERVICES</b>	
Emergency Care Coverage	\$50 copayment (waived if admitted)
Urgent Care Facility	\$40 copayment per visit
<b>DIAGNOSTIC SERVICES</b>	
Advanced Imaging (e.g. PET, MRI, etc.)	100%
Other Imaging (e.g. x-ray, sonogram, etc.)	100%
Lab and Other Services	100%
<b>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100%
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$20 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	100% (limit of 100 days/benefit period)
Home Health Care	100%
Hospice Care	100%
Therapeutic Manipulation	\$25 copayment (first visit); \$20 copayment thereafter (limit of 25 visits/benefit period)
Podiatric Care	\$25 copayment per visit
Allergy Testing and Serum	100%
Durable Medical Equipment and Corrective Appliances	100%
Fertility Testing	100%
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>	
<b>Behavioral Health</b>	
Inpatient	100%
Outpatient	\$25 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	100%
Inpatient Rehabilitation	100%
Outpatient Rehabilitation	\$25 copayment per visit
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## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$250/80% \$20/\$20**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	\$250
Family	\$500
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>	
Individual	\$500
Family	\$1,000
<b>PLAN PAYMENT LEVEL</b>	80% (after deductible)
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No
<b>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100% (deductible does not apply)
Screening Gynecological Exam	100% (deductible does not apply)
Screening Mammograms	100% (deductible does not apply)
Well-Child Exam	100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Provider Office Visit (for illness or injury)	\$20 copayment per visit
Specialist Office Visit	\$20 copayment per visit
Medical/Surgical Services	80% (after deductible)
<b>HOSPITAL SERVICES</b>	
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	80% (after deductible)
<b>EMERGENCY SERVICES</b>	
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)
Urgent Care Facility	\$20 copayment per visit
<b>DIAGNOSTIC SERVICES</b>	
Advanced Imaging (e.g. PET, MRI, etc.)	80% (after deductible)
Other Imaging (e.g. x-ray, sonogram, etc.)	80% (after deductible)
Lab and Other Services	80% (after deductible)
<b>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	80% (after deductible)
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$20 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	80% (after deductible) (limit of 100 days/benefit period)
Home Health Care	80% (after deductible)
Hospice Care	80% (after deductible)
Therapeutic Manipulation	\$25 copayment (first visit); \$20 copayment thereafter (limit of 25 visits/benefit period)
Podiatric Care	\$25 copayment per visit
Allergy Testing and Serum	80% (after deductible)
Durable Medical Equipment and Corrective Appliances	80% (after deductible)
Fertility Testing	80% (after deductible)
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>	
<b>Behavioral Health</b>	
Inpatient	80% (after deductible)
Outpatient	\$20 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	80% (after deductible)
Inpatient Rehabilitation	80% (after deductible)
Outpatient Rehabilitation	\$20 copayment per visit
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## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$250 \$40/\$40**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	\$250
Family	\$500
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>	
Individual	None
Family	None
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No
<b>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100% (deductible does not apply)
Screening Gynecological Exam	100% (deductible does not apply)
Screening Mammograms	100% (deductible does not apply)
Well-Child Exam	100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Provider Office Visit (for illness or injury)	\$40 copayment per visit
Specialist Office Visit	\$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	\$75 copayment (copayment waived if admitted)
Urgent Care Facility	\$40 copayment per visit
<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>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100% (after deductible)
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$25 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	100% (after deductible) (limit of 100 days/benefit period)
Home Health Care	100% (after deductible)
Hospice Care	100% (after deductible)
Therapeutic Manipulation	\$25 copayment per visit (limit of 25 visits/benefit period)
Podiatric Care	\$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>	
<b>Behavioral Health</b>	
Inpatient	100% (after deductible)
Outpatient	\$25 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	100% (after deductible)
Inpatient Rehabilitation	100% (after deductible)
Outpatient Rehabilitation	\$25 copayment per visit
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## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$500 \$40/\$40**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	\$500
Family	\$1,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>	
Individual	None
Family	None
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No
<b>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100% (deductible does not apply)
Screening Gynecological Exam	100% (deductible does not apply)
Screening Mammograms	100% (deductible does not apply)
Well-Child Exam	100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Provider Office Visit (for illness or injury)	\$40 copayment per visit
Specialist Office Visit	\$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	\$75 copayment (copayment waived if admitted)
Urgent Care Facility	\$40 copayment per visit
<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>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100% (after deductible)
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$25 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	100% (after deductible) (limit of 100 days/benefit period)
Home Health Care	100% (after deductible)
Hospice Care	100% (after deductible)
Therapeutic Manipulation	\$25 copayment per visit (limit of 25 visits/benefit period)
Podiatric Care	\$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>	
<b>Behavioral Health</b>	
Inpatient	100% (after deductible)
Outpatient	\$25 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	100% (after deductible)
Inpatient Rehabilitation	100% (after deductible)
Outpatient Rehabilitation	\$25 copayment per visit
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## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$750 \$40/\$40**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	\$750
Family	\$1,500
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>	
Individual	None
Family	None
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No
<b>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100% (deductible does not apply)
Screening Gynecological Exam	100% (deductible does not apply)
Screening Mammograms	100% (deductible does not apply)
Well-Child Exam	100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Provider Office Visit (for illness or injury)	\$40 copayment per visit
Specialist Office Visit	\$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	\$75 copayment (copayment waived if admitted)
Urgent Care Facility	\$40 copayment per visit
<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>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100% (after deductible)
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$25 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	100% (after deductible) (limit of 100 days/benefit period)
Home Health Care	100% (after deductible)
Hospice Care	100% (after deductible)
Therapeutic Manipulation	\$25 copayment per visit (limit of 25 visits/benefit period)
Podiatric Care	\$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>	
<b>Behavioral Health</b>	
Inpatient	100% (after deductible)
Outpatient	\$25 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	100% (after deductible)
Inpatient Rehabilitation	100% (after deductible)
Outpatient Rehabilitation	\$25 copayment per visit
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## EXCLUSIVE PROVIDER ORGANIZATION

**EPO \$1,000 \$40/\$40**

The Exclusive Provider Organization (EPO) plan offers one level of benefits. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from EPO network participating providers.

COVERED SERVICES	BENEFIT LEVEL
<b>ANNUAL DEDUCTIBLE</b>	
Individual	\$1,000
Family	\$2,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>	
Individual	None
Family	None
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No
<b>PROVIDER SERVICES</b>	
Adult Preventive/Health Screening Exam	100% (deductible does not apply)
Screening Gynecological Exam	100% (deductible does not apply)
Screening Mammograms	100% (deductible does not apply)
Well-Child Exam	100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Provider Office Visit (for illness or injury)	\$40 copayment per visit
Specialist Office Visit	\$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	\$75 copayment (copayment waived if admitted)
Urgent Care Facility	\$40 copayment per visit
<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>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, Radiation, Infusion Therapy, Dialysis	100% (after deductible)
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, Speech, and Occupational Therapy	\$25 copayment per visit Covered up to 60 visits per benefit period for all three therapies combined
<b>OTHER MEDICAL SERVICES</b>	
Skilled Nursing Facility	100% (after deductible) (limit of 100 days/benefit period)
Home Health Care	100% (after deductible)
Hospice Care	100% (after deductible)
Therapeutic Manipulation	\$25 copayment per visit (limit of 25 visits/benefit period)
Podiatric Care	\$25 copayment
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>	
<b>Behavioral Health</b>	
Inpatient	100% (after deductible)
Outpatient	\$25 copayment per visit
<b>Substance Abuse Services</b>	
Inpatient Detoxification	100% (after deductible)
Inpatient Rehabilitation	100% (after deductible)
Outpatient Rehabilitation	\$25 copayment per visit
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## PREFERRED PROVIDER ORGANIZATION

**PPO \$300/80% \$20/\$20**

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
<b>ANNUAL DEDUCTIBLE</b>		
Individual	\$300	\$500
Family	\$600	\$1,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>		
Individual	\$2,000	\$10,000
Family	\$4,000	\$20,000
<b>PLAN PAYMENT LEVEL</b>	80% (after deductible)	60% (after deductible) <sup>1</sup>
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No	No
<b>PROVIDER SERVICES</b>		
Adult Preventive/Health Screening Exam	100% (deductible does not apply)	Not Covered
Screening Gynecological Exam	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Screening Mammograms	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Well-Child Exam	100% (deductible does not apply)	Not Covered
Pediatric Immunizations	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Provider Office Visit (for illness or injury)	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
Specialist Office Visit	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
Medical/Surgical Services	80% (after deductible)	60% (after deductible) <sup>1</sup>
<b>HOSPITAL SERVICES</b>		
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	80% (after deductible)	60% (after deductible) <sup>1</sup>
<b>EMERGENCY SERVICES</b>		
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)	
Urgent Care Facility	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
<b>DIAGNOSTIC SERVICES</b>		
Advanced Imaging (e.g. PET, MRI, etc.)	80% (after deductible)	60% (after deductible) <sup>1</sup>
Other Imaging (e.g. x-ray, sonogram, etc.)	80% (after deductible)	60% (after deductible) <sup>1</sup>
Lab and Other Services	80% (after deductible)	60% (after deductible) <sup>1</sup>
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, Radiation, Infusion Therapy, Dialysis Treatment	80% (after deductible)	60% (after deductible) <sup>1</sup>
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, Speech, and Occupational Therapy	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
	Covered up to 60 visits per benefit period for all three therapies combined	
<b>OTHER MEDICAL SERVICES</b>		
Skilled Nursing Facility (limit of 100 days/benefit period)	80% (after deductible)	60% (after deductible) <sup>1</sup>
Home Health Care	80% (after deductible)	60% (after deductible) <sup>1</sup>
Hospice Care	80% (after deductible)	60% (after deductible) <sup>1</sup>
Therapeutic Manipulation (limit of 25 visits/benefit period)	\$25 copayment (first visit)/\$20 thereafter	60% (after deductible) <sup>1</sup>
Podiatric Care	\$25 copayment per visit	60% (after deductible) <sup>1</sup>
Allergy Testing and Serum	80% (after deductible)	60% (after deductible) <sup>1</sup>
Durable Medical Equipment and Corrective Appliances	80% (after deductible)	60% (after deductible) <sup>1</sup>
Fertility Testing	80% (after deductible)	60% (after deductible) <sup>1</sup>
<b>BEHAVIORAL HEALTH - Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
<b>Behavioral Health</b>		
Inpatient	80% (after deductible)	60% (after deductible) <sup>1</sup>
Outpatient	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
<b>Substance Abuse Services</b>		
Inpatient Detoxification	80% (after deductible)	60% (after deductible) <sup>1</sup>
Inpatient Rehabilitation	80% (after deductible)	60% (after deductible) <sup>1</sup>
Outpatient Rehabilitation	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
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<sup>1</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 may also have to pay the difference between the provider's charge and the UPMC Health Plan payment (reasonable and customary amount).		
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## PREFERRED PROVIDER ORGANIZATION

**PPO \$10/\$10**

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
<b>ANNUAL DEDUCTIBLE</b>		
Individual	None	\$250
Family	None	\$500
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>		
Individual	None	\$10,000
Family	None	\$20,000
<b>PLAN PAYMENT LEVEL</b>	100%	60% (after deductible) <sup>1</sup>
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No	No
<b>PROVIDER SERVICES</b>		
Adult Preventive/Health Screening Exam	100%	Not Covered
Screening Gynecological Exam	100%	60% (deductible does not apply) <sup>1</sup>
Screening Mammograms	100%	60% (deductible does not apply) <sup>1</sup>
Well-Child Exam	100%	Not Covered
Pediatric Immunizations	100%	60% (deductible does not apply) <sup>1</sup>
Provider Office Visit (for illness or injury)	\$10 copayment per visit	60% (after deductible) <sup>1</sup>
Specialist Office Visit	\$10 copayment per visit	60% (after deductible) <sup>1</sup>
Medical/Surgical Services	100%	60% (after deductible) <sup>1</sup>
<b>HOSPITAL SERVICES</b>		
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	100%	60% (after deductible) <sup>1</sup>
<b>EMERGENCY SERVICES</b>		
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)	
Urgent Care Facility	\$10 copayment per visit	60% (after deductible) <sup>1</sup>
<b>DIAGNOSTIC SERVICES</b>		
Advanced Imaging (e.g. PET, MRI, etc.)	100%	60% (after deductible) <sup>1</sup>
Other Imaging (e.g. x-ray, sonogram, etc.)	100%	60% (after deductible) <sup>1</sup>
Lab and Other Services	100%	60% (after deductible) <sup>1</sup>
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, Radiation, Infusion Therapy, Dialysis Treatment	100%	60% (after deductible) <sup>1</sup>
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, Speech, and Occupational Therapy	\$10 copayment per visit	60% (after deductible) <sup>1</sup>
	Covered up to 60 visits per benefit period for all three therapies combined	
<b>OTHER MEDICAL SERVICES</b>		
Skilled Nursing Facility (limit of 100 days/benefit period)	100%	60% (after deductible) <sup>1</sup>
Home Health Care	100%	60% (after deductible) <sup>1</sup>
Hospice Care	100%	60% (after deductible) <sup>1</sup>
Therapeutic Manipulation (limit of 25 visits/benefit period)	\$25 copayment (first visit)/\$10 thereafter	60% (after deductible) <sup>1</sup>
Podiatric Care	\$25 copayment per visit	60% (after deductible) <sup>1</sup>
Allergy Testing and Serum	100%	60% (after deductible) <sup>1</sup>
Durable Medical Equipment and Corrective Appliances	100%	60% (after deductible) <sup>1</sup>
Fertility Testing	100%	60% (after deductible) <sup>1</sup>
<b>BEHAVIORAL HEALTH - Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
<b>Behavioral Health</b>		
Inpatient	100%	60% (after deductible) <sup>1</sup>
Outpatient	\$10 copayment per visit	60% (after deductible) <sup>1</sup>
<b>Substance Abuse Services</b>		
Inpatient Detoxification	100%	60% (after deductible) <sup>1</sup>
Inpatient Rehabilitation	100%	60% (after deductible) <sup>1</sup>
Outpatient Rehabilitation	\$10 copayment per visit	60% (after deductible) <sup>1</sup>
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<sup>1</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 may also have to pay the difference between the provider's charge and the UPMC Health Plan payment (reasonable and customary amount).		
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## PREFERRED PROVIDER ORGANIZATION

