Summary of Benefits

University of Pittsburgh Panther Basic Plan

UPMC Health Plan PPO

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. The higher benefit level applies when you use providers participating in the UPMC Health Plan PPO network. The lower benefit level applies when using providers outside of the network.

Covered Services*	Participating Provider	Non-Participating Provider
Annual deductible		
Individual	$1,000 per Benefit Period.	$2,000 per Benefit Period.
Family	$2,000 per Benefit Period.	$4,000 per Benefit Period.
Deductible applies to all Covered Services furnished to a member during the Benefit Period, unless that service is specifically excluded. The family Deductible must be met by one or more members of the family before benefits will be paid.		
Annual out-of-pocket limit (includes Copayments, Coinsurance and Deductibles for Covered Services specified in this Summary of Benefits)		
Individual	$5,000 per Benefit Period.	$10,000 per Benefit Period.
Family	$10,000 per Benefit Period.	$20,000 per Benefit Period.
• For Family Policies, the entire family out-of-pocket must be met by one or a combination of the covered family members before the plan pays at 100% for covered benefits for the remainder of the benefit period. • Copayments, Coinsurance, and Deductibles apply toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits.		
Plan payment level	You pay 30% after Deductible.	You pay 50% after Deductible.[1]
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
Provider Medical Services[2]		
Adult Care		
Preventive/health screening examination	Covered at 100%; you pay $0.	You pay 50% after Deductible
Pediatric Care		
Preventive/health screening examination	Covered at 100%; you pay $0.	You pay 50% after Deductible
Pediatric immunizations	Covered at 100%; you pay $0.	You pay 50% (Deductible does not apply)
Well-baby visits	Covered at 100%; you pay $0.	You pay 50% after Deductible
Women's Care		
Screening gynecological exam and Pap test	Covered at 100%; you pay $0.	You pay 50% after Deductible.
Screening mammogram	Covered at 100%; you pay $0.	You pay 50% (Deductible does not apply)
Provider office visit (for illness or injury)	You pay 30% after Deductible.	You pay 50% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Specialist office visit	You pay 30% after Deductible.	You pay 50% after Deductible.
eVisit	You pay 30% after Deductible	Not covered.
Convenience care clinic	You pay 30% after Deductible	You pay 50% after Deductible.
Medical/surgical services	You pay 30% after Deductible.	You pay 50% after Deductible.
Hospital Services		
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	You pay 30% after Deductible.	You pay 50% after Deductible.
Emergency Services		
Emergency department	You pay 30% after in-network Deductible.	
Emergency transportation	You pay 30% after in-network Deductible.	
Urgent care facility	You pay 30% after in-network Deductible.	
Diagnostic Services		
Advanced imaging (e.g. PET, MRI, etc.)	You pay 30% after Deductible.	You pay 50% after Deductible.
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 30% after Deductible.	You pay 50% after Deductible.
Lab and other services	You pay 30% after Deductible.	You pay 50% after Deductible.
Medical Therapy Services		
Chemotherapy, radiation, dialysis treatment	You pay 30% after Deductible.	You pay 50% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 30% after Deductible.	You pay 50% after Deductible.
Rehabilitation/Habilitation Therapy Services		
Physical, speech and occupational therapy	You pay 30% after Deductible.	You pay 50% after Deductible.
	Covered up to 60 visits per Benefit Period for all three therapies combined	
Other Medical Services		
Acupuncture[3]	You pay 30% after Deductible.	You pay 50% after Deductible.
Allergy testing and serum	You pay 30% after Deductible.	You pay 50% after Deductible.
Durable medical equipment and corrective appliances	You pay 30% after Deductible.	You pay 50% after Deductible.
Fertility testing	You pay 30% after Deductible.	You pay 50% after Deductible.
Home health care	You pay 30% after Deductible.	You pay 50% after Deductible.
Hospice care	You pay 30% after Deductible.	You pay 50% after Deductible.
Podiatry care	You pay 30% after Deductible.	You pay 50% after Deductible.
Private duty nursing	You pay 30% after Deductible.	You pay 50% after Deductible.
Skilled nursing facility	You pay 30% after Deductible.	You pay 50% after Deductible.
	Limit of 90 days per Benefit Period	
Therapeutic manipulation	You pay 30% after Deductible.	You pay 50% after Deductible.
	Limit of 25 visits per Benefit Period	

Covered Services	Participating Provider	Non-Participating Provider
Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-877-461-8610		
Behavioral health		
Inpatient	You pay 30% after Deductible.	You pay 50% after Deductible.
Outpatient	You pay 30% after Deductible.	You pay 50% after Deductible.
Substance abuse services		
Inpatient detoxification	You pay 30% after Deductible.	You pay 50% after Deductible.
Inpatient rehabilitation	You pay 30% after Deductible.	You pay 50% after Deductible.
Outpatient rehabilitation	You pay 30% after Deductible.	You pay 50% after Deductible.
Prescription Drug Coverage – The *Your Choice* pharmacy program will apply (mandatory generic). Not subject to plan Deductible		
Retail prescription drug[4] • Prescriptions must be dispensed by a participating pharmacy	You pay $14 copayment for generic drugs You pay $40 copayment for preferred brand drugs You pay $80 copayment for non-preferred brand drugs 90-day maximum retail supply available for three 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 $90 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 $28 copayment for generic drugs You pay $80 copayment for preferred brand drugs You pay $160 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] 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] Your benefit plan covers acupuncture treatment only for specific conditions when Medically Necessary. Refer to the Certificate of Coverage for specific Benefit Limitations

[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.

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: 1-888-499-6885
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