

# Summary of Benefits

# UPMC Individual Advantage

## UPMC Health Plan

## Savings Plan 1300

### QHDP - Exclusive Provider Organization (with HSA)

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 participating providers and facilities in order for it to be a Covered Service. A qualified high-deductible plan (QHDP) is a government requirement for participation in tax-advantaged health savings accounts.

We encourage EPO policy owners to build a long-term relationship with their 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 aged 19 and older) may also select an ob-gyn to provide or coordinate all covered gynecological and obstetric care. However, women are not required to see the same ob-gyn on a regular basis.

You must use participating providers and facilities to receive covered benefits (except for emergency or urgent care, or very specialized care not available in our network, which has been prior authorized by UPMC Health Plan). If you choose to go to a non-participating provider or facility, you must pay for the services yourself.

Covered Services	Benefit Level
<b>Annual deductible</b>	
Individual	\$1,300
Family <sup>1</sup>	\$2,600
<b>Annual out-of-pocket limit<sup>2</sup></b>	
Individual	\$2,600
Family	\$2,600 per person, \$5,200 per family
Plan payment level	You pay 20% after deductible
Lifetime benefit limit	Unlimited
Primary care provider (PCP) required	No
Pre-existing condition limitations	None
Prior Authorization requirements	Provider or Insured responsibility
<b>Provider Medical Services<sup>3</sup></b>	
<b>Adult Care</b>	
Preventive/health screening examination	Covered at 100%. You pay \$0 (deductible does not apply)
<b>Pediatric Care</b>	
Preventive/health screening examination	Covered at 100%. You pay \$0 (deductible does not apply)
Pediatric immunizations	Covered at 100%. You pay \$0 (deductible does not apply)
Well-baby visits	Covered at 100%. You pay \$0 (deductible does not apply)
<b>Women's Care</b>	
Screening gynecological exam	Covered at 100%. You pay \$0 (deductible does not apply)
Screening Pap test and Screening mammogram	Covered at 100%. You pay \$0 (deductible does not apply)
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
Maternity	You pay \$2,500 after Deductible per cycle of care; this cycle consists of prenatal care, delivery, postpartum care, and all facility charges.
<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>Rehabilitation Therapy Services</b>	
Physical, speech, and occupational	You pay 20% after deductible Covered up to 60 visits per Benefit Period for all three therapies combined
<b>Medical Therapy Services</b>	
Chemotherapy, radiation, infusion therapy, and dialysis treatment	You pay 20% after deductible

Covered Services	Benefit Level
<b>Other Medical Services</b>	
Skilled nursing facility	You pay 20% after deductible (limit of 100 days per Benefit Period)
Home health care	You pay 20% after deductible
Hospice care	You pay 20% after deductible
Therapeutic manipulation	You pay 20% after deductible (limit of 25 visits per Benefit Period)
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>	
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
<b>Prescription Drug Coverage – The Value Choice pharmacy program will apply (Mandatory Generic). Subject to Plan Deductible.</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 \$4 copayment for generic drugs You pay 30% coinsurance for select brand drugs (up to \$100), per 30-day prescription 90-day maximum retail supply
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 50% coinsurance for specialty drugs (up to \$150), per 30-day prescription 30-day maximum specialty 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 \$8 copayment for generic drugs You pay 30% coinsurance for select brand drugs (up to \$200), per prescription 90-day maximum mail-order supply

UPMC Individual *Advantage - GR* is a product of UPMC Health Benefits, Inc., and is administered by UPMC Health Plan, Inc. Please note that throughout this document, we use the terms “UPMC Health Plan” and “the Health Plan” to refer to UPMC Health Benefits, Inc., as well as to UPMC Health Plan, Inc.

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

UPMC Health Plan Member Services: 1-866-353-3598.  
TTY Services: 1-800-361-2629

<sup>1</sup> The Family Deductible must be met by one or more members of the family before benefits will be paid.

<sup>2</sup> The annual out-of-pocket maximum does not include the deductible. The out-of-pocket limit must be met before pharmacy benefits are payable at 100%.

<sup>3</sup> Preventive Services will be covered with no member cost sharing as required by PPACA (Patient Protection and Affordable Care Act).

<sup>4</sup> Any time a member or a physician requests that a brand-name drug be filled for a drug that has a generic equivalent, the member must pay 100% of the contracted rate for that drug.

## UPMC HEALTH PLAN

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