**PPO \$300 \$15/\$15**

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
<b>ANNUAL DEDUCTIBLE</b>		
Individual	\$300	\$500
Family	\$600	\$1,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>		
Individual	None	\$10,000
Family	None	\$20,000
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No	No
<b>PROVIDER SERVICES</b>		
Adult Preventive/Health Screening Exam	100% (deductible does not apply)	Not Covered
Screening Gynecological Exam	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Screening Mammograms	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Well-Child Exam	100% (deductible does not apply)	Not Covered
Pediatric Immunizations	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Provider Office Visit (for illness or injury)	\$15 copayment per visit	60% (after deductible) <sup>1</sup>
Specialist Office Visit	\$15 copayment per visit	60% (after deductible) <sup>1</sup>
Medical/Surgical Services	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>HOSPITAL SERVICES</b>		
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>EMERGENCY SERVICES</b>		
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)	
Urgent Care Facility	\$15 copayment per visit	60% (after deductible) <sup>1</sup>
<b>DIAGNOSTIC SERVICES</b>		
Advanced Imaging (e.g. PET, MRI, etc.)	100% (after deductible)	60% (after deductible) <sup>1</sup>
Other Imaging (e.g. x-ray, sonogram, etc.)	100% (after deductible)	60% (after deductible) <sup>1</sup>
Lab and Other Services	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, Radiation, Infusion Therapy, Dialysis Treatment	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, Speech, and Occupational Therapy	\$15 copayment per visit	60% (after deductible) <sup>1</sup>
	Covered up to 60 visits per benefit period for all three therapies combined	
<b>OTHER MEDICAL SERVICES</b>		
Skilled Nursing Facility (limit of 100 days/benefit period)	100% (after deductible)	60% (after deductible) <sup>1</sup>
Home Health Care	100% (after deductible)	60% (after deductible) <sup>1</sup>
Hospice Care	100% (after deductible)	60% (after deductible) <sup>1</sup>
Therapeutic Manipulation (limit of 25 visits/benefit period)	\$25 copayment (first visit)/\$15 thereafter	60% (after deductible) <sup>1</sup>
Podiatric Care	\$25 copayment per visit	60% (after deductible) <sup>1</sup>
Allergy Testing and Serum	100% (after deductible)	60% (after deductible) <sup>1</sup>
Durable Medical Equipment and Corrective Appliances	100% (after deductible)	60% (after deductible) <sup>1</sup>
Fertility Testing	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>BEHAVIORAL HEALTH - Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
<b>Behavioral Health</b>		
Inpatient	100% (after deductible)	60% (after deductible) <sup>1</sup>
Outpatient	\$15 copayment per visit	60% (after deductible) <sup>1</sup>
<b>Substance Abuse Services</b>		
Inpatient Detoxification	100% (after deductible)	60% (after deductible) <sup>1</sup>
Inpatient Rehabilitation	100% (after deductible)	60% (after deductible) <sup>1</sup>
Outpatient Rehabilitation	\$15 copayment per visit	60% (after deductible) <sup>1</sup>
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<p><sup>1</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 may also have to pay the difference between the provider's charge and the UPMC Health Plan payment (reasonable and customary amount).</p>		

## PREFERRED PROVIDER ORGANIZATION

**PPO \$1,250 \$20/\$20**

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 SERVICE	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
<b>ANNUAL DEDUCTIBLE</b>		
Individual	\$1,250	\$2,500
Family	\$2,500	\$5,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>		
Individual	None	\$10,000
Family	None	\$20,000
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No	No
<b>PROVIDER SERVICES</b>		
Adult Preventive/Health Screening Exam	100% (deductible does not apply)	Not Covered
Screening Gynecological Exam	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Screening Mammograms	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Well Child-Exam	100% (deductible does not apply)	Not Covered
Pediatric Immunizations	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Provider Office Visit (for illness or injury)	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
Specialist Office Visit	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
Medical/Surgical Services	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>HOSPITAL SERVICES</b>		
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>EMERGENCY SERVICES</b>		
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)	
Urgent Care Facility	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
<b>DIAGNOSTIC SERVICES</b>		
Advanced Imaging (e.g. PET, MRI, etc.)	100% (after deductible)	60% (after deductible) <sup>1</sup>
Other Imaging (e.g. x-ray, sonogram, etc.)	100% (after deductible)	60% (after deductible) <sup>1</sup>
Lab and Other Services	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, Radiation, Infusion Therapy, Dialysis Treatment	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, Speech, and Occupational Therapy	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
	Covered up to 60 visits per benefit period for all three therapies combined	
<b>OTHER MEDICAL SERVICES</b>		
Skilled Nursing Facility (limit of 100 days/benefit period)	100% (after deductible)	60% (after deductible) <sup>1</sup>
Home Health Care	100% (after deductible)	60% (after deductible) <sup>1</sup>
Hospice Care	100% (after deductible)	60% (after deductible) <sup>1</sup>
Therapeutic Manipulation (limit of 25 visits/benefit period)	\$25 copayment (first visit)/\$20 thereafter	60% (after deductible) <sup>1</sup>
Podiatric Care	\$25 copayment per visit	60% (after deductible) <sup>1</sup>
Allergy Testing and Serum	100% (after deductible)	60% (after deductible) <sup>1</sup>
Durable Medical Equipment and Corrective Appliances	100% (after deductible)	60% (after deductible) <sup>1</sup>
Fertility Testing	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>BEHAVIORAL HEALTH - Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
<b>Behavioral Health</b>		
Inpatient	100% (after deductible)	60% (after deductible) <sup>1</sup>
Outpatient	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
<b>Substance Abuse Services</b>		
Inpatient Detoxification	100% (after deductible)	60% (after deductible) <sup>1</sup>
Inpatient Rehabilitation	100% (after deductible)	60% (after deductible) <sup>1</sup>
Outpatient Rehabilitation	\$20 copayment per visit	60% (after deductible) <sup>1</sup>
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<sup>1</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 may also have to pay the difference between the provider's charge and the UPMC Health Plan payment (reasonable and customary amount).		
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## PREFERRED PROVIDER ORGANIZATION

**PPO \$20/\$20**

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
<b>ANNUAL DEDUCTIBLE</b>		
Individual	None	\$500
Family	None	\$1,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>		
Individual	None	\$10,000
Family	None	\$20,000
<b>PLAN PAYMENT LEVEL</b>	100%	80% (after deductible) <sup>1</sup>
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No	No
<b>PROVIDER SERVICES</b>		
Adult Preventive/Health Screening Exam	100%	Not Covered
Screening Gynecological Exam	100%	80% (deductible does not apply) <sup>1</sup>
Screening Mammograms	100%	80% (deductible does not apply) <sup>1</sup>
Well-Child Exam	100%	Not Covered
Pediatric Immunizations	100%	80% (deductible does not apply) <sup>1</sup>
Provider Office Visit (for illness or injury)	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
Specialist Office Visit	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
Medical/Surgical Services	100%	80% (after deductible) <sup>1</sup>
<b>HOSPITAL SERVICES</b>		
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	100%	80% (after deductible) <sup>1</sup>
<b>EMERGENCY SERVICES</b>		
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)	
Urgent Care Facility	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
<b>DIAGNOSTIC SERVICES</b>		
Advanced Imaging (e.g. PET, MRI, etc.)	100%	80% (after deductible) <sup>1</sup>
Other Imaging (e.g. x-ray, sonogram, etc.)	100%	80% (after deductible) <sup>1</sup>
Lab and Other Services	100%	80% (after deductible) <sup>1</sup>
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, Radiation, Infusion Therapy, Dialysis Treatment	100%	80% (after deductible) <sup>1</sup>
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, Speech, and Occupational Therapy	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
	Covered up to 60 visits per benefit period for all three therapies combined	
<b>OTHER MEDICAL SERVICES</b>		
Skilled Nursing Facility (limit of 100 days/benefit period)	100%	80% (after deductible) <sup>1</sup>
Home Health Care	100%	80% (after deductible) <sup>1</sup>
Hospice Care	100%	80% (after deductible) <sup>1</sup>
Therapeutic Manipulation (limit of 25 visits/benefit period)	\$25 copayment (first visit)/\$15 thereafter	80% (after deductible) <sup>1</sup>
Podiatric Care	\$25 copayment per visit	80% (after deductible) <sup>1</sup>
Allergy Testing and Serum	100%	80% (after deductible) <sup>1</sup>
Durable Medical Equipment and Corrective Appliances	100%	80% (after deductible) <sup>1</sup>
Fertility Testing	100%	80% (after deductible) <sup>1</sup>
<b>BEHAVIORAL HEALTH - UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
<b>Behavioral Health</b>		
Inpatient	100%	80% (after deductible) <sup>1</sup>
Outpatient	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
<b>Substance Abuse Services</b>		
Inpatient Detoxification	100%	80% (after deductible) <sup>1</sup>
Inpatient Rehabilitation	100%	80% (after deductible) <sup>1</sup>
Outpatient Rehabilitation	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
This is not a contract. If differences exist between this summary and a group's contract or a member's certificate of coverage (COC), the contract or COC prevails.		
<sup>1</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 may also have to pay the difference between the provider's charge and the UPMC Health Plan payment (reasonable and customary amount).		
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## PREFERRED PROVIDER ORGANIZATION

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

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
<b>ANNUAL DEDUCTIBLE</b>		
Individual	\$250	\$500
Family	\$500	\$1,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>		
Individual	None	\$10,000
Family	None	\$20,000
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)	80% (after deductible) <sup>1</sup>
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No	No
<b>PROVIDER SERVICES</b>		
Adult Preventive/Health Screening Exam	100% (deductible does not apply)	Not Covered
Screening Gynecological Exam	100% (deductible does not apply)	80% (deductible does not apply) <sup>1</sup>
Screening Mammograms	100% (deductible does not apply)	80% (deductible does not apply) <sup>1</sup>
Well-Child Exam	100% (deductible does not apply)	Not Covered
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply) <sup>1</sup>
Provider Office Visit (for illness or injury)	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
Specialist Office Visit	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
Medical/Surgical Services	100% (after deductible)	80% (after deductible) <sup>1</sup>
<b>HOSPITAL SERVICES</b>		
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	100% (after deductible)	80% (after deductible) <sup>1</sup>
<b>EMERGENCY SERVICES</b>		
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)	
Urgent Care Facility	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
<b>DIAGNOSTIC SERVICES</b>		
Advanced Imaging (e.g. PET, MRI, etc.)	100% (after deductible)	80% (after deductible) <sup>1</sup>
Other Imaging (e.g. x-ray, sonogram, etc.)	100% (after deductible)	80% (after deductible) <sup>1</sup>
Lab and Other Services	100% (after deductible)	80% (after deductible) <sup>1</sup>
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, Radiation, Infusion Therapy, Dialysis Treatment	100% (after deductible)	80% (after deductible) <sup>1</sup>
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, Speech, and Occupational Therapy	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
	Covered up to 60 visits per benefit period for all three therapies combined	
<b>OTHER MEDICAL SERVICES</b>		
Skilled Nursing Facility (limit of 100 days/benefit period)	100% (after deductible)	80% (after deductible) <sup>1</sup>
Home Health Care	100% (after deductible)	80% (after deductible) <sup>1</sup>
Hospice Care	100% (after deductible)	80% (after deductible) <sup>1</sup>
Therapeutic Manipulation (limit of 25 visits/benefit period)	\$25 copayment (first visit)/\$15 thereafter	80% (after deductible) <sup>1</sup>
Podiatric Care	\$25 copayment per visit	80% (after deductible) <sup>1</sup>
Allergy Testing and Serum	100% (after deductible)	80% (after deductible) <sup>1</sup>
Durable Medical Equipment and Corrective Appliances	100% (after deductible)	80% (after deductible) <sup>1</sup>
Fertility Testing	100% (after deductible)	80% (after deductible) <sup>1</sup>
<b>BEHAVIORAL HEALTH - UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
<b>Behavioral Health</b>		
Inpatient	100% (after deductible)	80% (after deductible) <sup>1</sup>
Outpatient	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
<b>Substance Abuse Services</b>		
Inpatient Detoxification	100% (after deductible)	80% (after deductible) <sup>1</sup>
Inpatient Rehabilitation	100% (after deductible)	80% (after deductible) <sup>1</sup>
Outpatient Rehabilitation	\$20 copayment per visit	80% (after deductible) <sup>1</sup>
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<sup>1</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 may also have to pay the difference between the provider's charge and the UPMC Health Plan payment (reasonable and customary amount).		
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 Advocates: 1-888-876-2756. TTD Services: 1-800-361-2629.		

