

UPMC Health Benefits, Inc. (An affiliate of UPMC Health Plan)

2018 National Complementary Plan w/ Rx - University of Pittsburgh

Covered Services	Benefits
HOSPITAL SERVICES¹	
Inpatient Hospitalization <u>Includes:</u> <ul style="list-style-type: none"> • Inpatient Mental Health • Inpatient Substance Abuse 	<ul style="list-style-type: none"> • You pay \$100 inpatient deductible on your first hospital stay per year. • UPMC Complementary Plan pays 100% of medically necessary costs after the primary carrier has paid and the \$100 deductible has been met. • UPMC Complementary Plan will pay 365 days additional coverage after primary coverage has exhausted.
Skilled Nursing Facility Care²	<ul style="list-style-type: none"> • For days 1-100, UPMC Complementary Plan pays 100% of the remaining medically necessary costs after the primary carrier has paid. • You pay all costs for days 101 and after per benefit period.
Home Health Care	<ul style="list-style-type: none"> • UPMC Complementary Plan pays 100% of medically necessary costs after the primary carrier has paid.
Hospice Care (Medicare-Certified)	<ul style="list-style-type: none"> • UPMC Complementary Plan pays 100% of medically necessary costs after the primary carrier has paid.
MEDICAL SERVICES¹	
Physician Visits <u>Includes:</u> <ul style="list-style-type: none"> • Primary Care Physicians (PCP) & Specialists • Chiropractic Services (non-routine) • Podiatry Services (non-routine) • Outpatient Mental Health Visits • Outpatient Substance Abuse Visits 	<ul style="list-style-type: none"> • UPMC Complementary Plan pays 100% of medically necessary costs after the primary carrier has paid. • Routine chiropractic care and routine podiatry care is not covered by the plan.
Emergency Services, Surgical Services, & Ambulance	<ul style="list-style-type: none"> • UPMC Complementary Plan pays 100% of medically necessary costs after the primary carrier has paid.
Diagnostic Tests, X-Rays, & Labs <u>Includes:</u> <ul style="list-style-type: none"> • X-Rays, Laboratory tests & Blood • Radiation Therapy • MRI, MRA, CT & PET scans, Nuclear Medicine 	<ul style="list-style-type: none"> • UPMC Complementary Plan pays 100% of medically necessary costs after the primary carrier has paid.
Durable Medicare Equipment, Supplies & Part B Drugs <u>Includes:</u> <ul style="list-style-type: none"> • Durable Medical Equipment & Prosthetics • Diabetes Supplies & Training • Part B drugs 	<ul style="list-style-type: none"> • UPMC Complementary Plan pays 100% of medically necessary costs after the primary carrier has paid.
Rehabilitation Services <u>Includes:</u> <ul style="list-style-type: none"> • Physical Therapy • Occupational Therapy • Speech Therapy • Cardiac Rehabilitation Therapy 	<ul style="list-style-type: none"> • UPMC Complementary Plan pays 100% of medically necessary costs after the primary carrier has paid.
Preventive Services <u>Includes:</u> <ul style="list-style-type: none"> • Annual Wellness Exam • Immunizations (flu, pneumonia, Hepatitis B) • Pap Smear & Pelvic Exam • Mammogram • Prostate Exam • Colorectal Screening Exams • Bone Mass Measurements • HIV Screenings • Smoking and Tobacco Cessation Counselling • Other Preventive Services covered by Medicare 	<ul style="list-style-type: none"> • UPMC Complementary Plan pays 100% of medically necessary costs after the primary carrier has paid. • You pay \$0 copay for 4 additional visits of Smoking and Tobacco Cessation Counselling.
ADDITIONAL BENEFITS	
Hearing Services³ <u>Includes:</u> <ul style="list-style-type: none"> • 1 routine hearing exam per year. • 1 fitting evaluation for a hearing aid(s), every 3 years (each ear). • 1 hearing aid allowance every 3 years (not to exceed the cost of the aid). 	<ul style="list-style-type: none"> • You pay \$25 copay for a routine hearing exam; up to 1 exam per year. • You pay \$25 copay for a fitting evaluation for a hearing aid(s); up to 1 fitting evaluation every 3 years. • UPMC Complementary Plan will pay the remainder balance after the copayments have been met on the hearing exam and fitting evaluation. • UPMC Complementary Plan will pay up to \$1,000 for a hearing aid every 3 years. You are responsible for any costs above \$1,000 for the hearing aid.
Vision Services <u>Includes:</u> <ul style="list-style-type: none"> • 1 routine eye exam every two years. • 1 pair of eye glasses (including a standard lens) or contact lenses every 2 years. 	<ul style="list-style-type: none"> • You pay \$0 copay for routine vision exams; up to 1 exam every 2 years. • UPMC Complementary Plan will pay up to \$250 for routine vision eyewear, every two years. You are responsible for any costs above \$250 for routine vision eyewear.

