

# Gold \$750/\$10 Partner Network: UPMC Health Plan

Summary of Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: All coverage levels | Plan Type: EPO



**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 [www.upmchealthplan.com](http://www.upmchealthplan.com) or by calling 1-855-489-3494.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	Calendar year deductible Participating Provider: <b>\$750 Individual/ \$1,500 Family</b> Deductible does not apply to Preventive Services	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> 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 <b><u>deductible</u></b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. Participating Provider: <b>\$3,000 Individual/\$6,000 Family</b>	The <b><u>out-of-pocket limit</u></b> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes. See <a href="http://www.upmchealthplan.com">www.upmchealthplan.com</a> or call 1-855-489-3494 for a list of <b><u>in-network providers</u></b> .	If you use an in-network doctor or other health care <b><u>provider</u></b> , 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 <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No. You don't need a referral to see a specialist.	You can see the <b><u>specialist</u></b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b><u>excluded services</u></b> .

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-855-489-3494 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$10 copay/visit	Not Covered	_____none_____
	Specialist visit	\$45 copay/visit	Not Covered	_____none_____
	Other practitioner office visit	\$10 copay/visit	Not Covered	_____none_____
	Preventive care/screening/immunization	No Cost	Not Covered	_____none_____
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	\$30 copay/test	Not Covered	Certain Diagnostic Services may have different cost share values; please see your Schedule of Benefits for additional details.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not Covered	_____none_____
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	\$8 copay/prescription (Retail), \$16 copay/prescription (Mail order)	Not Covered	90-day maximum mail-order supply
	Preferred brand drugs	\$45 copay/prescription (Retail), \$112.50 copay/prescription (Mail order)	Not Covered	90-day maximum mail-order supply

More information about **prescription drug coverage** is available at [www.upmchealthplan.com](http://www.upmchealthplan.com).

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Non-preferred brand drugs	\$90 copay/prescription (Retail), \$270 copay/prescription (Mail order)	Not Covered	90-day maximum mail-order supply
	Specialty drugs	50% coinsurance*	Not Covered	Maximum coinsurance of \$500
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	—————none—————
	Physician/surgeon fees	10% coinsurance	Not Covered	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	10% coinsurance	10% coinsurance	—————none—————
	Emergency medical transportation	10% coinsurance	10% coinsurance	—————none—————
	Urgent care	\$45 copay	Not Covered	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	—————none—————
	Physician/surgeon fee	10% coinsurance	Not Covered	—————none—————
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copay/office visit	Not Covered	—————none—————
	Mental/Behavioral health inpatient services	10% coinsurance	Not Covered	—————none—————
	Substance use disorder outpatient services	\$30 copay/office visit	Not Covered	—————none—————
	Substance use disorder inpatient services	10% coinsurance	Not Covered	—————none—————
<b>If you are pregnant</b>	Prenatal and postnatal care	10% coinsurance	Not Covered	—————none—————
	Delivery and all inpatient services	10% coinsurance	Not Covered	—————none—————
<b>If you need help recovering or have other special health needs</b>	Home health care	10% coinsurance	Not Covered	Limit of 60 days per Benefit Period
	Rehabilitation services	\$30 copay/visit	Not Covered	Limit of 30 visits per Benefit Period for Physical and Occupational Therapies combined. Limit of 30 visits per Benefit Period for Speech Therapy

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Habilitation services	\$30 copay/visit	Not Covered	Limit of 30 visits per Benefit Period for Physical and Occupational Therapies combined. Limit of 30 visits per Benefit Period for Speech Therapy
	Skilled nursing care	10% coinsurance	Not Covered	Limit 120 days per benefit period.
	Durable medical equipment	50% coinsurance	Not Covered	_____none_____
	Hospice service	10% coinsurance	Not Covered	_____none_____
<b>If your child needs dental or eye care</b>	Eye exam	No Cost	Full Cost. Reimbursement of \$35	Limit of one exam per year.
	Glasses	No Cost	Full Cost. Reimbursement of \$70-\$95	Limit of one pair of glasses per year.
	Dental check-up	No Cost	Not Covered	Limit of two exams per year.

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul>
<b>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.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture only covered for specific diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care covered with limitations</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care only covered for specific diagnosis</li> </ul>

**Your Rights to Continue Coverage:**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1-855-489-3494**. You may also contact your state insurance department at **1-877-881-6388**.

### **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 your state insurance department at **1-877-881-6388**. Additionally, a consumer assistance program can help you file your appeal. Contact **1-877-881-6388**.

### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan does provide minimum essential coverage.**

### **Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al **1-855-489-3494**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-855-489-3494**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-855-489-3494**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-855-489-3494**.

—————*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 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.

**Note:** These Coverage Examples illustrate individual (self-only) coverage.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,540
- Patient pays \$2,000

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$800
Copays	\$400
Coinsurance	\$600
Limits or exclusions	\$200
<b>Total</b>	<b>\$2,000</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$3,020
- Patient pays \$2,380

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$800
Copays	\$1,100
Coinsurance	\$400
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,380</b>

## 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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

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