## PREFERRED PROVIDER ORGANIZATION

**PPO \$500 \$15/\$25**

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
<b>ANNUAL DEDUCTIBLE</b>		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>		
Individual	None	\$10,000
Family	None	\$20,000
<b>PLAN PAYMENT LEVEL</b>	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No	No
<b>PROVIDER SERVICES</b>		
Adult Preventive/Health Screening Exam	100% (deductible does not apply)	Not Covered
Screening Gynecological Exam	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Screening Mammograms	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Well-Child Exam	100% (deductible does not apply)	Not Covered
Pediatric Immunizations	100% (deductible does not apply)	60% (deductible does not apply) <sup>1</sup>
Provider Office Visit (for illness or injury)	\$15 copayment per visit	60% (after deductible) <sup>1</sup>
Specialist Office Visit	\$25 copayment per visit	60% (after deductible) <sup>1</sup>
Medical/Surgical Services	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>HOSPITAL SERVICES</b>		
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>EMERGENCY SERVICES</b>		
Emergency Care Coverage	\$50 copayment (copayment waived if admitted)	
Urgent Care Facility	\$25 copayment per visit	60% (after deductible) <sup>1</sup>
<b>DIAGNOSTIC SERVICES</b>		
Advanced Imaging (e.g. PET, MRI, etc.)	100% (after deductible)	60% (after deductible) <sup>1</sup>
Other Imaging (e.g. x-ray, sonogram, etc.)	100% (after deductible)	60% (after deductible) <sup>1</sup>
Lab and Other Services	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, Radiation, Infusion Therapy, Dialysis Treatment	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, Speech, and Occupational Therapy	\$15 copayment per visit	60% (after deductible) <sup>1</sup>
	Covered up to 60 visits per benefit period for all three therapies combined	
<b>OTHER MEDICAL SERVICES</b>		
Skilled Nursing Facility (limit of 100 days/benefit period)	100% (after deductible)	60% (after deductible) <sup>1</sup>
Home Health Care	100% (after deductible)	60% (after deductible) <sup>1</sup>
Hospice Care	100% (after deductible)	60% (after deductible) <sup>1</sup>
Therapeutic Manipulation (limit of 25 visits/benefit period)	\$25 copayment (first visit)/\$15 thereafter	60% (after deductible) <sup>1</sup>
Podiatric Care	\$25 copayment per visit	60% (after deductible) <sup>1</sup>
Allergy Testing and Serum	100% (after deductible)	60% (after deductible) <sup>1</sup>
Durable Medical Equipment and Corrective Appliances	100% (after deductible)	60% (after deductible) <sup>1</sup>
Fertility Testing	100% (after deductible)	60% (after deductible) <sup>1</sup>
<b>BEHAVIORAL HEALTH - Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
<b>Behavioral Health</b>		
Inpatient	100% (after deductible)	60% (after deductible) <sup>1</sup>
Outpatient	\$25 copayment per visit	60% (after deductible) <sup>1</sup>
<b>Substance Abuse Services</b>		
Inpatient Detoxification	100% (after deductible)	60% (after deductible) <sup>1</sup>
Inpatient Rehabilitation	100% (after deductible)	60% (after deductible) <sup>1</sup>
Outpatient Rehabilitation	\$25 copayment per visit	60% (after deductible) <sup>1</sup>
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<sup>1</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 may also have to pay the difference between the provider's charge and the UPMC Health Plan payment (reasonable and customary amount).		
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## PREFERRED PROVIDER ORGANIZATION

**PPO \$2,500/90% \$25/\$40**

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
<b>ANNUAL DEDUCTIBLE</b>		
Individual		\$2,500 - combined
Family		\$5,000 - combined
<b>ANNUAL OUT-OF-POCKET LIMIT (excludes deductibles and copayments)</b>		
Individual	\$1,500	\$10,000
Family	\$3,000	\$20,000
<b>PLAN PAYMENT LEVEL</b>	90% (after deductible)	70% (after deductible) <sup>1</sup>
<b>LIFETIME BENEFIT LIMIT</b>	Unlimited	Unlimited
<b>PRIMARY CARE PROVIDER (PCP) REQUIRED</b>	No	No
<b>PROVIDER SERVICES</b>		
Adult Preventive/Health Screening Exam	100% (deductible does not apply)	Not Covered
Screening Gynecological Exam	100% (deductible does not apply)	70% (deductible does not apply) <sup>1</sup>
Screening Mammograms	100% (deductible does not apply)	70% (deductible does not apply) <sup>1</sup>
Well-Child Exam	100% (deductible does not apply)	Not Covered
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply) <sup>1</sup>
Provider Office Visit (for illness or injury)	\$25 copayment per visit	70% (after deductible) <sup>1</sup>
Specialist Office Visit	\$40 copayment per visit	70% (after deductible) <sup>1</sup>
Medical/Surgical Services	90% (after deductible)	70% (after deductible) <sup>1</sup>
<b>HOSPITAL SERVICES</b>		
Inpatient/Outpatient Care, Medical/Surgical Services, Ancillary Services, and Supplies	90% (after deductible)	70% (after deductible) <sup>1</sup>
<b>EMERGENCY SERVICES</b>		
Emergency Care Coverage	\$100 copayment (copayment waived if admitted)	
Urgent Care Facility	\$40 copayment per visit	70% (after deductible) <sup>1</sup>
<b>DIAGNOSTIC SERVICES</b>		
Advanced Imaging (e.g. PET, MRI, etc.)	90% (after deductible)	70% (after deductible) <sup>1</sup>
Other Imaging (e.g. x-ray, sonogram, etc.)	90% (after deductible)	70% (after deductible) <sup>1</sup>
Lab and Other Services	90% (after deductible)	70% (after deductible) <sup>1</sup>
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, Radiation, Infusion Therapy, Dialysis Treatment	90% (after deductible)	70% (after deductible) <sup>1</sup>
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, Speech, and Occupational Therapy	\$25 copayment per visit	70% (after deductible) <sup>1</sup>
	Covered up to 60 visits per benefit period for all three therapies combined	
<b>OTHER MEDICAL SERVICES</b>		
Skilled Nursing Facility (limit of 100 days/benefit period)	90% (after deductible)	70% (after deductible) <sup>1</sup>
Home Health Care	90% (after deductible)	70% (after deductible) <sup>1</sup>
Hospice Care	90% (after deductible)	70% (after deductible) <sup>1</sup>
Therapeutic Manipulation (limit of 25 visits/benefit period)	\$25 copayment per visit	70% (after deductible) <sup>1</sup>
Podiatric Care	\$25 copayment per visit	70% (after deductible) <sup>1</sup>
Allergy Testing and Serum	90% (after deductible)	70% (after deductible) <sup>1</sup>
Durable Medical Equipment and Corrective Appliances	90% (after deductible)	70% (after deductible) <sup>1</sup>
Fertility Testing	90% (after deductible)	70% (after deductible) <sup>1</sup>
<b>BEHAVIORAL HEALTH - Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
<b>Behavioral Health</b>		
Inpatient	90% (after deductible)	70% (after deductible) <sup>1</sup>
Outpatient	\$25 copayment per visit	70% (after deductible) <sup>1</sup>
<b>Substance Abuse Services</b>		
Inpatient Detoxification	90% (after deductible)	70% (after deductible) <sup>1</sup>
Inpatient Rehabilitation	90% (after deductible)	70% (after deductible) <sup>1</sup>
Outpatient Rehabilitation	\$25 copayment per visit	70% (after deductible) <sup>1</sup>
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<sup>1</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 may also have to pay the difference between the provider's charge and the UPMC Health Plan payment (reasonable and customary amount).		
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# HEALTHY HIA PPO 750

## Preferred Provider Organization

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
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)	
<b>COMBINED ANNUAL DEDUCTIBLE</b>		
Individual coverage	\$750	Combined with Participating Provider Deductible
Family coverage	\$1,500	
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>		
Individual coverage	\$2,000	\$10,000
Family coverage	\$2,000 Ind./\$4,000 Fam.	\$10,000 Ind./\$20,000 Fam.
<b>PLAN PAYMENT LEVEL</b>	80% (after the deductible)	70% (after the deductible)
Lifetime benefit limit	Unlimited	Unlimited
Primary care provider (PCP) required	No	No
<b>PROVIDER MEDICAL SERVICES</b>		
Adult preventive/health screening examination	Covered 100%, you pay \$0	Not Covered
Pediatric preventive/health screening examination	Covered 100%, you pay \$0	Not Covered
Pediatric immunizations	Covered 100%, you pay \$0	Not Covered
Well-baby visits	Covered 100%, you pay \$0	Not Covered
Women's care	Covered 100%, you pay \$0	Not Covered
Screening gynecological exam	Covered 100%, you pay \$0	Not Covered
Screening Pap test and screening mammogram	Covered 100%, you pay \$0	Not Covered
Provider office visit (for illness or injury)	You pay 20% after deductible	You pay 30% after deductible
Specialist office visit	You pay 20% after deductible	You pay 30% after deductible
Medical/surgical services	You pay 20% after deductible	You pay 30% after deductible
<b>HOSPITAL SERVICES</b>		
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 20% after deductible	You pay 30% after deductible
<b>EMERGENCY SERVICES</b>		
Emergency care coverage	You pay 20% after deductible	You pay 20% after deductible
Urgent care facility	You pay 20% after deductible	You pay 30% after deductible
<b>DIAGNOSTIC SERVICES</b>		
Advanced imaging (e.g., PET, MRI, etc.)	You pay 20% after deductible	You pay 30% after deductible
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 20% after deductible	You pay 30% after deductible
Lab and other services	You pay 20% after deductible	You pay 30% after deductible
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 20% after deductible	You pay 30% after deductible
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 20% after deductible	You pay 30% after deductible
<b>OTHER MEDICAL SERVICES</b>		
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 20% after deductible	You pay 30% after deductible
Home health care	You pay 20% after deductible	You pay 30% after deductible
Hospice care	You pay 20% after deductible	You pay 30% after deductible
Therapeutic manipulation (Limit of 25 visits per benefit period)	You pay 20% after deductible	You pay 30% after deductible
Podiatric care	You pay 20% after deductible	You pay 30% after deductible
Allergy testing and serum	You pay 20% after deductible	You pay 30% after deductible
Durable medical equipment and corrective appliances	You pay 20% after deductible	You pay 30% after deductible
Fertility testing	You pay 20% after deductible	You pay 30% after deductible
<b>BEHAVIORAL HEALTH — CONTACT UPMC HEALTH PLAN BEHAVIORAL HEALTH SERVICES AT 1-888-251-0083.</b>		
<b>Behavioral Health</b>		
Inpatient	You pay 20% after deductible	You pay 30% after deductible
Outpatient	You pay 20% after deductible	You pay 30% after deductible
<b>Substance Abuse Services</b>		
Inpatient detoxification	You pay 20% after deductible	You pay 30% after deductible
Inpatient rehabilitation	You pay 20% after deductible	You pay 30% after deductible
Outpatient rehabilitation	You pay 20% after deductible	You pay 30% after deductible
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The deductible does not count toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.		
Out-of-Pocket Limit applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded.		
If care is from a Non-Participating (Out-of-Network) Provider, benefits are paid at a lower level after your annual deductible is met. If you go to a Non-Participating Provider, you may also have to pay the difference between the provider's charge and the UPMC Health Network, Inc., payment (reasonable and customary amount).		
HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.		

