Summary of Benefits
UPMC Health Plan
Small Business Advantage Enhanced Silver 1500 Rx:$8/$38/$76/$95

The Exclusive Provider Organization (EPO) plan blends elements of a traditional HMO with elements of a preferred provider organization (PPO). Similar to a PPO, the EPO does not require you to select a primary care physician to act as a "gatekeeper." But like an HMO, the EPO does require you to receive your care from network physicians and facilities in order for it to be covered.

While PCPs are not required, UPMC Health Plan still believes that PCPs play a vital role in managed care. We encourage EPO members to build long-term relationships with your physician, who can be a family or general practitioner, an internist, or a pediatrician.

Your personal physician performs routine and preventive care, and can coordinate specialist care. Most important, your personal physician is in the best position to become familiar with your medical profile. Women (usually age 19 and older) also may select an ob-gyn to provide or coordinate all covered gynecological/obstetric care. However, women are not required to see the same ob-gyn on a regular basis.

As an EPO member, you must use network providers and facilities to receive covered benefits (except for emergency or urgent care, or very specialized care not available in our network; UPMC Health Plan must first authorize any services for specialized care not available in our network). If you choose to go to a provider or facility outside of the UPMC Health Plan network, you must pay for the services yourself.

Covered Services*	Benefit Level
Annual deductible	
Individual	$1,500 per Benefit Period.
Family	$3,000 per Benefit Period.
Annual out-of-pocket limit (includes Copayments, Coinsurance and Deductibles for Covered Services specified in this Summary of Benefits)	
Individual	$6,350 per Benefit Period.
Family	$12,700 per Benefit Period.
Plan payment level	You pay 20% after Deductible[1]
Lifetime benefit limit	Unlimited
Primary care provider (PCP) required	No
Pre-existing condition limitations	None
Pre-certification requirements	Provider responsibility.
Provider Medical Services[2]	
Adult Care	
Preventive/health screening examination	Covered at 100%; you pay $0.
Pediatric Care	
Preventive/health screening examination	Covered at 100%; you pay $0.
Pediatric immunizations	Covered at 100%; you pay $0.
Well-baby visits	Covered at 100%; you pay $0.
Women's Care	
Screening gynecological exam	Covered at 100%; you pay $0.
Screening Pap test and screening mammogram	Covered at 100%; you pay $0.

Covered Services	Benefit Level
Provider Medical Services[2] (Continued)	
Provider office visit (for illness or injury)	You pay 20% after Deductible.
eVisit	You pay 20% after Deductible.
Specialist office visit	You pay 20% after Deductible.
Medical/surgical services	You pay 20% after Deductible.
Hospital Services	
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 20% after Deductible.
Emergency Services	
Emergency department	You pay 20% after Deductible.
Emergency transportation	You pay 20% after Deductible.
Urgent care facility	You pay 20% after Deductible.
Diagnostic Services	
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.
Medical Therapy Services	
Chemotherapy, radiation, dialysis treatment	You pay 20% 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.
Rehabilitation/Habilitation Therapy Services	
Physical and occupational therapy	You pay 20% after Deductible.
	Covered up to 30 visits per Benefit Period for both therapies combined
Speech therapy	You pay 20% after Deductible.
	Limit of 30 visits per Benefit Period
Other Medical Services	
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.
Home health care	You pay 20% after Deductible.
	Limit of 60 days per Benefit Period
Hospice care	You pay 20% after Deductible.
Podiatry care	You pay 20% after Deductible.
Skilled nursing facility	You pay 20% after Deductible.
	Limit of 120 days per Benefit Period
Therapeutic manipulation	You pay 20% after Deductible.
	Limit of 20 visits per Benefit Period

Covered Services	Benefit Level
Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083	
Behavioral health	
Inpatient	You pay 20% after Deductible.
Outpatient	You pay 20% after Deductible.
Substance abuse services	
Inpatient detoxification	You pay 20% after Deductible.
Inpatient rehabilitation	You pay 20% after Deductible.
Outpatient rehabilitation	You pay 20% after Deductible.
Prescription Drug Coverage – The *Advantage Choice* pharmacy program will apply (mandatory generic). Subject to Plan Deductible	
Retail prescription drug[3] • 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[3] • 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 $95 copayment for specialty drugs 30-day maximum supply
Mail-order prescription drug[3] • 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

Covered Services	Depending upon size of group
Pediatric Dental and Vision Services	
For members of group plans with 50 or fewer employees ■ Eligible members can find details in their Dental and Vision Essential Health Benefits Riders. ■ These documents are available online at MyHealth OnLine or by calling Member Services.	Pediatric Dental and Vision Services are covered in compliance with requirements under the Affordable Care Act for members of group plans with 50 or fewer employees. Find eligibility and benefit details in your Summary of Benefits and Coverage.

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

[1] Copayments may apply to certain services.

[2] 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.

[3] 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., UPMC Health Options, Inc., and/or 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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