UPMC LIFE CHANGING MEDICINE

Out of Area 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/SPD 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 **$200 individual*** **$400 family***	Out-of Network **$800 individual*** **$1,600 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 **$200 individual*** **$400 family***	Out-of Network **$5,200 individual*** **$10,400 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. If you aren't clear about any of the underlined terms used in this form, 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.

- **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 Health Plan Network	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% co-insurance	————none————
	Specialist visit	$40 copay/visit	30% 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)	30% co-insurance	————none————
	Preventive care/screening/immunization	0% co-insurance	30% co-insurance	Deductible does not apply in-network.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/visit	30% co-insurance	Limit 6 copays per benefit period. 100% coverage thereafter. Blood work not included.
	Imaging (CT/PET scans, MRIs)	$80 copay/visit	30% co-insurance	Limit 6 copays per benefit period. 100% coverage thereafter.

Common Medical Event	Services You May Need	Your cost if you use an Health Plan Network	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.upmchealthplan.com.	Generic drugs	$15 copay (30-day) $30 copay (90-day)	Not covered	Prescriptions must be filled at a UPMC Health Plan Participating Pharmacy.
	Preferred brand drugs	$40 copay (30-day) $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) $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	30% co-insurance	——————none——————
	Physician/surgeon fees	0% co-insurance	30% 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	30% 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	30% co-insurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-insurance	30% co-insurance	——————none——————
	Physician/surgeon fee	0% co-insurance	30% co-insurance	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an Health Plan Network	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	30% co-insurance	——————none——————
	Mental/Behavioral health inpatient services	0% co-insurance	30% co-insurance	——————none——————
	Substance use disorder outpatient services	$25 copay/visit	30% co-insurance	——————none——————
	Substance use disorder inpatient services	0% co-insurance	30% co-insurance	——————none——————
If you are pregnant	Prenatal and postnatal care	$20 copay/visit.	30% co-insurance	——————none——————
	Delivery and all inpatient services	0% co-insurance	30% co-insurance	——————none——————
If you need help recovering or have other special health needs	Home health care	0% co-insurance	30% co-insurance	——————none——————
	Rehabilitation services	$20 copay/visit for outpatient	30% co-insurance	Limitation on this benefit.
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	0% co-insurance	30% co-insurance	Limited to a maximum of 100 days per calendar year.
	Durable medical equipment	0% co-insurance	30% co-insurance	——————none——————
	Hospice service	0% co-insurance	30% 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

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 within 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, Option 3. 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.

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** $6,740
- **Patient pays** $800

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	$200
Co-pays	$400
Co-insurance	$0
Limits or exclusions	$200
Total	**$800**

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** $3,920
- **Patient pays** $1,408

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	$200
Co-pays	$1,200
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,480**

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.