# HEALTHYU HRA PPO 750

## Preferred Provider Organization

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
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)	
<b>ANNUAL HRA ALLOCATION</b>		
Individual coverage	\$125	HRA funds can be used for both Participating and Non-Participating Providers.
Family coverage	\$250	
<b>COMBINED ANNUAL DEDUCTIBLE</b>		
Individual coverage	\$750	Combined with Participating Provider Deductible
Family coverage	\$1,500	
<b>ANNUAL OUT-OF-POCKET LIMIT</b>		
Individual	\$2,000	\$10,000
Family	\$2,000 Ind./\$4,000 Fam.	\$10,000 Ind./\$20,000 Fam.
<b>PLAN PAYMENT LEVEL</b>		
Lifetime benefit limit	80% (after the deductible)	70% (after the deductible)
Primary care provider (PCP) required	Unlimited	Unlimited
	No	No
<b>PROVIDER MEDICAL SERVICES</b>		
Adult preventive/health screening examination	Covered 100%; you pay \$0	Not Covered
Pediatric preventive/health screening examination	Covered 100%; you pay \$0	Not Covered
Pediatric immunizations	Covered 100%; you pay \$0	Not Covered
Well-baby visits	Covered 100%; you pay \$0	Not Covered
Women's care	Covered 100%; you pay \$0	Not Covered
Screening gynecological exam	Covered 100%; you pay \$0	Not Covered
Screening Pap test and screening mammogram	Covered 100%; you pay \$0	Not Covered
Provider office visit (for illness or injury)	You pay 20% after deductible	You pay 30% after deductible
Specialist office visit	You pay 20% after deductible	You pay 30% after deductible
Medical/surgical services	You pay 20% after deductible	You pay 30% after deductible
<b>HOSPITAL SERVICES</b>		
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 20% after deductible	You pay 30% after deductible
<b>EMERGENCY SERVICES</b>		
Emergency care coverage	You pay 20% after deductible	You pay 20% after deductible
Urgent care facility	You pay 20% after deductible	You pay 30% after deductible
<b>DIAGNOSTIC SERVICES</b>		
Advanced imaging (e.g., PET, MRI, etc.)	You pay 20% after deductible	You pay 30% after deductible
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 20% after deductible	You pay 30% after deductible
Lab and other services	You pay 20% after deductible	You pay 30% after deductible
<b>MEDICAL THERAPY SERVICES</b>		
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 20% after deductible	You pay 30% after deductible
<b>REHABILITATION THERAPY SERVICES</b>		
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 20% after deductible	You pay 30% after deductible
<b>OTHER MEDICAL SERVICES</b>		
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 20% after deductible	You pay 30% after deductible
Home health care	You pay 20% after deductible	You pay 30% after deductible
Hospice care	You pay 20% after deductible	You pay 30% after deductible
Therapeutic manipulation (Limit of 25 visits per benefit period)	You pay 20% after deductible	You pay 30% after deductible
Podiatric care	You pay 20% after deductible	You pay 30% after deductible
Allergy testing and serum	You pay 20% after deductible	You pay 30% after deductible
Durable medical equipment and corrective appliances	You pay 20% after deductible	You pay 30% after deductible
Fertility testing	You pay 20% after deductible	You pay 30% after deductible
<b>BEHAVIORAL HEALTH — CONTACT UPMC HEALTH PLAN BEHAVIORAL HEALTH SERVICES AT 1-888-251-0083.</b>		
<b>Behavioral Health</b>		
Inpatient	You pay 20% after deductible	You pay 30% after deductible
Outpatient	You pay 20% after deductible	You pay 30% after deductible
<b>Substance Abuse Services</b>		
Inpatient detoxification	You pay 20% after deductible	You pay 30% after deductible
Inpatient rehabilitation	You pay 20% after deductible	You pay 30% after deductible
Outpatient rehabilitation	You pay 20% after deductible	You pay 30% after deductible

Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The deductible does not count toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.

Out-of-Pocket Limit applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded.

If care is from a Non-Participating (Out-of-Network) Provider, benefits are paid at a lower level after your annual deductible is met. If you go to a Non-Participating Provider, you may also have to pay the difference between the provider's charge and the UPMC Health Network, Inc., payment (reasonable and customary amount).

HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.

# HEALTHYU HIA EPO 750

## Exclusive Provider Organization

The Exclusive Provider Organization (EPO) plan offers you one benefit level. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from the EPO network participating providers.

COVERED SERVICES	PARTICIPATING PROVIDER
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)
<b>COMBINED ANNUAL DEDUCTIBLE</b>	
Individual coverage	\$750
Family coverage	\$1,500
<b>ANNUAL OUT-OF-POCKET LIMIT</b>	
Individual coverage	\$2,000
Family coverage	\$2,000 Ind./\$4,000 Fam.
<b>PLAN PAYMENT LEVEL</b>	
Lifetime benefit limit	80% (after the deductible)
Primary care provider (PCP) required	Unlimited
<b>PROVIDER MEDICAL SERVICES</b>	
Adult preventive/health screening examination	No
Pediatric preventive/health screening examination	Covered 100%; you pay \$0
Pediatric immunizations	Covered 100%; you pay \$0
Well-baby visits	Covered 100%; you pay \$0
Women's care	Covered 100%; you pay \$0
Screening gynecological exam	Covered 100%; you pay \$0
Screening Pap test and screening mammogram	Covered 100%; you pay \$0
Provider office visit (for illness or injury)	You pay 20% after deductible
Specialist office visit	You pay 20% after deductible
Medical/surgical services	You pay 20% after deductible
<b>HOSPITAL SERVICES</b>	
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 20% after deductible
<b>EMERGENCY SERVICES</b>	
Emergency care coverage	You pay 20% after deductible
Urgent care facility	You pay 20% after deductible
<b>DIAGNOSTIC SERVICES</b>	
Advanced imaging (e.g., PET, MRI, etc.)	You pay 20% after deductible
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 20% after deductible
Lab and other services	You pay 20% after deductible
<b>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 20% after deductible
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 20% after deductible
<b>OTHER MEDICAL SERVICES</b>	
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 20% after deductible
Home health care	You pay 20% after deductible
Hospice care	You pay 20% after deductible
Therapeutic manipulation (Limit of 25 visits per benefit period)	You pay 20% after deductible
Podiatric care	You pay 20% after deductible
Allergy testing and serum	You pay 20% after deductible
Durable medical equipment and corrective appliances	You pay 20% after deductible
Fertility testing	You pay 20% after deductible
<b>BEHAVIORAL HEALTH — CONTACT UPMC HEALTH PLAN BEHAVIORAL HEALTH SERVICES AT 1-888-251-0083.</b>	
<b>Behavioral Health</b>	
Inpatient	You pay 20% after deductible
Outpatient	You pay 20% after deductible
<b>Substance Abuse Services</b>	
Inpatient detoxification	You pay 20% after deductible
Inpatient rehabilitation	You pay 20% after deductible
Outpatient rehabilitation	You pay 20% after deductible
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The Deductible does not count toward satisfaction of the Out-of-Pocket Limits specified in the Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.	
HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.	

## HEALTHYU HRA EPO 750

### Exclusive Provider Organization

The Exclusive Provider Organization (EPO) plan offers you one benefit level. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from the EPO network participating providers.

COVERED SERVICES	PARTICIPATING PROVIDER
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)
<b>ANNUAL HRA ALLOCATION</b>	
Individual coverage	\$125
Family coverage	\$250
<b>COMBINED ANNUAL DEDUCTIBLE</b>	
Individual coverage	\$750
Family coverage	\$1,500
<b>ANNUAL OUT-OF-POCKET LIMIT</b>	
Individual coverage	\$2,000
Family coverage	\$2,000 Ind./\$4,000 Fam.
<b>PLAN PAYMENT LEVEL</b>	80% (after the deductible)
Lifetime benefit limit	Unlimited
Primary care provider (PCP) required	No
<b>PROVIDER MEDICAL SERVICES</b>	
Adult preventive/health screening examination	Covered 100%; you pay \$0
Pediatric preventive/health screening examination	Covered 100%; you pay \$0
Pediatric immunizations	Covered 100%; you pay \$0
Well-baby visits	Covered 100%; you pay \$0
Women's care	Covered 100%; you pay \$0
Screening gynecological exam	Covered 100%; you pay \$0
Screening Pap test and screening mammogram	Covered 100%; you pay \$0
Provider office visit (for illness or injury)	You pay 20% after deductible
Specialist office visit	You pay 20% after deductible
Medical/surgical services	You pay 20% after deductible
<b>HOSPITAL SERVICES</b>	
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 20% after deductible
<b>EMERGENCY SERVICES</b>	
Emergency care coverage	You pay 20% after deductible
Urgent care facility	You pay 20% after deductible
<b>DIAGNOSTIC SERVICES</b>	
Advanced imaging (e.g., PET, MRI, etc.)	You pay 20% after deductible
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 20% after deductible
Lab and other services	You pay 20% after deductible
<b>MEDICAL THERAPY SERVICES</b>	
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 20% after deductible
<b>REHABILITATION THERAPY SERVICES</b>	
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 20% after deductible
<b>OTHER MEDICAL SERVICES</b>	
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 20% after deductible
Home health care	You pay 20% after deductible
Hospice care	You pay 20% after deductible
Therapeutic manipulation (Limit of 25 visits per benefit period)	You pay 20% after deductible
Podiatric care	You pay 20% after deductible
Allergy testing and serum	You pay 20% after deductible
Durable medical equipment and corrective appliances	You pay 20% after deductible
Fertility testing	You pay 20% after deductible
<b>BEHAVIORAL HEALTH — CONTACT UPMC HEALTH PLAN BEHAVIORAL HEALTH SERVICES AT 1-888-251-0083.</b>	
<b>Behavioral Health</b>	
Inpatient	You pay 20% after deductible
Outpatient	You pay 20% after deductible
<b>Substance Abuse Services</b>	
Inpatient detoxification	You pay 20% after deductible
Inpatient rehabilitation	You pay 20% after deductible
Outpatient rehabilitation	You pay 20% after deductible
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The Deductible does not count toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.	
HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.	

# HEALTHYU HIA PPO MULTIPLE PLANS (1250, 2500, 3750)

## Preferred Provider Organization

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		
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)					
<b>COMBINED ANNUAL DEDUCTIBLE</b>	A	B	C	Combined with Participating Provider Deductible		
Individual coverage	\$1,250	\$2,500	\$3,750			
Family coverage	\$2,500	\$5,000	\$7,500			
<b>ANNUAL OUT-OF-POCKET LIMIT</b>	A	B	C	A	B	C
Individual coverage	\$1,250	\$2,500	\$3,750	\$10,000	\$10,000	\$10,000
Family coverage	\$1,250 Ind. \$2,500 Fam.	\$2,500 Ind. \$5,000 Fam.	\$3,750 Ind. \$7,500 Fam.	\$10,000 Ind. \$20,000 Fam.	\$10,000 Ind. \$20,000 Fam.	\$10,000 Ind. \$20,000 Fam.
<b>PLAN PAYMENT LEVEL</b>	90% (after the deductible)			70% (after the deductible)		
Lifetime benefit limit	Unlimited			Unlimited		
Primary care provider (PCP) required	No			No		
<b>PROVIDER MEDICAL SERVICES</b>						
Adult preventive/health screening examination	Covered 100%; you pay \$0			Not Covered		
Pediatric preventive/health screening examination	Covered 100%; you pay \$0			Not Covered		
Pediatric immunizations	Covered 100%; you pay \$0			Not Covered		
Well-baby visits	Covered 100%; you pay \$0			Not Covered		
Women's care	Covered 100%; you pay \$0			Not Covered		
Screening gynecological exam	Covered 100%; you pay \$0			Not Covered		
Screening Pap test and screening mammogram	Covered 100%; you pay \$0			Not Covered		
Provider office visit (for illness or injury)	You pay 10% after deductible			You pay 30% after deductible		
Specialist office visit	You pay 10% after deductible			You pay 30% after deductible		
Medical/surgical services	You pay 10% after deductible			You pay 30% after deductible		
<b>HOSPITAL SERVICES</b>						
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 10% after deductible			You pay 30% after deductible		
<b>EMERGENCY SERVICES</b>						
Emergency care coverage	You pay 10% after deductible			You pay 10% after deductible		
Urgent care facility	You pay 10% after deductible			You pay 30% after deductible		
<b>DIAGNOSTIC SERVICES</b>						
Advanced imaging (e.g., PET, MRI, etc.)	You pay 10% after deductible			You pay 30% after deductible		
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 10% after deductible			You pay 30% after deductible		
Lab and other services	You pay 10% after deductible			You pay 30% after deductible		
<b>MEDICAL THERAPY SERVICES</b>						
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 10% after deductible			You pay 30% after deductible		
<b>REHABILITATION THERAPY SERVICES</b>						
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 10% after deductible			You pay 30% after deductible		
<b>OTHER MEDICAL SERVICES</b>						
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 10% after deductible			You pay 30% after deductible		
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 (Limit of 25 visits per benefit period)	You pay 10% after deductible			You pay 30% after deductible		
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		
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.</b>						
<b>Behavioral Health</b>						
Inpatient	You pay 10% after deductible			You pay 30% after deductible		
Outpatient	You pay 10% after deductible			You pay 30% after deductible		
<b>Substance Abuse Services</b>						
Inpatient detoxification	You pay 10% after deductible			You pay 30% after deductible		
Inpatient rehabilitation	You pay 10% after deductible			You pay 30% after deductible		
Outpatient rehabilitation	You pay 10% after deductible			You pay 30% after deductible		
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. Deductible does not apply toward satisfaction of Out-of-Pocket Limits specified in this Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.						
Out-of-Pocket Limit applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded.						
If care is from a Non-Participating (Out-of-Network) Provider, benefits are paid at a lower level after your annual deductible is met. If you go to a Non-Participating Provider, you may also have to pay the difference between the provider's charge and the UPMC Health Network, Inc., payment (reasonable and customary amount).						
HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.						