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Fitness Center Benefit <u>Includes:</u> <ul style="list-style-type: none"> Fitness center basic membership through the Silver&Fit® fitness facility network 	<ul style="list-style-type: none"> UPMC Complementary Plan pays qualified services at 100%. You pay \$0 copay for a fitness center basic membership through the Silver&Fit® fitness facility network.
Emergency Worldwide Travel Assistance	<ul style="list-style-type: none"> UPMC Complementary Plan pays qualified services at 100%. Travel assistance must be obtained through Assist America.
PRESCRIPTION DRUG COVERAGE	
Tier 1: Preferred Generic Drugs <i>(previously Tier 5 Select Care Drugs)</i>	\$0 copay - 30 day \$0 copay - 90 day
Tier 2: Generic Drugs <i>(previously Tier 1 Preferred Generic Drugs)</i>	\$10 copay - 30 day \$20 copay - 90 day
Tier 3: Preferred Brand Drugs <i>(previously Tier 2 Preferred Brand Drugs)</i>	\$30 copay - 30 day \$60 copay - 90 day
Tier 4: Non-Preferred Drugs <i>(previously Tier 3 Non-Preferred Drugs)</i>	\$60 copay - 30 day \$120 copay - 90 day
Tier 5: Specialty Drugs <i>(previously Tier 4 Specialty Drugs)</i>	25% coinsurance (30 day supply only)
Initial Coverage Limit	\$3,750
Coverage Gap Cost-Sharing <i>During the Coverage Gap Stage, the member will continue to pay the same copays as in the Initial Coverage stage.</i>	Full Coverage with Wrap-around as follows:
	30-day Supply
	Once the member's yearly drug costs reach \$3,750 and until the member's yearly out-of-pocket costs reach \$5,000 the prescription drug copay/coinsurance amounts are: \$0 copay for Preferred Generic Drugs \$10 copay for Generic Drugs \$30 copay for Preferred Brand Drugs \$60 for Non-Preferred Drugs 25% coinsurance for Specialty Drugs
	90-day Supply
	Once the member's yearly drug costs reach \$3,750 and until the member's yearly out-of-pocket costs reach \$5,000 , the prescription drug copay/coinsurance amounts are: \$0 copay for Preferred Generic Drugs \$20 copay for Generic Drugs \$60 copay for Preferred Brand Drugs \$120 for Non-Preferred Drugs
Out-of-Pocket Maximum (TrOOP)	\$5,000
Catastrophic Coverage Copays	Greater of: \$3.35 generic/brand treated as generic \$8.35 or 5% all others

¹ Please submit claims to your Primary Insurance Carrier, prior to submitting to UPMC Health Benefits, Inc. Complementary Plan. (Primary Carrier e.g., Medicare, Veteran's Administration, Aetna, etc.)

² A benefit period begins the first day you receive services as an inpatient or skilled nursing patient and ends after you have been discharged from the facility and have not been readmitted to any facility for 60 days in a row.

NOTE: UPMC Health Plan, Inc., has determined that the prescription drug coverage offered by this employer group plan for 2018 is creditable coverage.

UPMC HEALTH BENEFITS, INC.

This grid is not intended to provide a full description of benefits. Please refer to the Certificate of Coverage for complete benefit information.