

# Summary of Benefits

## UPMC Health Plan

### Small Business Advantage Premium Platinum

Rx: \$8/\$38/\$76/\$95

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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	\$1,000 per Benefit Period.
Family	None	\$2,000 per Benefit Period.
<b>Annual out-of-pocket limit (includes Copayments, Coinsurance and Deductibles for Covered Services specified in this Summary of Benefits)</b>		
Individual	\$1,000 per Benefit Period.	\$10,000 per Benefit Period.
Family	\$2,000 per Benefit Period.	\$20,000 per Benefit Period.
Plan payment level	Covered at 100% <sup>1</sup>	You pay 40% after Deductible. <sup>2</sup>
Lifetime benefit limit	Unlimited	Unlimited
Primary care provider (PCP) required	No	No
Pre-existing condition limitations	None	None
Pre-certification requirements	Provider responsibility.	Member responsibility - \$500 penalty per incident for failure to pre-certify non emergency inpatient admissions.
<b>Provider Medical Services<sup>3</sup></b>		
<b>Adult Care</b>		
Preventive/health screening examination	Covered at 100%; you pay \$0.	Not covered.
<b>Pediatric Care</b>		
Preventive/health screening examination	Covered at 100%; you pay \$0.	Not covered.
Pediatric immunizations	Covered at 100%; you pay \$0.	You pay 40% (Deductible does not apply).
Well-baby visits	Covered at 100%; you pay \$0.	Not Covered
<b>Women's Care</b>		
Screening gynecological exam	Covered at 100%; you pay \$0.	You pay 40% (Deductible does not apply).
Screening Pap test and screening mammogram	Covered at 100%; you pay \$0.	You pay 40% (Deductible does not apply).
Provider office visit (for illness or injury)	Covered at 100% after \$10 Copayment per visit.	You pay 40% after Deductible.
eVisit	Covered at 100% after \$5 Copayment per visit.	You pay 40% after Deductible.
Specialist office visit	Covered at 100% after \$25 Copayment per visit.	You pay 40% after Deductible.
Medical/surgical services	Covered at 100%; You pay \$0.	You pay 40% after Deductible.

<b>Covered Services</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>
<b>Hospital Services</b>		
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
<b>Emergency Services</b>		
Emergency department	Covered at 100% after \$100 Copayment per visit. Copayment waived if member admitted to hospital.	
Emergency transportation	Covered at 100%; You pay \$0.	
Urgent care facility	Covered at 100% after \$25 Copayment per visit.	You pay 40% after Deductible.
<b>Diagnostic Services</b>		
Advanced imaging (e.g. PET, MRI, etc.)	Covered at 100% after \$150 Copayment per visit.	You pay 40% after Deductible.
Other imaging (e.g., x-ray, sonogram, etc.)	Covered at 100% after \$10 Copayment per visit.	You pay 40% after Deductible.
Lab and other services	Covered at 100% after \$10 Copayment per visit.	You pay 40% after Deductible.
<b>Medical Therapy Services</b>		
Chemotherapy, radiation, dialysis treatment	Covered at 100% after \$25 Copayment per visit.	You pay 40% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
<b>Rehabilitation/Habilitation Therapy Services</b>		
Physical and occupational therapy	Covered at 100% after \$10 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 30 visits per Benefit Period for both therapies combined	
Speech therapy	Covered at 100% after \$10 Copayment per visit.	You pay 40% after Deductible.
	Limit of 30 visits per Benefit Period	
<b>Other Medical Services</b>		
Acupuncture	Covered at 100% after \$25 Copayment per visit.	You pay 40% after Deductible.
Allergy testing and serum	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
Bariatric surgery	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
Durable medical equipment and corrective appliances	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
Fertility testing	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
Home health care	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
	Limit of 60 days per Benefit Period	
Hospice care	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
Podiatry care	Covered at 100% after \$25 Copayment per visit.	You pay 40% after Deductible.
Private duty nursing	Covered at 100%; You pay \$0.	You pay 40% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Skilled nursing facility	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
	Limit of 120 days per Benefit Period	
Therapeutic manipulation	Covered at 100% after \$15 Copayment per visit.	You pay 40% after Deductible.
	Limit of 20 visits per Benefit Period	
<b>Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
Behavioral health		
Inpatient	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
Outpatient	Covered at 100% after \$25 Copayment per visit.	You pay 40% after Deductible.
Substance abuse services		
Inpatient detoxification	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
Inpatient rehabilitation	Covered at 100%; You pay \$0.	You pay 40% after Deductible.
Outpatient rehabilitation	Covered at 100% after \$25 Copayment per visit.	You pay 40% after Deductible.
<b>Prescription Drug Coverage – The <i>Advantage Choice</i> pharmacy program will apply (mandatory generic).</b>		
Retail prescription drug <sup>4</sup> <ul style="list-style-type: none"> <li>Prescriptions must be dispensed by a participating pharmacy</li> </ul>	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 <sup>4</sup> <ul style="list-style-type: none"> <li>Specialty medications are limited to a 30-day supply</li> <li>Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request)</li> </ul>	You pay \$95 copayment for specialty drugs  30-day maximum supply	
Mail-order prescription drug <sup>4</sup> <ul style="list-style-type: none"> <li>A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy</li> </ul>	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	
<b>Pediatric Dental and Vision Services</b>		
<b>For members of group plans with 50 or fewer employees</b> <ul style="list-style-type: none"> <li>Eligible members can find details in their Dental and Vision Essential Health Benefits Riders.</li> <li>These documents are available online at MyHealth OnLine or by calling Member Services.</li> </ul>	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.

<sup>1</sup> Copayments may apply to certain services.

<sup>2</sup> If care is out-of-network, benefits are paid at a lower level after your annual deductible is met. If you go to an out-of-network provider, you also may have to pay the difference between the provider's charge and the UPMC Health Plan payment (reasonable and customary amount).

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

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

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

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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