

**UPMC Health Plan**  
Preferred Provider Organization

**University of Pittsburgh**  
**Graduate School Plan**

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 (referrals) by a Primary Care Provider (PCP) is not required.

<b>Covered Services</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>
Annual deductible		
Individual	None	\$250
Family	None	\$500
Annual out-of-pocket limit		
Individual	None	\$2,000
Family	None	\$4,000
Plan payment level	100%	80% after deductible <sup>1</sup>
Lifetime benefit limit	\$5,000,000	\$300,000
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
<b>Preventive Care</b>		
Adult		
Routine physical exam	100% after \$5 copayment per visit	Not covered
Pediatric		
Routine physical exam	100% after \$5 copayment per visit	Not covered
Pediatric immunizations	100%	80% (deductible does not apply) <sup>1</sup>
Well-baby visits	100% after \$5 copayment per visit	Not covered
<b>Physician Services</b>		
Physician office visit (for illness or injury)	100% after \$5 copayment per visit	80% after deductible <sup>1</sup>
Specialist office visit	100% after \$10 copayment per visit	80% after deductible <sup>1</sup>
Medical/surgical services	100%	80% after deductible <sup>1</sup>
<b>Women's Care</b>		
Routine gynecological exam, Pap test, mammogram, prenatal visit, diagnostic tests, and surgical services	100% after \$5 copayment applies to routine gynecologic exam only; All other care is provided at 100%	80% after deductible <sup>1</sup> Routine gynecological exam, PAP test, and mammogram not subject to deductible
<b>Hospital Services</b>		
Inpatient/outpatient care, medical/surgical services, ancillary services, and supplies	100%	80% after deductible <sup>1</sup>
<b>Emergency Services</b>		
Emergency care coverage	100% after \$25 copayment per visit (copayment waived if admitted)	100% after \$25 copayment/visit deductible does not apply (copayment waived if admitted)
<b>Diagnostic Services</b>		
Advanced imaging (e.g. PET, MRI, etc.)	100%	80% after deductible <sup>1</sup>
Other imaging (e.g. X-ray, sonogram, etc.)	100%	80% after deductible <sup>1</sup>
Lab and other diagnostic services	100%	80% after deductible <sup>1</sup>
<b>Medical Therapy Services</b>		
Chemotherapy, radiation, infusion therapy, dialysis treatment	100%	80% after deductible <sup>1</sup>
<b>Rehabilitation Therapy Services</b>		
Physical, speech, and occupational	100%	80% after deductible <sup>1</sup>
	Covered up to 60 visits per Benefit Period for all three therapies combined	
<b>Other Medical Services</b>		
Skilled nursing facility	100%	80% after deductible <sup>1</sup>
	Limit of 100 days per Benefit Period	

Covered Services	Participating Provider	Non-Participating Provider
<b>Other Medical Services</b>		
Home health care	100%	80% after deductible <sup>1</sup>
	Limit of 50 days per Benefit Period	
Hospice care	100%	80% after deductible <sup>1</sup>
Therapeutic manipulation/ chiropractic care	100% after \$10 copayment for first visit, \$5 copayment per visit thereafter	80% after deductible <sup>1</sup>
	Limit of 25 visits per Benefit Period	
Podiatric care	100% after \$25 copayment per visit	80% after deductible <sup>1</sup>
Allergy testing and serum	100%	80% after deductible <sup>1</sup>
Durable medical equipment and corrective appliances	100%	80% after deductible <sup>1</sup>
<b>Behavioral Health — Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083</b>		
Behavioral health		
Inpatient <sup>2</sup>	100%	80% after deductible <sup>1</sup>
	Limit of 30 days per Benefit Period; Lifetime maximum of 90 days	
Outpatient <sup>2</sup>	100% after \$5 copayment per visit	50% after deductible <sup>1</sup>
	Unlimited visits per Benefit Period	
Substance abuse services	100%	50% after deductible <sup>1</sup>
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	
<b>Prescription Drug Coverage— The <i>Your Choice</i> pharmacy program will apply (Mandatory Generic)</b>		
Retail prescription drug <sup>3</sup> <b>Pitt Student Health Service Pharmacy</b> <ul style="list-style-type: none"> <li>Lower copayments for prescriptions dispensed at this pharmacy only</li> </ul>		\$5 copayment for generic drugs \$15 copayment for preferred brand drugs \$35 copayment for non-preferred brand drugs  30-day maximum retail supply
Retail prescription drug <sup>3</sup> <b>Other Participating Pharmacies</b> <ul style="list-style-type: none"> <li>Higher copayments for prescriptions dispensed by other participating pharmacies</li> </ul>		\$10 copayment for generic drugs \$20 copayment for preferred brand drugs \$40 copayment for non-preferred brand drugs  30-day maximum retail supply
Specialty prescription drug <sup>3</sup> <b>Pitt Student Health Service Pharmacy</b> <ul style="list-style-type: none"> <li>Specialty medications are limited to a 30-day supply and must be filled by a contracted specialty pharmacy provider</li> <li>Lower copayments for prescriptions dispensed at this pharmacy only</li> </ul>		\$35 copayment for specialty drugs  30-day maximum specialty supply
Specialty prescription drug <sup>3</sup> <b>Other Participating Pharmacies</b> <ul style="list-style-type: none"> <li>Specialty medications are limited to a 30-day supply and must be filled by a contracted specialty pharmacy provider (list available upon request)</li> <li>Higher copayments for prescriptions dispensed by other participating pharmacies</li> </ul>		\$40 copayment for specialty drugs  30-day maximum specialty supply
Mail-order prescription drug <sup>3</sup> <b>Both Pitt Student Health Service Pharmacy and through Mail-Order Pharmacy</b> <ul style="list-style-type: none"> <li>For the same copayment at either pharmacy, a three-month supply (up to 90 days) of medication may be dispensed through the SHS Pharmacy or contracted mail service pharmacy</li> </ul>		\$10 copayment for generic drugs \$30 copayment for preferred brand drugs \$70 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: 1-888-499-6885.  
TTD service for hearing-impaired: 1-800-361-2629.

<sup>1</sup> 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).

<sup>2</sup> 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 UPMC Health Plan Behavioral Health Services at 1-888-251-0083.

<sup>3</sup> 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.

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