# HEALTHYU HRA PPO MULTIPLE PLANS (1250, 2500, 3750)

## Preferred Provider Organization

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		
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)					
<b>ANNUAL HRA ALLOCATION</b>	A	B	C	HRA funds can be used for both Participating and Non-Participating Providers		
Individual coverage	\$125	\$750	\$1,375			
Family coverage	\$250	\$1,500	\$2,750			
<b>COMBINED ANNUAL DEDUCTIBLE</b>	A	B	C	Combined with Participating Provider Deductible		
Individual coverage	\$1,250	\$2,500	\$3,750			
Family coverage	\$2,500	\$5,000	\$7,500			
<b>ANNUAL OUT-OF-POCKET LIMIT</b>	A	B	C	A	B	C
Individual coverage	\$1,250	\$2,500	\$3,750	\$10,000	\$10,000	\$10,000
Family coverage	\$1,250 Ind. \$2,500 Fam.	\$2,500 Ind. \$5,000 Fam.	\$3,750 Ind. \$7,500 Fam.	\$10,000 Ind. \$20,000 Fam.	\$10,000 Ind. \$20,000 Fam.	\$10,000 Ind. \$20,000 Fam.
<b>PLAN PAYMENT LEVEL</b>	90% (after the deductible)			70% (after the deductible)		
Lifetime benefit limit	Unlimited			Unlimited		
Primary care provider (PCP) required	No			No		
<b>PROVIDER MEDICAL SERVICES</b>						
Adult preventive/health screening examination	Covered 100%, you pay \$0			Not Covered		
Pediatric preventive/health screening examination	Covered 100%, you pay \$0			Not Covered		
Pediatric immunizations	Covered 100%, you pay \$0			Not Covered		
Well-baby visits	Covered 100%, you pay \$0			Not Covered		
Women's care	Covered 100%, you pay \$0			Not Covered		
Screening gynecological exam	Covered 100%, you pay \$0			Not Covered		
Screening Pap test and screening mammogram	Covered 100%, you pay \$0			Not Covered		
Provider office visit (for illness or injury)	You pay 10% after deductible			You pay 30% after deductible		
Specialist office visit	You pay 10% after deductible			You pay 30% after deductible		
Medical/surgical services	You pay 10% after deductible			You pay 30% after deductible		
<b>HOSPITAL SERVICES</b>						
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 10% after deductible			You pay 30% after deductible		
<b>EMERGENCY SERVICES</b>						
Emergency care coverage	You pay 10% after deductible			You pay 10% after deductible		
Urgent care facility	You pay 10% after deductible			You pay 30% after deductible		
<b>DIAGNOSTIC SERVICES</b>						
Advanced imaging (e.g., PET, MRI, etc.)	You pay 10% after deductible			You pay 30% after deductible		
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 10% after deductible			You pay 30% after deductible		
Lab and other services	You pay 10% after deductible			You pay 30% after deductible		
<b>MEDICAL THERAPY SERVICES</b>						
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 10% after deductible			You pay 30% after deductible		
<b>REHABILITATION THERAPY SERVICES</b>						
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 10% after deductible			You pay 30% after deductible		
<b>OTHER MEDICAL SERVICES</b>						
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 10% after deductible			You pay 30% after deductible		
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 (Limit of 25 visits per benefit period)	You pay 10% after deductible			You pay 30% after deductible		
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		
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.</b>						
<b>Behavioral Health</b>						
Inpatient	You pay 10% after deductible			You pay 30% after deductible		
Outpatient	You pay 10% after deductible			You pay 30% after deductible		
<b>Substance Abuse Services</b>						
Inpatient detoxification	You pay 10% after deductible			You pay 30% after deductible		
Inpatient rehabilitation	You pay 10% after deductible			You pay 30% after deductible		
Outpatient rehabilitation	You pay 10% after deductible			You pay 30% after deductible		

Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. Deductible does not apply toward satisfaction of Out-of-Pocket Limits specified in this Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.

Out-of-Pocket Limit applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded.

If care is from a Non-Participating (Out-of-Network) Provider, benefits are paid at a lower level after your annual deductible is met. If you go to a Non-Participating Provider, you may also have to pay the difference between the provider's charge and the UPMC Health Network, Inc., payment (reasonable and customary amount).

HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.

## HEALTHYU HIA EPO MULTIPLE PLANS (1250, 2500, 3750)

### Exclusive Provider Organization

The Exclusive Provider Organization (EPO) plan offers you one benefit level. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from the EPO network participating providers.

COVERED SERVICES	PARTICIPATING PROVIDER		
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)		
<b>COMBINED ANNUAL DEDUCTIBLE</b>	A	B	C
Individual coverage	\$1,250	\$2,500	\$3,750
Family coverage	\$2,500	\$5,000	\$7,500
<b>ANNUAL OUT-OF-POCKET LIMIT</b>	A	B	C
Individual coverage	\$1,250	\$2,500	\$3,750
Family coverage	\$1,250 Ind. \$2,500 Fam.	\$2,500 Ind. \$5,000 Fam.	\$3,750 Ind. \$7,500 Fam.
<b>PLAN PAYMENT LEVEL</b>	90% (after the deductible)		
Lifetime benefit limit	Unlimited		
Primary care provider (PCP) required	No		
<b>PROVIDER MEDICAL SERVICES</b>			
Adult preventive/health screening examination	Covered 100%; you pay \$0		
Pediatric preventive/health screening examination	Covered 100%; you pay \$0		
Pediatric immunizations	Covered 100%; you pay \$0		
Well-baby visits	Covered 100%; you pay \$0		
Women's care	Covered 100%; you pay \$0		
Screening gynecological exam	Covered 100%; you pay \$0		
Screening Pap test and screening mammogram	Covered 100%; you pay \$0		
Provider office visit (for illness or injury)	You pay 10% after deductible		
Specialist office visit	You pay 10% after deductible		
Medical/surgical services	You pay 10% after deductible		
<b>HOSPITAL SERVICES</b>			
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 10% after deductible		
<b>EMERGENCY SERVICES</b>			
Emergency care coverage	You pay 10% after deductible		
Urgent care facility	You pay 10% after deductible		
<b>DIAGNOSTIC SERVICES</b>			
Advanced imaging (e.g., PET, MRI, etc.)	You pay 10% after deductible		
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 10% after deductible		
Lab and other services	You pay 10% after deductible		
<b>MEDICAL THERAPY SERVICES</b>			
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 10% after deductible		
<b>REHABILITATION THERAPY SERVICES</b>			
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 10% after deductible		
<b>OTHER MEDICAL SERVICES</b>			
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 10% after deductible		
Home health care	You pay 10% after deductible		
Hospice care	You pay 10% after deductible		
Therapeutic manipulation (Limit of 25 visits per benefit period)	You pay 10% after deductible		
Podiatric care	You pay 10% after deductible		
Allergy testing and serum	You pay 10% after deductible		
Durable medical equipment and corrective appliances	You pay 10% after deductible		
Fertility testing	You pay 10% after deductible		
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.</b>			
<b>Behavioral Health</b>			
Inpatient	You pay 10% after deductible		
Outpatient	You pay 10% after deductible		
<b>Substance Abuse Services</b>			
Inpatient detoxification	You pay 10% after deductible		
Inpatient rehabilitation	You pay 10% after deductible		
Outpatient rehabilitation	You pay 10% after deductible		
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The Deductible does not count toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.			
HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.			

## HEALTHYU HRA EPO MULTIPLE PLANS (1250, 2500, 3750)

### Exclusive Provider Organization

The Exclusive Provider Organization (EPO) plan offers you one benefit level. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from the EPO network participating providers.

COVERED SERVICES	PARTICIPATING PROVIDER		
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)		
<b>ANNUAL HRA ALLOCATION</b>	A	B	C
Individual coverage	\$125	\$750	\$1,375
Family coverage	\$250	\$1,500	\$2,750
<b>COMBINED ANNUAL DEDUCTIBLE</b>	A	B	C
Individual coverage	\$1,250	\$2,500	\$3,750
Family coverage	\$2,500	\$5,000	\$7,500
<b>ANNUAL OUT-OF-POCKET LIMIT</b>	A	B	C
Individual	\$1,250	\$2,500	\$3,750
Family	\$1,250 Ind. \$2,500 Fam.	\$2,500 Ind. \$5,000 Fam.	\$3,750 Ind. \$7,500 Fam.
<b>PLAN PAYMENT LEVEL</b>	90% (after the deductible)		
Lifetime benefit limit	Unlimited		
Primary care provider (PCP) required	No		
<b>PROVIDER MEDICAL SERVICES</b>			
Adult preventive/health screening examination	Covered 100%; you pay \$0		
Pediatric preventive/health screening examination	Covered 100%; you pay \$0		
Pediatric immunizations	Covered 100%; you pay \$0		
Well-baby visits	Covered 100%; you pay \$0		
Women's care	Covered 100%; you pay \$0		
Screening gynecological exam	Covered 100%; you pay \$0		
Screening Pap test and screening mammogram	Covered 100%; you pay \$0		
Provider office visit (for illness or injury)	You pay 10% after deductible		
Specialist office visit	You pay 10% after deductible		
Medical/surgical services	You pay 10% after deductible		
<b>HOSPITAL SERVICES</b>			
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 10% after deductible		
<b>EMERGENCY SERVICES</b>			
Emergency care coverage	You pay 10% after deductible		
Urgent care facility	You pay 10% after deductible		
<b>DIAGNOSTIC SERVICES</b>			
Advanced imaging (e.g., PET, MRI, etc.)	You pay 10% after deductible		
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 10% after deductible		
Lab and other services	You pay 10% after deductible		
<b>MEDICAL THERAPY SERVICES</b>			
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 10% after deductible		
<b>REHABILITATION THERAPY SERVICES</b>			
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 10% after deductible		
<b>OTHER MEDICAL SERVICES</b>			
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 10% after deductible		
Home health care	You pay 10% after deductible		
Hospice care	You pay 10% after deductible		
Therapeutic manipulation (Limit of 25 visits per benefit period)	You pay 10% after deductible		
Podiatric care	You pay 10% after deductible		
Allergy testing and serum	You pay 10% after deductible		
Durable medical equipment and corrective appliances	You pay 10% after deductible		
Fertility testing	You pay 10% after deductible		
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.</b>			
<b>Behavioral Health</b>			
Inpatient	You pay 10% after deductible		
Outpatient	You pay 10% after deductible		
<b>Substance Abuse Services</b>			
Inpatient detoxification	You pay 10% after deductible		
Inpatient rehabilitation	You pay 10% after deductible		
Outpatient rehabilitation	You pay 10% after deductible		
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The Deductible does not count toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.			
HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.			

## HEALTHYU HSA EPO MULTIPLE PLANS (1250, 2500, 3750)

### Exclusive Provider Organization

The Exclusive Provider Organization (EPO) plan offers you one benefit level. There is no requirement to select a primary care physician (PCP) to coordinate your care. Except for emergency services, all covered care must be received from the EPO network participating providers.

