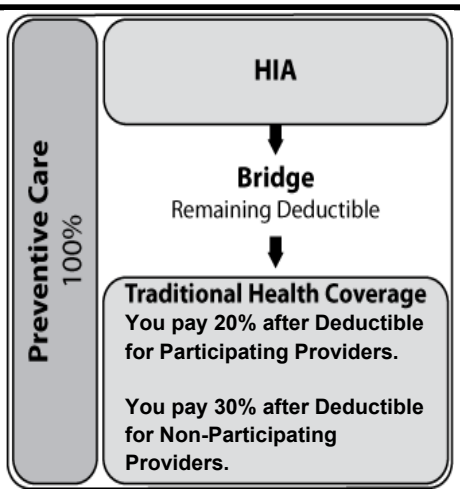
Summary of Benefits
UPMC Health Plan
HIA PPO $750-80% Rx: $8/$38/$76/$76

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

UPMC HealthyU

will provide incentives to help you *Understand* your health, *Improve* your health status, and *Partner* with your doctor for ongoing involvement.

You can earn up to $500 with individual coverage and up to $1,000 with family coverage. When you complete eligible healthy activities, you earn reward dollars that automatically go toward your deductibles, coinsurance, and copayments.



HIA Information

HIA annual incentive dollars are used to pay eligible expenses, including deductible, coinsurance, and copayments. You can roll over twice your deductible amount from year to year if you have unused funds.

Earn Reward Dollars

Members and their families have the opportunity to earn reward dollars in a Health Incentive Account (HIA). You earn these reward dollars by completing healthy activities in three easy ways.

Understand, Improve and Partner

1. *Understand* – Learn more about your health status by completing a confidential health risk assessment (HRA) or biometric screening.
2. *Improve* – Once you understand the areas that you need to improve, you can talk with our health coaches to get you started. You can track your progress in areas like quitting smoking, losing weight, understanding and managing a disease/health condition, or increasing physical activity in your busy life. Completing eligible healthy activities will improve your health and earn money in your Health Incentive Account.
3. *Partner* – Take your activities to the next level by getting your annual physical, eye, or dental and other preventive exams. Your doctor can help you develop strategies and suggest resources to help you achieve your health-related goals.

Covered Services*	Participating Provider	Non-Participating Provider
Annual health incentives dollars		
Individual Coverage	$500 - combined	
Family Coverage	$1,000 - combined	
Annual deductible [1,2]		
Individual Coverage	$750 - combined per Benefit Period.	
Family Coverage	$1,500 - 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	$1,750 per Benefit Period.	$10,000 per Benefit Period.
Family Coverage	$3,500 per Benefit Period.	$20,000 per Benefit Period.
Plan payment level	You pay 20% after Deductible.	You pay 30% after Deductible.
Lifetime benefit limit	Unlimited	Unlimited
Pre-existing condition limitations	None	None
Primary care provider (PCP) required	No	No
Pre-certification requirements	Provider responsibility.	Member responsibility - $500 penalty per incident for failure to pre-certify non emergency inpatient admissions.

Template: TMPL-MG8-HUP-HIA Plan Code: IPF05 Plan Name: HIA PPO $750-80% Plan Number: 3027 Rx Code: 1A04

Covered Services	Participating Provider	Non-Participating Provider
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 30%. (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 30%. (Deductible does not apply).
Screening Pap test and screening mammogram	Covered at 100%; you pay $0.	You pay 30%. (Deductible does not apply).
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.
Hospital Services		
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 20% after Deductible.	You pay 30% after Deductible.
Emergency Services		
Emergency department	You pay 20% after Deductible.	
Emergency transportation	You pay 20% after Deductible.	
Urgent care	You pay 20% after Deductible.	You pay 30% after Deductible.
Diagnostic Services		
Imaging (advanced and other)	You pay 20% after Deductible.	You pay 30% after Deductible.
Lab and other services	You pay 20% after Deductible.	You pay 30% after Deductible.
Medical Therapy Services		
Chemotherapy, radiation, dialysis treatment	You pay 20% after Deductible.	You pay 30% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 20% after Deductible.	You pay 30% after Deductible.
Rehabilitation/Habilitation Therapy Services		
Physical and occupational therapy	You pay 20% after Deductible.	You pay 30% after Deductible.
	Covered up to 30 visits per Benefit Period for both therapies combined	
Speech therapy	You pay 20% after Deductible.	You pay 30% after Deductible.
	Limit of 30 visits per Benefit Period	
Other Medical Services		
Acupuncture	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.

Covered Services	Participating Provider	Non-Participating Provider
Home health care	You pay 20% after Deductible.	You pay 30% after Deductible.
	Limit of 60 days per Benefit Period	
Hospice care	You pay 20% after Deductible.	You pay 30% after Deductible.
Podiatry care	You pay 20% after Deductible.	You pay 30% after Deductible.
Private duty nursing	You pay 20% after Deductible.	You pay 30% after Deductible.
Skilled nursing facility	You pay 20% after Deductible.	You pay 30% after Deductible.
	Limit of 120 days per Benefit Period	
Therapeutic manipulation	You pay 20% after Deductible.	You pay 30% after Deductible.
	Limit of 20 visits per Benefit Period	
Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083		
Behavioral health		
Inpatient /outpatient	You pay 20% after Deductible.	You pay 30% after Deductible.
Substance abuse services		
Inpatient detoxification	You pay 20% after Deductible.	You pay 30% after Deductible.
Inpatient /outpatient rehabilitation	You pay 20% after Deductible.	You pay 30% 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

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