UPMC Health Plan

University of Pittsburgh PA Child Welfare Training Program

Preferred Provider Organization

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
Annual deductible		
Individual	None	$500
Family	None	$1,000
Annual out-of-pocket limit		
Individual	None	$1,000
Family	None	$2,000
Plan payment level	Covered at 100%[1]	You pay 30% after deductible[2]
Lifetime benefit limit	Unlimited	Unlimited
Primary care provider (PCP) required	No	No
Pre-existing condition limitations	None	None
Precertification requirements	Provider responsibility	Member responsibility - $500 penalty per incident for failure to pre-certify non emergency inpatient admissions
Provider Medical Services[3]		
Adult Care		
Preventive/health screening examination	Covered at 100%, You pay $0	You pay 30% after deductible
Pediatric Care		
Preventive/health screening examination	Covered at 100%, You pay $0	You pay 30% after deductible
Pediatric immunizations	Covered at 100%, You pay $0	You pay 30% (deductible does not apply)
Well-baby visits	Covered at 100%, You pay $0	You pay 30% after deductible
Women's Care		
Screening gynecological exam and Pap test	Covered at 100%, You pay $0	You pay 30% after deductible
Screening Mammogram	Covered at 100%, You pay $0	You pay 30% (deductible does not apply)
Provider office visit (for illness or injury)	Covered at 100% after $20 copayment per visit	You pay 30% after deductible
Specialist office visit, including ob-gyn	Covered at 100% after $35 copayment per visit	You pay 30% after deductible
Medical/surgical services	Covered at 100%, You pay $0	You pay 30% after deductible
Hospital Services		
Inpatient care	Covered at 100% after $300 copayment per inpatient stay; (Limit of 2 copayments per Benefit Period; 100% coverage thereafter)	You pay 30% after deductible
Outpatient surgery	Covered at 100% after $100 copayment per visit; (Limit of 4 copayments per Benefit Period; 100% coverage thereafter)	
Outpatient care, medical services, ancillary services, colonoscopy and supplies	Covered at 100%, You pay $0	You pay 30% after deductible
Emergency Services		
Emergency services coverage	Covered at 100% after $40 copayment per visit for members 18 years old and under Covered at 100% after $80 copayment per visit for members 19 years old and over	
	Copayment waived if admitted	
Urgent care facility	Covered at 100% after $40 copayment per visit	Covered at 100% after $40 copayment per visit
Diagnostic Services		
Advanced imaging (e.g., PET, MRI, etc.)	Covered at 100%, You pay $0	You pay 30% after deductible
Other imaging (e.g., X-ray, sonogram, etc.)	Covered at 100%, You pay $0	You pay 30% after deductible
Lab and other services	Covered at 100%, You pay $0	You pay 30% after deductible

Covered Services	Participating Provider	Non-Participating Provider
Medical Therapy Services		
Chemotherapy, radiation, infusion therapy, dialysis treatment	Covered at 100%, You pay $0	You pay 30% after deductible
Rehabilitation Therapy Services		
Physical, speech, and occupational	Covered at 100% after $10 copayment per visit	You pay 30% after deductible
	Covered up to 60 visits per Benefit Period for all three therapies combined	
Other Medical Services		
Acupuncture	Covered at 100%, You pay $0	You pay 30% after deductible
	Please reference your Certificate of Coverage or call Member Services for details	
Skilled nursing facility	Covered at 100%, You pay $0	You pay 30% after deductible
	Limit of 90 days per Benefit Period	
Home health care	Covered at 100%, You pay $0	You pay 30% after deductible
Hospice care	Covered at 100%, You pay $0	You pay 30% after deductible
Therapeutic manipulation/Chiropractic care	Covered at 100% after $30 copayment for first visit, $15 copayment per visit thereafter	You pay 30% after deductible
	Limit of 25 visits per Benefit Period	
Podiatric care	Covered at 100% after $25 copayment per visit	You pay 30% after deductible
Allergy testing and serum	Covered at 100%, You pay $0	You pay 30% after deductible
Durable medical equipment and corrective appliances	Covered at 100%, You pay $0	You pay 30% after deductible
Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-877-461-8610		
Behavioral health		
Inpatient	Covered at 100%, You pay $0	You pay 30% after deductible
Outpatient	Covered at 100% after $20 copayment per visit	You pay 30% after deductible
Substance abuse services		
Inpatient detoxification	Covered at 100%, You pay $0	You pay 30% after deductible
Inpatient rehabilitation	Covered at 100%, You pay $0	You pay 30% after deductible
Outpatient rehabilitation	Covered at 100%, You pay $0	You pay 30% after deductible
Prescription Drug Coverage– The *Your Choice* pharmacy program will apply (Mandatory Generic)		
Retail prescription drug[4] • Prescriptions must be dispensed by a participating pharmacy	You pay $12 copayment for generic drugs You pay $36 copayment for preferred brand drugs You pay $72 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 $80 copayment for specialty drugs 30-day maximum specialty 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 $24 copayment for generic drugs You pay $72 copayment for preferred brand drugs You pay $144 copayment for non-preferred brand drugs 90-day maximum mail-order supply	

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.
TTD service for hearing-impaired: 1-800-361-2629.

[1] Copayments may apply to certain services.

[2] 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).

[3] UPMC Health Plan maintains that the coverage described in this document is at all times administered in compliance with applicable laws and regulations, including but not limited to the Patient Protection and Affordable Care Act of 2010. 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 a Physician demonstrates that the Brand Name Drug is Medically Necessary and Appropriate, the Member will pay only the Non-Preferred Brand Name Drug Copayment.

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.

UPMC HEALTH PLAN

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