COVERED SERVICES	PARTICIPATING PROVIDER		
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)		
<b>COMBINED ANNUAL DEDUCTIBLE</b>	A	B	C
Individual coverage	\$1,250	\$2,500	\$3,750
Family coverage	\$2,500	\$5,000	\$7,500
<b>ANNUAL OUT-OF-POCKET LIMIT</b>	A	B	C
Individual coverage	\$1,250	\$2,500	\$2,300
Family coverage	\$1,250 Ind. \$2,500 Fam.	\$2,500 Ind. \$5,000 Fam.	\$2,300 Ind. \$4,600 Fam.
<b>PLAN PAYMENT LEVEL</b>	90% (after the deductible)		
Lifetime benefit limit	Unlimited		
Primary care provider (PCP) required	No		
<b>PROVIDER MEDICAL SERVICES</b>			
Adult preventive/health screening examination	Covered 100%; you pay \$0		
Pediatric preventive/health screening examination	Covered 100%; you pay \$0		
Pediatric immunizations	Covered 100%; you pay \$0		
Well-baby visits	Covered 100%; you pay \$0		
Women's care	Covered 100%; you pay \$0		
Screening gynecological exam	Covered 100%; you pay \$0		
Screening Pap test and screening mammogram	Covered 100%; you pay \$0		
Provider office visit (for illness or injury)	You pay 10% after deductible		
Specialist office visit	You pay 10% after deductible		
Medical/surgical services	You pay 10% after deductible		
<b>HOSPITAL SERVICES</b>			
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 10% after deductible		
<b>EMERGENCY SERVICES</b>			
Emergency care coverage	You pay 10% after deductible		
Urgent care facility	You pay 10% after deductible		
<b>DIAGNOSTIC SERVICES</b>			
Advanced imaging (e.g., PET, MRI, etc.)	You pay 10% after deductible		
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 10% after deductible		
Lab and other services	You pay 10% after deductible		
<b>MEDICAL THERAPY SERVICES</b>			
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 10% after deductible		
<b>REHABILITATION THERAPY SERVICES</b>			
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 10% after deductible		
<b>OTHER MEDICAL SERVICES</b>			
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 10% after deductible		
Home health care	You pay 10% after deductible		
Hospice care	You pay 10% after deductible		
Therapeutic manipulation (Limit of 25 visits per benefit period)	You pay 10% after deductible		
Podiatric care	You pay 10% after deductible		
Allergy testing and serum	You pay 10% after deductible		
Durable medical equipment and corrective appliances	You pay 10% after deductible		
Fertility testing	You pay 10% after deductible		
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.</b>			
<b>Behavioral Health</b>			
Inpatient	You pay 10% after deductible		
Outpatient	You pay 10% after deductible		
<b>Substance Abuse Services</b>			
Inpatient detoxification	You pay 10% after deductible		
Inpatient rehabilitation	You pay 10% after deductible		
Outpatient rehabilitation	You pay 10% after deductible		
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The Deductible does not count toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.			
HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.			

# HEALTHYU HSA PPO MULTIPLE PLANS (1250, 2500, 3750)

## Preferred Provider Organization

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		
<b>HEALTH INCENTIVE ACCOUNT ANNUAL LIMIT</b>	\$500 (individual)/\$1,000 (family)					
<b>COMBINED ANNUAL DEDUCTIBLE</b>	A	B	C	Combined with Participating Provider Deductible		
Individual coverage	\$1,250	\$2,500	\$3,750			
Family coverage	\$2,500	\$5,000	\$7,500			
<b>ANNUAL OUT-OF-POCKET LIMIT</b>	A	B	C	A	B	C
Individual coverage	\$1,250	\$2,500	\$2,300	\$10,000	\$10,000	\$10,000
Family coverage	\$1,250 Ind. \$2,500 Fam.	\$2,500 Ind. \$5,000 Fam.	\$2,300 Ind. \$4,600 Fam.	\$10,000 Ind. \$20,000 Fam.	\$10,000 Ind. \$20,000 Fam.	\$10,000 Ind. \$20,000 Fam.
<b>PLAN PAYMENT LEVEL</b>	90% (after the deductible)			70% (after the deductible)		
Lifetime benefit limit	Unlimited			Unlimited		
Primary care provider (PCP) required	No			No		
<b>PROVIDER MEDICAL SERVICES</b>						
Adult preventive/health screening examination	Covered 100%; you pay \$0			You pay 30% after deductible		
Pediatric preventive/health screening examination	Covered 100%; you pay \$0			You pay 30% after deductible		
Pediatric immunizations	Covered 100%; you pay \$0			You pay 30% after deductible		
Well-baby visits	Covered 100%; you pay \$0			You pay 30% after deductible		
Women's care	Covered 100%; you pay \$0			You pay 30% after deductible		
Screening gynecological exam	Covered 100%; you pay \$0			You pay 30% after deductible		
Screening Pap test and screening mammogram	Covered 100%; you pay \$0			You pay 30% after deductible		
Provider office visit (for illness or injury)	You pay 10% after deductible			You pay 30% after deductible		
Specialist office visit	You pay 10% after deductible			You pay 30% after deductible		
Medical/surgical services	You pay 10% after deductible			You pay 30% after deductible		
<b>HOSPITAL SERVICES</b>						
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 10% after deductible			You pay 30% after deductible		
<b>EMERGENCY SERVICES</b>						
Emergency care coverage	You pay 10% after deductible			You pay 10% after deductible		
Urgent care facility	You pay 10% after deductible			You pay 30% after deductible		
<b>DIAGNOSTIC SERVICES</b>						
Advanced imaging (e.g., PET, MRI, etc.)	You pay 10% after deductible			You pay 30% after deductible		
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 10% after deductible			You pay 30% after deductible		
Lab and other services	You pay 10% after deductible			You pay 30% after deductible		
<b>MEDICAL THERAPY SERVICES</b>						
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 10% after deductible			You pay 30% after deductible		
<b>REHABILITATION THERAPY SERVICES</b>						
Physical, speech, and occupational (Covered up to 60 visits per Benefit Period for all three therapies combined.)	You pay 10% after deductible			You pay 30% after deductible		
<b>OTHER MEDICAL SERVICES</b>						
Skilled nursing facility (Limit of 100 days per benefit period)	You pay 10% after deductible			You pay 30% after deductible		
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 (Limit of 25 visits per benefit period)	You pay 10% after deductible			You pay 30% after deductible		
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		
<b>BEHAVIORAL HEALTH — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.</b>						
<b>Behavioral Health</b>						
Inpatient	You pay 10% after deductible			You pay 30% after deductible		
Outpatient	You pay 10% after deductible			You pay 30% after deductible		
<b>Substance Abuse Services</b>						
Inpatient detoxification	You pay 10% after deductible			You pay 30% after deductible		
Inpatient rehabilitation	You pay 10% after deductible			You pay 30% after deductible		
Outpatient rehabilitation	You pay 10% after deductible			You pay 30% after deductible		
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The Deductible does not count toward satisfaction of the						
Out-of-Pocket Limits specified in this Schedule of Benefits. The Family Deductible must be met by one or more members of the family before benefits subject to a deductible will be paid.						
Out-of-Pocket Limit applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded.						
If care is from a Non-Participating (Out-of-Network) Provider, benefits are paid at a lower level after your annual deductible is met. If you go to a Non-Participating Provider, you may also have to pay the difference between the provider's charge and the UPMC Health Network, Inc., payment (reasonable and customary amount).						
HIA funds are earned by members participating in healthy activities. These activities have a predetermined dollar amount. Funds earned in the Health Incentive Account are used to pay coinsurance, copayments, and deductibles.						

**Footnotes for Commercial Summaries of Benefits (pages 20-47)**

- The term “UPMC Health Plan” collectively refers to UPMC Health Plan, Inc., and UPMC Health Network, Inc. UPMC Health Plan, Inc., administers benefits for UPMC Health Network, Inc.
- If care is out-of-network, benefits are paid at a lower level according to each plan design (except for emergency services). If a member goes to an out-of-network provider, the member may also have to pay the difference between the provider’s charge and the UPMC Health Plan payment (reasonable and customary amount).
- All self-directed care for HMO/EPO members, as well as for the in-network level of benefits for PPO members, must be to in-network providers.
- This managed care plan may not cover all health care expenses. Members should read their certificates of coverage carefully for complete information about benefits and exclusions. If members have any questions, they should call our UPMC Health Plan Member Advocates at the number listed on their identification card or on their Summary of Benefits.

# Pharmacy Plan Options

PPO and EPO Plan Options		
Prescription Options	Copayment (generic/preferred/non-preferred)	
	Retail (30-day supply)	Mail Order (90-day supply)
Option 1	\$10/\$20/\$40	\$20/\$40/\$80
Option 2	\$15/\$30/\$50	\$30/\$60/\$100
Option 3	\$5/\$28/\$56	\$10/\$56/\$112
Option 6	\$8/\$38/\$76	\$16/\$76/\$152
Option 7	\$12/\$24/\$48	\$24/\$48/\$96

HealthyU HIA and HRA Pharmacy Options				
Option 1 Integrated	During deductible period	After the deductible has been met		
		Generic	Preferred brand	Non-preferred brand/specialty
	<b>Actual drug cost</b>	<b>\$8</b>	<b>\$38</b>	<b>\$76</b>
Option 2 Non-Integrated	Both During Deductible Period and After Deductible Has Been Met			
	Generic	Preferred brand	Non-preferred brand/Specialty	
	<b>\$5</b>	<b>30% of actual drug cost (up to \$100)</b>	<b>50% of actual drug cost (up to \$150)</b>	

HealthyU HSA Pharmacy Options				
	During deductible period	After the deductible has been met		
		Generic	Preferred brand	Non-preferred brand/specialty
Option 1	Actual drug cost	\$8	\$38	\$76
Option 2	Actual drug cost	\$5	30% of actual drug cost (up to \$100)	50% of actual drug cost (up to \$150)

IRS regulations require the full deductible (combined medical and pharmacy) to be satisfied before prescription drug benefits apply.



# PLAN ADMINISTRATION

# 3



# UNDERWRITING GUIDELINES - MEDICAL PLANS

## Employer Eligibility

Eligible employer groups must employ 2 to 99 eligible employees. An employer/employee relationship between each individual seeking coverage and the small business entity, regardless of the marital or ownership status of any individual seeking coverage, must be present in order for an individual to be eligible for coverage. Employee eligibility is further defined in the next section.

Employer groups must be in business for a minimum of three months to be eligible for coverage.

Employer group contributions toward cost of medical coverage must be no less than 50 percent of the total cost of each rating tier or 75 percent of the individual premium in each of the tiers. Underwriting may consider exceptions when reviewing cases as long as participation guidelines are met.

Union employees may be carved-out. Non-union carve-outs are considered on a case-by-case basis. Executive management level carve-outs are not permitted.

Employer groups terminated by UPMC Health Plan for nonpayment of premium are not eligible to reapply for coverage until 12 months have lapsed after termination date. If the Health Plan grants reapplication, a required payment of two months premium is due before the policy will be issued.

Out-of-area coverage is limited to the following:

Out-of-Area Coverage	
# of Eligible Employees	Maximum Out-of-Area % of Total Eligible Employees
2-6	No coverage available
7-20	15%
21-99	25%

If for any reason, an existing group's out-of-area enrollment becomes greater than the 15% or 25% guidelines listed, the entire group may be non-renewed for failure to meet UPMC Health Plan participation guidelines.

For groups with 2-50 eligible employees, only one out-of-area benefit plan is permitted per group.

Out-of-area benefit plans are applicable only if UPMC Health Plan is offered as the total replacement carrier. Preferred Provider Organization (PPO) and *HealthyU* PPO (HIA, HRA, HSA) products are the only out-of-area plans offered. If the in-area plan selected is a PPO or *HealthyU* PPO, the out-of-area plan must be equivalent to or of lesser benefit than the in-area plan.

For groups with 51-99 eligible employees UPMC Health Plan will allow blended rates for in-area and out-of-area plan offerings. In no event will a blended out-of-area rate be approved if sold with a non-blended in-area rate or vice versa.

**Employee Eligibility**

Eligible employees are active, full-time employees, as defined by the employer, who have met the employer’s probationary period. UPMC Health Plan requires employees to work a minimum of 25 hours per week to be considered a full-time employee. Part-time employees (those working fewer than 25 hours per week), absentee owners, seasonal workers, IRS 1099 contractors who are not employees, directors and trustees of the company, and Medicare-eligible retirees are not eligible for coverage. UPMC Health Plan offers group and individual Medicare Advantage plans for Medicare-eligible retirees.

An owner must receive full-time compensation from the company to be considered for coverage. If the owner is not reflected on the UC-2A, include the most recent Schedule C and a letter on company letterhead with the owner’s name, exact hours worked, and duties performed, and indicate that he/she is a full-time employee of the business enterprise (working 25+ hours per week).

The employer group determines waiting periods, which must be applied consistently to all employees.

All employer groups with 50 or fewer eligible employees must submit a copy of their most recent PA UC-2A/Quarterly Wage and Tax Statement (Unemployment Compensation Tax Form), which must contain names, salaries, and weeks worked for all employees of the employer group.

