UPMC LIFE CHANGING MEDICINE

# Open Access PPO

**Coverage Period: 01/01/2013 – 12/31/2013**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual, Individual & Spouse / Domestic Partner, Individual and Child, Individual & Family | **Plan Type:** PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://infonet.upmc.com **or** by calling 1-800-994-2752, Option 3 for the Employee Service Center.

| Important Questions | Answers | | Why this Matters: |
|---|---|---|---|
| **What is the overall deductible?** | Health Plan Network<br>**$400 individual ***<br>**$800 family *** | Out-of- Network<br>**$1,100 individual***<br>**$2,200 family *** | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | **No.** | | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Health Plan Network<br>**$400 individual ***<br>**$800 family *** | Out-of- Network<br>**$6,200 individual***<br>**$12,400 family *** | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Copayments, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover. | | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network providers, see http://www.upmchealthplan.com/doctor/hospital.aspx, or call 1-888-876-2756 (TTY: 1-800-361-2629). | | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term-in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | Referrals to specialists are not required. | | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | | Some of the services this plan doesn't cover are listed on page 5. |

**Questions:** Call 1-800-994-2752 or http//infonet.upmc.com/medical. If you aren't clear about any of the underlined terms used above, see the Glossary. You can view the Glossary at http://cciio.cms.gov or call 1-800-994-2752, Option 3 to request a copy.

*** (above)** when MyHealth requirements are fully met

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Health Plan Network | Out-of-network Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay/visit | 40% co-insurance | ——————none—————— |
| | Specialist visit | $40 copay/visit | 40% co-insurance | ——————none—————— |
| | Other practitioner office visit | $20 copay for convenience care clinic, $25 copay for Podiatric care, $25 copay for therapeutic manipulation (e.g. chiropractic care) | 40% co-insurance | ——————none—————— |
| | Preventive care/screening/immunization | $0 co-pay | 40% co-insurance | Deductible does not apply in-network. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $20 co-pay (waived after 6 copayments per calendar year) | 40% co-insurance | Limit 6 copays per benefit period. 100% coverage thereafter. Blood work not included. |
| | Imaging (CT/PET scans, MRIs) | $80 co-pay (waived after 6 copayments per calendar year) | 40% co-insurance | Limit 6 copays per benefit period. 100% coverage thereafter. |

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| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Health Plan Network | Out-of-network Provider | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.upmchealthplan.com. | Generic drugs | $15 copay (30-day)<br>$30 copay (90-day) | Not covered | Prescriptions must be filled at a UPMC Health Plan Participating Pharmacy. |
| | Preferred brand drugs | $40 copay (30-day)<br>$80 copay (90-day) | Not covered | Prescriptions must be filled at a UPMC Health Plan Participating Pharmacy. |
| | Non-preferred brand drugs | $80 copay (30-day)<br>$160 copay(90-day) | Not covered | Prescriptions must be filled at a UPMC Health Plan Participating Pharmacy. |
| | Specialty drugs | $80 copay (30-day) | Not covered | Prescriptions must be filled at a UPMC Health Plan Participating Pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% co-insurance | 40% co-insurance | ——————none—————— |
| | Physician/surgeon fees | 0% co-insurance | 40% co-insurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | $75 copay/visit | $75 copay/visit | Co-pay waived if admitted. |
| | Emergency medical transportation | 0% co-insurance | 40% co-insurance | In event of an emergency, coverage will be at the highest level of benefit. Only when service is a non-emergency and prior authorization is received does the network cost applies. |
| | Urgent care | $40 copay/visit | 40% co-insurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% co-insurance | 40% co-insurance | ——————none—————— |
| | Physician/surgeon fee | 0% co-insurance | 40% co-insurance | ——————none—————— |

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| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Health Plan Network | Out-of-network Provider | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $25 copay/visit | 40% co-insurance | ————————none———————— |
| | Mental/Behavioral health inpatient services | 0% co-insurance | 40% co-insurance | ————————none———————— |
| | Substance use disorder outpatient services | $25 copay/visit | 40% co-insurance | ————————none———————— |
| | Substance use disorder inpatient services | 0% co-insurance | 40% co-insurance | ————————none———————— |
| **If you are pregnant** | Prenatal and postnatal care | $20 copay/visit | 40% co-insurance | ————————none———————— |
| | Delivery and all inpatient services | 0% co-insurance | 40% co-insurance | ————————none———————— |
| **If you need help recovering or have other special health needs** | Home health care | 0% co-insurance | 40% co-insurance | ————————none———————— |
| | Rehabilitation services | $20 copay/visit if outpatient. | 40% co-insurance | ————————none———————— |
| | Habilitation services | (Not covered) | (Not covered) | ————————none———————— |
| | Skilled nursing care | 0% co-insurance | 40% co-insurance | Limited to a maximum of 100 days per calendar year. |
| | Durable medical equipment | 0% co-insurance | 40% co-insurance | ————————none———————— |
| | Hospice service | 0% co-insurance | 40% co-insurance | ————————none———————— |
| **If your child needs dental or eye care** | Eye exam | In-Network 0% co-insurance | Out-of- Network Plan pays $40 | ————————none———————— |
| | Glasses | In-Network $15 copay, then 0% co-insurance. $50 wholesale allowance on frames. | Out-of-Network Plan pays $50 for frames, and $40 - $100 depending on lens type. | Dollar amounts listed are for the maximum amount reimbursed. |
| | Dental check-up | In-Network 0% co-insurance on diagnostic / preventive | Out-of-Network 20% co-insurance | Dental benefits are available through a separate plan election. Deductible does apply before co-insurance for dental check-up out of network. |

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## Excluded Services & Other Covered Services:

| **Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.) | | |
|---|---|---|
| • Acupuncture | • Bariatric surgery | • Chiropractic care |
| • Cosmetic Surgery | • Infertility treatment | • Long-term care |
| • Non-emergency care when travelling outside the U.S. | • Weight loss programs | |
| **NOTICE TO UPMC MERCY PLAN PARTICIPANTS** The organization that sponsors your group health plan has certified that it qualifies for a temporary enforcement safe harbor with respect to the Federal requirement to cover contraceptive services without cost sharing. During this one-year period, coverage under your group health plan will not include coverage of contraceptive services. | | |

| **Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) | | |
|---|---|---|
| • Dental care (Adult) | • Acupuncture only covered for specific diagnosis | • Private-duty nursing |
| • Routine eye care (Adult) | • Routine foot care only covered for specific diagnosis | • Skilled nursing care is limited to 100 days per calendar year |
| • Chiropractic care covered with limitations | • Bariatric surgery subject to medical review | |

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-876-2756. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov.ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: UPMC Health Plan at 1-888-876-2756, or the UPMC Employee Service Center at 1-800-994-2752. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

**Coverage Examples**

**Coverage for:** Individual, Individual & Spouse / Domestic Partner, Individual and Child, Individual & Family | **Plan Type:** PPO

## About these Coverage Examples:

These examples show how this plan might cover medical care for individual coverage in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,540
- **Patient pays** $1000

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $400 |
| Co-pays | $400 |
| Co-insurance | $0 |
| Limits or exclusions | $200 |
| **Total** | **$1,000** |

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact the Health Plan.

## Managing type 2 diabetes
(routine maintenance of a well-controlled)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,720
- **Patient pays** $1,680

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $400 |
| Co-pays | $1,200 |
| Co-insurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$1,680** |

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact the Health Plan.

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓**Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.