

UPMC Health Plan

HSA Option 6

Covered Services	Participating Provider	Non-Participating Provider
Annual deductible ¹		
Individual		\$3,750 – combined
Family ²		\$7,500 – combined
Annual out-of-pocket maximum		
Individual	\$1,250	\$2,500
Family ³	\$2,500	\$5,000
Coinsurance	80% after deductible	60% after deductible
Lifetime maximum	Unlimited	\$1,000,000
Primary care provider (PCP) required	No	No
Pre-existing condition limitations	None	None
Precertification requirements	Provider responsibility	Member Responsibility. Required for select services, \$500 financial penalty per incident for failure to comply
Preventive Care⁴		
Adult		
Routine physical exam	100% (deductible does not apply)	Not covered
Pediatric		
Routine physical exam	100% (deductible does not apply)	Not covered
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Well-baby visits	100% (deductible does not apply)	Not covered
Physician Services		
Physician office visit (for illness or injury)	80% after deductible	60% after deductible
Medical/Surgical services (inpatient medical and surgical care, outpatient surgeon's fees, anesthesia)	80% after deductible	60% after deductible
Women's Care		
Routine gynecological exam, Pap test, mammogram, prenatal visit, diagnostic tests, and surgical services	100% (applies to Routine Gynecological exam only) Routine gynecological exam, Pap test and mammogram are not subject to deductible 80% after deductible for all other care	60% after deductible Routine gynecological exam, PAP test, and mammogram not subject to deductible
Hospital Services		
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	80% after deductible	60% after deductible
Emergency Department Services⁵		
Must contact Member/Provider Services department within 24 hours or as soon as reasonably possible	80% after deductible	60% after deductible
Diagnostic Services		
Advanced imaging (e.g. PET, MRI, etc)	80% after deductible	60% after deductible
Other imaging (e.g. X-ray, Sonogram, etc.)	80% after deductible	60% after deductible
Lab and other services	80% after deductible	60% after deductible
Medical Therapy Services		
Chemotherapy, radiation, infusion therapy, dialysis treatment	80% after deductible	60% after deductible

Covered Services	Participating Provider	Non-Participating Provider
Rehabilitation Therapy Services		
Physical, speech, and occupational	80% after deductible Limited to the greater of: 60 consecutive days of coverage OR 25 visits per condition, per benefit period, for all therapies combined.	60% after deductible
Other Medical Services		
Skilled nursing facility	80% after deductible Limit of 100 days per benefit period	60% after deductible
Home health care	80% after deductible	60% after deductible
Hospice care	80% after deductible	60% after deductible
Therapeutic manipulation	80% after deductible Limit of 25 visits per benefit period	60% after deductible
Podiatric care	80% after deductible	60% after deductible
Allergy testing and serum	80% after deductible	60% after deductible
Durable medical equipment and corrective appliances	80% after deductible	60% after deductible
Behavioral Health — Contact Western Behavioral Health Care at 1-888-251-0083		
Mental health		
Inpatient ⁶	80% after deductible Limit of 30 days per benefit period; lifetime maximum of 90 days. 30 inpatient days may be exchanged on a 1:2 basis to secure up to a maximum of 60 transitional partial hospitalization days.	60% after deductible
Outpatient ⁶	80% after deductible Limit of 20 visits per benefit period	60% after deductible
Chemical dependency treatment	80% after deductible	60% after deductible
Inpatient detoxification	Limit of 7 days per admission, lifetime maximum of 4 admissions	
Inpatient rehabilitation	Limit of 30 days per benefit period, lifetime maximum of 90 days	
Outpatient rehabilitation	Limit of 60 visits per benefit period, lifetime maximum of 120 visits	
Prescription Drug Coverage		
Subject to Plan Deductible		
Retail prescription drug ⁷ <ul style="list-style-type: none"> Prescriptions must be dispensed by a participating pharmacy The <i>Your Choice</i> pharmacy program will apply. 		\$15 copayment for generic drugs \$30 copayment for preferred brand drugs \$50 copayment for non-preferred brand drugs Mandatory generic 30-day maximum retail supply
Specialty prescription drug ³ <ul style="list-style-type: none"> Specialty medications are limited to a 30-day supply Most specialty medications must be filed at our contracted specialty pharmacy provider* <p>*Drugs in limited distribution may not be available from UPMC Health Plan's contracted specialty provider.</p>		\$50 copayment for specialty drugs Mandatory generic 30-day maximum specialty supply
Mail-order prescription drug ⁷ <ul style="list-style-type: none"> You must use an initial 30-day supply of a new prescription before you may request a 90-day mail-order supply. 		\$30 copayment for generic drugs \$60 copayment for preferred brand drugs \$100 copayment for non-preferred brand drugs Mandatory generic 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

UPMC HEALTH PLAN
Where you belong.

One Chatham Center
112 Washington Place
Pittsburgh, Pennsylvania 15219

www.upmchealthplan.com

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 Network, Inc. payment (reasonable and customary amount). Deductible applies to all services except preventive services. Annual OOP Max excludes deductible.

² The Family Deductible must be met by one or more Members of the family before benefits will be paid.

³ The Family Out-of-Pocket must be met by one or more Members of the family before benefits are payable at 100%.

⁴ Preventive care as defined by UPMC Health Plans standard PPO schedule of benefits.

⁵ Emergency Services provided at participating facilities are covered at the higher benefit level. If it is not reasonably possible to seek treatment at a participating facility, and a member requires and receives emergency services at a non-participating facility, all charges for such covered services will be paid at the higher benefit level except any cost-sharing that is the member's responsibility.

⁶ Pennsylvania Act 1998-150 mandates 30 inpatient days per Benefit Period (no lifetime maximum) and 60 outpatient visits per Benefit Period for certain diagnoses based on Medical Necessity and Appropriateness. For additional information concerning coverage and diagnosis requirements call Western Behavioral Health Care Network at 1-888-251-0083.

⁷ If you receive a brand-name drug instead of the generic equivalent, you must pay the brand-name copayment as well as the retail price difference between the brand and generic drug