Employees who have been terminated or work part time must be noted accordingly on the UC-2A. Recently hired employees not listed on the UC-2A must have a W4 or payroll stub submitted with the UC-2A.

There are circumstances when an employee will not be included on a UC-2A form or when the company is not required to file a UC-2A. Refer to the following table for alternate types of acceptable documentation.

<b>If a UC-2A is not available, submit one from Category A</b>		<b>... and one from Category B</b>
<b>Category A</b>	<b>Category B</b>	
IRS 1040 - Schedule C or F	K-1s or Articles of Incorporation	
IRS 1065 - Partnership Income	K-1s or Partnership Agreement	
IRS 1120 - Corporate Income	Current Business License	
IRS 941 - Not-for-Profit Use Only*	Leases and Other Contracts	
IRS 990 - Return of Organization Exempt from Tax*		

\*Must submit copy of payroll journal; no Category B information required.

Only new employees and employees experiencing a documented qualifying event will be permitted to enroll outside the open enrollment period during the benefit year. For the purposes of this section, a qualifying event is defined as a (1) marriage, (2) birth/adoption of a child, or (3) a loss of other existing coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or other verifiable reason for loss of coverage eligibility.

additional dependents (other than those resulting from a documented qualifying event) will be permitted at the employer group’s benefit plan anniversary date or during open enrollment.

Employees initially waiving group coverage for any reason other than the employer’s waiting period must wait until the next open enrollment period to enroll, unless there is a documented qualifying event.

Dependent coverage will be permitted to begin on the effective date of the covered employee’s coverage. Coverage for

# UNDERWRITING GUIDELINES - DENTAL AND VISION ADVANTAGE PLANS

## A. Employer Eligibility

Eligible employer groups must employ 2 to 50 eligible employees. An employer-employee relationship between each individual seeking coverage and the small business entity, regardless of the marital or ownership status of any individual seeking coverage, must be present in order for an individual to be eligible for coverage. Employee eligibility is further defined in the next section.

Employer groups must be in business for a minimum of three (3) months to be eligible for coverage.

Employer group contributions toward the cost of dental and vision coverage must be equal to or greater than contributions for the employer's group medical coverage as a percentage of the premium.

Union employees may be carved-out. Non-union carve-outs will be considered on a case-by-case basis. Executive management level carve-outs will not be permitted.

Employer groups that have been terminated by UPMC Health Plan for non-payment of premium will not be eligible to reapply for coverage until 12 months have lapsed after the termination date. In the event that UPMC Health Plan grants the reapplication, UPMC Health Plan will require payment of two months of premium in advance of issuance of the policy.

Out-of-area coverage is limited to 10% of the enrolled population. If for any reason an existing group's out-of-area enrollment becomes greater than 10%, the entire group may be non-renewed for failure to meet UPMC Health Plan participation guidelines.

## B. Employee Eligibility

Eligible employees are active, full-time employees, as defined by the employer, who have met the employer's probationary period. UPMC Health Plan considers full-time employees as employees who work a minimum of 25 hours per week. Part-time employees (employees working less than 25 hours per week), absentee owners, seasonal workers, 1099 employees, directors and trustees of the company, and Medicare-eligible retirees are not eligible for coverage. An owner must receive full-time compensation from the company to be considered for coverage.

Waiting periods are determined by the employer group and must be applied consistently to all employees.

Only new employees and employees experiencing a documented qualifying event will be permitted to enroll outside the open enrollment period during the benefit year. For the purposes of this section, a qualifying event is defined as a (1) marriage, (2) birth/adoption of a child, or (3) a loss of other existing coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or other verifiable reason for loss of coverage eligibility.

Dependent coverage will be permitted to begin on the effective date of the covered employee's coverage. Employees enrolling with UPMC medical for themselves and their dependents may elect UPMC Dental *Advantage* for themselves, but they are not required to enroll all of their dependents. Dependent only coverage is not available; the employee must elect UPMC Dental *Advantage* for themselves before their dependents could be eligible for coverage. Additional dependents not enrolled on the effective date (other than those resulting from a documented qualifying event) will be permitted to enroll at the employer group's benefit plan anniversary date or during open enrollment.

Employees initially waiving group coverage for any reason other than the employer's waiting period must wait until the next open enrollment period to enroll, unless there is a documented qualifying event.

## C. Group Size and Enrollment Requirements

After the initial effective date, UPMC Dental *Advantage* and/or UPMC Vision *Advantage* quoted in combination with UPMC medical must renew on the same renewal date. Plan deductibles and annual maximums will need to be re-satisfied based on the new effective date of the UPMC dental and/or UPMC vision coverage.

For groups with 2 to 9 eligible employees, At least 100% of all employees enrolled in UPMC medical must enroll for UPMC dental and/or UPMC vision. Coverage may be terminated if required participation levels and minimum enrolled contracts are not met and maintained throughout the policy period. Coverage will not be

accepted if the overall average number of members per contract is 5 or more. UPMC Dental *Advantage* and/or UPMC Vision *Advantage* purchased as stand-alone coverage(s) will require 100% participation and will only be eligible for basic dental and/or basic vision coverage.

For groups with 10+ eligible employees, rates quoted in combination with UPMC medical require that a minimum of 50% of the employees enrolled for UPMC medical coverage elect UPMC dental and/or UPMC vision. UPMC will allow eligible employees who waive UPMC medical coverage to elect UPMC dental and/or UPMC vision coverage for themselves and their dependents. These employees will not be counted toward the participation requirement. If required participation levels are not met by the effective date of coverage, dental rates will be adjusted to the quoted stand-alone dental rates. If the overall average number of members per contract is 5 or more, UPMC Health Plan reserves the right to re-evaluate our quoted rates.

For groups with 10+ eligible employees, rates quoted for stand-alone dental and/or stand-alone vision require that a minimum of 70% of all eligible employees must enroll in UPMC dental and/or UPMC vision coverage, including employees waiving for spousal coverage. Coverage may be terminated if required participation levels and minimum enrolled contracts are not met and maintained throughout the policy period. If the overall average number of members per contract is 5 or more, UPMC Health Plan reserves the right to re-evaluate our quoted rates.

UPMC Health Plan must be offered as total replacement coverage for groups of 2 to 50 eligible employees. Dual option plans are not permitted for groups with less than 51 eligible employees.

Groups with no prior dental coverage will only be permitted to enroll in basic dental for the first 12 months of coverage.

Consolidated Omnibus Budget Reconciliation Act (COBRA) will be offered to eligible individuals who formerly received coverage through employer groups that have active enrollment in UPMC Health Plan and/or to those whom UPMC Health Plan is required to offer coverage under state or federal law. The percentage of COBRA subscribers cannot exceed 10% of the total number of enrolled subscribers.

All employer groups must submit their first month's premium no later than the 10th of the month prior to the effective date of the benefit plan.

Should final enrollment change by +/- 10% during new group implementation or at annual open enrollment either in total or by tier, UPMC Health Plan reserves the right to re-evaluate rates.

Dental and vision benefit plan changes/ additions/deletions are permitted at time of renewal only.

Non-standard dental and vision benefit plans will not be permitted.

All rates must be approved by the UPMC Health Plan Underwriting Department.

**Any deviation from the underwriting guidelines must have UPMC Health Plan Underwriting Department approval.**

***This document is meant to be informative and is not intended to be an all-inclusive statement of UPMC Health Plan underwriting guidelines. Other policies and guidelines may apply.***

## GROUP SIZE AND ENROLLMENT REQUIREMENTS

A minimum of 75% of eligible employees must have coverage in a health benefit plan either through the plan offered by the employer group, a spouse's employer, a government program (Medicare, Medical Assistance, military), a union, or other comparable coverage.

At least 50% of all eligible employees must be enrolled in a plan offered by UPMC Health Plan. A minimum of two employees must be enrolled with UPMC Health Plan. Medicare-eligible retirees do not qualify as eligible employees. For groups with 2 to 50 eligible employees, employees covered by another plan must complete the waiver section on the Member Enrollment Application and provide their sponsor plan number or a copy of their ID card.

UPMC Health Plan must be offered as total replacement coverage for groups of 2 to 50 eligible employees. **Dual option plans are not permitted for in-area employees in groups with less than 20 eligible employees.**

Plan options are limited to two plans and cannot be multiple Health Maintenance Organization (HMO) or multiple Point of Service (POS) plans.

*HealthyU* plans may be offered as a dual option for groups with 20-99 eligible employees. *HealthyU* HIA/HRA/HSA plans can only be offered alongside a PPO/EPO plan with a minimum deductible of \$500. Two HIA/HRA/HSA plan options are also permitted.

Dual option must be a true "buy up" situation and cannot be used to carve out management-level employees, offering a

richer benefit. UPMC Health Plan requires that there is at least one enrollee in the dual option plan. Dual option rates must have a rate differential of no less than 7% and no greater than 35%.

UPMC Health Plan may be offered as a benefit plan along with other competing plans for groups of 51-99 eligible employees. If the plan is offered on an optional basis, the employer group must agree to make no attempt, whether through differential premium contributions or otherwise, to encourage or discourage enrollment in any one plan. In the event that UPMC Health Plan is offered on an optional basis, a minimum of 40% of all eligible employees residing within the UPMC Health Plan service area must enroll in the UPMC plan. Additional participation requirements may be set at the discretion of the UPMC Health Plan Underwriting Department. Out-of-area enrollment maximums still apply.

Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage will be offered to eligible individuals who formerly received coverage through employer groups that have active enrollment in UPMC Health Plan and/or to those whom UPMC Health Plan is required to offer coverage under state or federal law. Total COBRA enrolled employees cannot exceed 15% of total enrolled subscribers for the 51-99 eligible employee groups.

All employer groups must submit their first month's premium no later than the 10th of the month prior to the effective date of the benefit plan.

# RATE DETERMINATION

The UPMC Health Plan demographic rating applies to groups with eligible 2-99 employees. Employer Standard SIC code or description of industry as well as census data must be provided for all eligible employees.

Industry classification for a particular group is based on overall description of the employer group's business and not on the individual duties of its employees or locations.

Submitted census data must include the names of employees who are waiving coverage as well as COBRA participants and must reflect date of birth, gender, residence zip code, and tier status on each employee.

UPMC Health Plan will apply medical underwriting to new business quotes for groups with 2-50 eligible employees by collecting and reviewing individual medical questionnaires for each enrolling employee, spouse, and dependent. Groups will be rated appropriately for medical conditions, but cannot be denied coverage.

Medical questionnaires received for underwriting for one quarter can be used to re-rate a 2-50 eligible employees group for only the next consecutive quarter. Thereafter, new questionnaires must be completed.

All questionnaires must be signed by the applicant and spouse, if applicable, to be considered a complete application. The option to submit electronic questionnaires is available via the UPMC Health Plan Web-based portal.

Quoted rates are subject to change pending validation of group demographics, tier status, group SIC, and review of applicable medical questionnaires based on demographic changes.

If enrollment of an existing group changes by more than 50 percent (+/-) within the contract period, Underwriting has the right to re-underwrite the group to determine if rates need to be adjusted accordingly. Medical questionnaires may be requested for new employees in such situations.

Should final enrollment change during new group implementation or at annual open enrollment either in total or by tier, UPMC Health Plan reserves the right to re-evaluate rates based on the following:

Enrolled Contracts Prior to Change	Where Enrollment Changes by +/-
<10	50%
10-25	25%
26-50	15%

All *HealthyU* plans quoted by UPMC Health Plan assume standard plan setup. The HIA will pay first (if/when available), then the HRA (if/when available), then the member. The HRA administration is assumed to be the responsibility of UPMC Health Plan. Any deviation from these assumptions may result in a change in the quoted rates. Employers' choice of HSA funding will not affect quoted rates.

All PPO and EPO plans with deductibles quoted by UPMC Health Plan assume that the employee is paying 100% of the total plan deductible. Any deviation from these assumptions will result in a change in the quoted rates.

All UPMC *HealthyU* products assume that the Health Incentive Accounts (HIAs) are funded by UPMC Health Plan and have maximum limits of \$500 individual/\$1,000 family. HRA rates assume that employer HRA allocation is 50% of the total plan deductible minus the HIA limit (HRA allocation + HIA limit = 50% of total plan deductible). Employer HRA allocation for \$750/\$1,500 deductible plans will be \$125 individual/\$250 family. HRA administration is assumed to be the responsibility of UPMC Health Plan. The employer's level of HSA funding will not affect quoted rates. Deviations from these assumptions will not be permitted for employer groups with less than 200 eligible employees.

Self-funded arrangements will not be permitted for Small Business *Advantage* groups.

Prescription drug carve-out will not be permitted for Small Business *Advantage* groups.

