Summary of Benefits UPMC Health Plan Health Savings Account $1250	**UPMC Business *Advantage*** **Self Assure*** Rx: $8/$38/$76/$76

*Self Assure plans are self-funded plans.

Covered Services*	**Participating Provider**	**Non-Participating Provider**
Annual deductible		
Individual Coverage	$2,500 - combined per Benefit Period.	
Family Coverage	$5,000 - combined per Benefit Period.	
Annual out-of-pocket limit (includes Copayments, Coinsurance and Deductibles for Covered Services specified in this Summary of Benefits)		
Individual Coverage	None	$10,000 per Benefit Period.
Family Coverage	None	$20,000 per Benefit Period.
Plan payment level	Covered at 100% after deductible.	You pay 20% after deductible.
Lifetime benefit limit	Unlimited	Unlimited
Primary care provider (PCP) required	No	No
Pre-existing condition limitations	None	None
Pre-certification requirements	Provider responsibility	Member responsibility - $500 penalty per incident for failure to pre-certify nonemergency inpatient admissions.
Provider Medical Services[3]		
Adult Care		
Preventive/health screening examination	Covered at 100%; you pay $0.	Not covered.
Pediatric Care		
Preventive/health screening examination	Covered at 100%; you pay $0.	Not covered.
Pediatric immunizations	Covered at 100%; you pay $0.	You pay 20% (deductible does not apply).
Well-baby visits	Covered at 100%; you pay $0.	Not covered.
Women's Care		
Screening gynecological exam	Covered at 100%; you pay $0.	You pay 20% (deductible does not apply).
Screening Pap test and screening mammogram	Covered at 100%; you pay $0.	You pay 20% (deductible does not apply).
Provider office visit (for illness or injury)	Covered at 100% after deductible.	You pay 20% after deductible.
Specialist office visit	Covered at 100% after deductible.	You pay 20% after deductible.
Medical/surgical services	Covered at 100% after deductible.	You pay 20% after deductible.
Hospital Services		
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	Covered at 100% after deductible.	You pay 20% after deductible.

Covered Services	Participating Provider	Non-Participating Provider
Emergency Services		
Emergency department	Covered at 100% after deductible.	
Emergency transportation	Covered at 100% after deductible.	
Urgent care facility	Covered at 100% after deductible.	You pay 20% after deductible.
Diagnostic Services		
Advanced imaging (e.g. PET, MRI, etc.)	Covered at 100% after deductible.	You pay 20% after deductible.
Other imaging (e.g., x-ray, sonogram, etc.)	Covered at 100% after deductible.	You pay 20% after deductible.
Lab and other services	Covered at 100% after deductible.	You pay 20% after deductible.
Medical Therapy Services		
Chemotherapy, radiation, dialysis treatment	Covered at 100% after deductible.	You pay 20% after deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	Covered at 100% after deductible.	You pay 20% after deductible.
Rehabilitation/Habilitation Therapy Services		
Physical and occupational therapy	Covered at 100% after deductible.	You pay 20% after deductible.
	Covered up to 30 visits per Benefit Period both therapies combined	
Speech therapy	Covered at 100% after deductible.	You pay 20% after deductible.
	Limit of 30 visits per Benefit Period	
Other Medical Services		
Acupuncture	Covered at 100% after deductible.	You pay 20% after deductible.
Allergy testing and serum	Covered at 100% after deductible.	You pay 20% after deductible.
Durable medical equipment and corrective appliances	Covered at 100% after deductible.	You pay 20% after deductible.
Fertility testing	Covered at 100% after deductible.	You pay 20% after deductible.
Home health care	Covered at 100% after deductible.	You pay 20% after deductible.
	Benefit Limit of 60 days per Benefit Period	
Hospice care	Covered at 100% after deductible.	You pay 20% after deductible.
Podiatry care	Covered at 100% after deductible.	You pay 20% after deductible.
Private duty nursing	Covered at 100% after deductible.	You pay 20% after deductible.
Skilled nursing facility	Covered at 100% after deductible.	You pay 20% after deductible.
	Limit of 120 days per Benefit Period	
Therapeutic manipulation	Covered at 100% after deductible.	You pay 20% after deductible.
	Limit of 20 visits per Benefit Period	

Covered Services	Participating Provider	Non-Participating Provider
Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083		
Behavioral health		
Inpatient	Covered at 100% after deductible.	You pay 20% after deductible.
Outpatient	Covered at 100% after deductible.	You pay 20% after deductible.
Substance abuse services		
Inpatient detoxification	Covered at 100% after deductible.	You pay 20% after deductible.
Inpatient rehabilitation	Covered at 100% after deductible.	You pay 20% after deductible.
Outpatient rehabilitation	Covered at 100% after deductible.	You pay 20% after deductible.
Prescription Drug Coverage – The *Your Choice* pharmacy program will apply (mandatory generic). Subject to Plan Deductible		
Retail prescription drug[4] • Prescriptions must be dispensed by a participating pharmacy	You pay $8 copayment for generic drugs You pay $38 copayment for preferred brand drugs You pay $76 copayment for non-preferred brand drugs 90-day maximum retail supply available for 3 copayments	
Specialty prescription drug[4] • Specialty medications are limited to a 30-day supply • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request)	You pay $76 copayment for specialty drugs 30-day maximum supply	
Mail-order prescription drug[4] • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy	You pay $16 copayment for generic drugs You pay $76 copayment for preferred brand drugs You pay $152 copayment for non-preferred brand drugs 90-day maximum mail-order supply	

* All services must be Medically Necessary and, when required, Prior authorization must be obtained.

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

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

[3] UPMC Health Plan maintains that the coverage described in this document is at all times administered in compliance with applicable laws and regulations. If at any time any part or provision of this Statement of Benefits is in conflict with any applicable law, regulation, or other controlling authority, the requirements of that authority shall prevail.

[4] If the brand-name drug is dispensed instead of the generic equivalent, you must pay the copayment associated with the brand-name drug as well as the retail price difference between the brand-name drug and the generic drug.

This summary is meant to assist in comparing the benefit plans. It is not a contract. If differences exist between this summary and a group's contract or a member's Certificate of Coverage, the contract or Certificate of Coverage prevails.

In this document, the term "UPMC Health Plan" refers to benefit plans offered by UPMC Health Network, Inc., as well as plans offered by UPMC Health Plan, Inc.

This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

UPMC Health Plan Member Services: 1-888-876-2756
TTY Services: 1-800-361-2629

UPMC Health Plan

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