Benefit plan changes/additions/deletions are permitted at renewal of the benefit plan only.

All rates must be approved by the UPMC Health Plan Underwriting Department.

Predetermined nonstandard plan designs are available for "flexing" plan options for new businesses. Any other nonstandard plan designs will not be permitted for Small Business *Advantage* groups.

## COMMON OWNERSHIP

If the controlling owner/decision maker owns more than one company, common ownership must be documented and the owner/decision maker must have majority ownership in each company. Shareholders are not considered to be controlling owners/decision makers.

If groups have only one SIC code, the companies can be rated as one employer group, or at the request of the employer group, UPMC Health Plan will permit separate rate development.

### **2 to 50 eligible employees:**

If groups have different SIC codes, the groups will be medically underwritten and rated as two separate groups. Requests for blended rates will be permitted following the initial rating.

### **More than 50 eligible employees:**

Underwriting will prepare blended rates to develop one rate for the group.

Any deviation from underwriting guidelines must have UPMC Health Plan Underwriting Department approval.

## Mini-COBRA

Under the Pennsylvania Mini-COBRA Act, insured group health plans offered by employers with 2-19 employees must provide continuation of coverage to employees and dependents after certain qualifying events.

UPMC Health Plan has modified its member material going forward with respect to the availability of Mini-COBRA. Accordingly, it will be the responsibility of the employers (or their designated COBRA administrators) to notify employees regarding the availability of Mini-COBRA coverage.

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**This information is meant to be informative and is not intended to be an all-inclusive statement of UPMC Health Plan underwriting guidelines. Other policies and guidelines may apply.**

# TIPS FOR ADMINISTERING YOUR COVERAGE

Employers may choose to use **Employer OnLine** at [www.upmhealthplan.com](http://www.upmhealthplan.com) OR submit paper forms.

**Additions** are effective the date of hire and/or fulfillment of the company waiting period. To enroll new employees, submit a new enrollment application with the employee's name, Social Security number, effective date of enrollment, and coverage code.

**Terminations** are always effective on the date of termination. To terminate employees, submit an orange termination request with the employee's name, Social Security number, and effective date of termination.

## Changes

- For address changes and dependent updates, the employer must submit a Member Application and Change Form to UPMC Health Plan's Enrollment Department.

- Employees may add dependents only during the company's annual open enrollment period or following a documented qualifying event.

Event	Effective First Day of Month After	Documentation Required
Birth	Date of birth	Indicate the birth in the "Date of Qualifying Event" box on the Membership Application and Change form
Adoption	Date of adoption	Copy of legal adoption document
Loss of coverage	Date of loss	Notice from dependent's carrier or employer
Marriage	Date of marriage	Indicate in "Date of Qualifying Event" box on Member Application and Change Form
Divorce or legal separation	Date of divorce or legal separation	Note the date of the divorce or separation and provide a copy of legal document of divorce or separation

Employer OnLine enables employers to review existing member information, make changes to demographic information, and terminate and reinstate members.

Submit Membership Termination and Member Application and Change forms to UPMC Health Plan's Enrollment Department at:

UPMC Health Plan  
Suite 500, One Chatham Center  
Pittsburgh, PA 15219  
Fax: 412-454-7770

## Online Administration

UPMC Health Plan employer groups have access to online administration capabilities. Through Employer OnLine at [www.upmhealthplan.com](http://www.upmhealthplan.com), employers can provide demographics on eligible members and their

dependents by using an electronic application and submitting the information to the Health Plan. Employer OnLine also allows employers to review member information, make changes to demographic information, terminate members, and reinstate members.

# PREMIUM PAYMENTS

## **Paying by Mail**

- Make checks payable to UPMC Health Plan.
- Include the payment coupon from your monthly billing statement, which is the first page (Remittance Advice page).
- Mail to UPMC Health Plan, Box 371842, Pittsburgh, PA 15250-7842.

***Do not send any kind of membership change forms with your payment. Submit changes through Employer OnLine or mail the UPMC Health Plan Member Application and Change Form to the address in the Changes section.***

## **Online Payments**

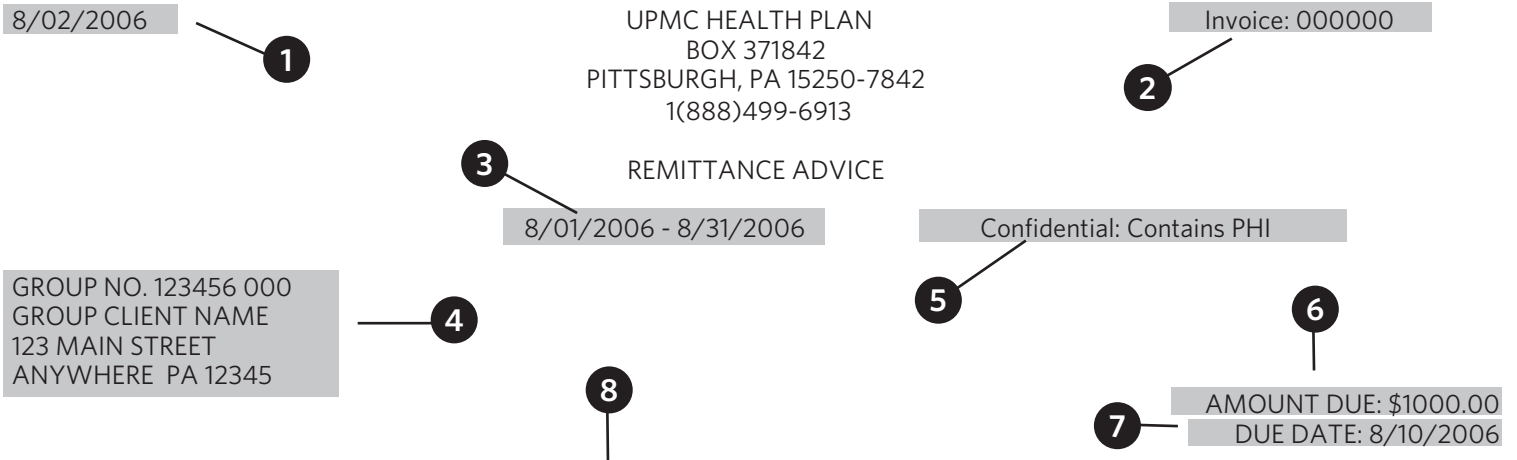
Go to <http://paybill.upmc.com>.

At "Paying Your Bills Online," click on UPMC Health Plan and then select "UPMC Health Plan Commercial." Click on the YES button and follow the directions at "Online Bill Payment."

You'll receive a detailed e-mail confirmation of your payment.

If you have questions about your billing statement, please contact UPMC Health Plan's Member Advocates at 1-888-876-2756 Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m.

On the following pages you will find an example of an updated monthly billing statement, complete with sample data and explanations of the various line items on the statement.



----DETACH HERE AND RETURN BOTTOM PORTION WITH YOUR PAYMENT---

UPMC HEALTH PLAN  
BOX 371842  
PITTSBURGH, PA 15250-7842

CUSTOMER NUMBER	INVOICE DATE
CUSTOMER NAME	INVOICE NUMBER
CUSTOMER ADDRESS	INV. COVERAGE PERIOD
CUSTOMER ADDRESS	AMOUNT DUE
CITY, STATE ZIP	DUE DATE OF PAYMENT

AMOUNT ENCLOSED: \_\_\_\_\_

I 0001234567 000000987654 0000007400 0000014800 200608 7

- 1** The date that UPMC Health Plan printed the statement.
- 2** A number, unique to your statement, that you can reference in any questions or correspondence that you may have.
- 3** The service dates to which the billing statement applies.
- 4** Your main account number, group name, and billing address.
- 5** A reminder that the statement contains confidential information. "PHI" stands for "protected health information" and refers to any name, address, ID number, or other data on the statement that could identify an individual member.
- 6** The total amount of money that you owe to UPMC Health Plan or the amount of credit that UPMC Health Plan owes to you. If your amount due is positive, this is the amount that you must pay in order for your UPMC Health Plan coverage to continue. If your amount due is negative, UPMC Health Plan will give you credit in this amount toward your next premium.
- 7** The date by which UPMC Health Plan must receive your payment. Payments received after this date are considered delinquent.
- 8** Instructions or notes from UPMC Health Plan that pertain to your billing statement. This area usually includes directions for paying your premium along with your payment coupon, the address to which you should send your payment, telephone numbers to call in case you have any questions about your billing statement, and any other important information that UPMC Health Plan needs to communicate to you.

8/01/2006

BOX 371842

UPMC HEALTH PLAN  
Page: 1  
PITTSBURGH, PA 15250-7842  
1(888)499-6913

Invoice: 000000

\*-----\*  
\* BILLING STATEMENT \*  
\*-----\*

8/01/2006 - 8/31/2006

Confidential: Contains PHI

GROUP NO. 123456  
GROUP CLIENT NAME  
123 MAIN STREET  
ANYWHERE PA 12345

Balance Forward  
Received check dated 8/01/2006 No. 000000

ID	SUBSCRIBER	TYPE	PLAN DESCRIPTION	COVERAGE	PERIOD	AMOUNT
000000000	MEMBER NAME	PREM	A60 ENHANCED ACCESS HMO	FAMILY	AUG 2006	1000.00
TOTAL BILLED AMOUNT:						1000.00
TOTAL AMOUNT DUE:						1000.00

Due Date: 8/10/2006

- The date that UPMC Health Plan printed the billing statement.
- A number, unique to your billing statement, that you can reference in any questions or correspondence that you may have.
- The service dates to which the billing statement applies.
- A reminder that the statement contains confidential information. "PHI" stands for "protected health information" and refers to any name, address, ID number, or other data on the statement that could identify an individual member.
- Your main account number, group name, and billing address.
- The amount you owed, or the amount of credit owed to you, as of the last billing statement that UPMC Health Plan sent you. This item also includes a description of any payments that you made, or any credits issued to you, since the last statement that UPMC Health Plan sent you. If your payment was made by check, this note will also include your check number.
- The unique contract or member identification number assigned to each individual listed under your group coverage.
- The name of the individual referenced in #7.
- An internal code that the Billing department uses to identify reports. This will always be "PREM" on a premium billing statement.
- The internal UPMC Health Plan code for your benefit plan design and a short description of your plan.
- The type of coverage each covered individual carries, i.e., Individual, Individual and Spouse, Family.
- The coverage period that applies to each line item on your billing statement.
- The actual dollar amount of the charge for each line item on your billing statement.
- The date by which UPMC Health Plan must receive your payment. Payments received after this date are considered delinquent.
- The total of the dollar amounts in the "Amount" column.
- The total of your Balance Forward (#6), less any payments that you have made to UPMC Health Plan since your last billing statement, plus your charges for this billing period (#15).

8/01/2006  
1

UPMC HEALTH PLAN  
Page: 2

Invoice: 000000  
2

8/01/2006 - 8/31/2006  
3

Confidential: Contains PHI  
4

5  
GROUP NO. 123456 000  
GROUP CLIENT NAME

ACTIVITY ANALYSIS  
(See previous page for amount due)  
SUMMARY OF PREMIUM AND RIDER CHARGES BY MONTH:

6 MONTH	PLAN	DESCRIPTION	AMOUNT	9
3/2004	A60	PREMIUM	250.05	8
4/2004	A60	PREMIUM	250.05	
5/2004	A60	PREMIUM	250.05	
6/2004	A60	PREMIUM	8,205.15	
			TOTAL BILLED:	9,277.12

SUMMARY OF COVERAGE (TIERING) LEVELS FOR CURRENT MONTH:

	# SUBS
EE ONLY	4
EE + SPOUSE	5
EE + TWO/MORE DEPS	1
EE + SP + DEPS	5
	15

10

- 1 The date that UPMC Health Plan printed the billing statement.
- 2 A number, unique to your billing statement, that you can reference in any questions or correspondence that you may have.
- 3 The service dates to which the billing statement applies.
- 4 A reminder that the statement contains confidential information. "PHI" stands for "protected health information" and refers to any name, address, ID number, or other data on the statement that could identify an individual member.
- 5 Your main account number and group name.
- 6 The coverage period that applies to each line on the Activity Analysis page of your billing statement.
- 7 The internal UPMC Health Plan code for your benefit plan design.
- 8 Short description of each line on the Activity Analysis page of your billing statement.
- 9 The actual dollar amounts on your billing statement, totaled and sorted by coverage period.
- 10 The total number of subscribers on your billing statement, totaled and sorted by the type of coverage each subscriber carries, i.e., Individual, Individual and Spouse, Family.

# UPMC HEALTH PLAN

One Chatham Center  
112 Washington Place  
Pittsburgh, PA 15219

[www.upmchealthplan.com](http://www.upmchealthplan.com)