UPMC Health Plan Schedule of Benefits

UPMC Business *Advantage*	
PPO - Premium Network	
Deductible	$100 /$200
Coinsurance	You pay $0 after Deductible
Total Annual Out-of-Pocket	$6,600 /$13,200
Primary care provider	You pay $20 Copayment per visit
Specialist office visit	You pay $20 Copayment per visit
Emergency Department	You pay $50 Copayment per visit
Urgent Care Facility	You pay $20 Copayment per visit.
Rx	$0 /$15 /$30 /$30 after Deductible
Pharmacy Deductible	$15/$25

This Schedule of Benefits will be an important part of your Certificate of Coverage (COC) or your Summary Plan Description (SPD). If your plan has an SPD, it is issued by your employer or labor trust fund. It is not issued by UPMC Health Plan. It is important that you review and understand your COC and/or SPD because they describe in detail the services your plan covers. The Schedule of Benefits describes what you pay for those services.

For Covered Services to be paid at the level described in your Schedule of Benefits, they must be Medically Necessary. They must also meet all other criteria described in your COC. Criteria may include Prior Authorization requirements.

Please note that your plan may not cover all of your health care expenses, such as Copayments and Coinsurance. To understand what your plan covers, review your COC. You may also have Riders and Amendments that expand or restrict your benefits. Please note that UPMC Health Plan reserves the right to reduce or waive your cost-sharing for certain services, if necessary for compliance with the Mental Health Parity and Addiction Equity Act.

If you have any questions about your benefits, or would like to find a Participating Provider near you, visit **www.upmchealthplan.com.** You can also call UPMC Health Plan Member Services at the phone number on your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider	Non-Participating Provider
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Encouraged, but not required	
Prior Authorization Requirements	Provider Responsibility	Member Responsibility
If you fail to obtain Prior Authorization for certain services, you may not be eligible for reimbursement under your plan. Please see additional information below.		

Member Cost Sharing	Participating Provider	Non-Participating Provider
Annual Deductible		
Individual	$100	$6,000
Family	$200	$18,000
Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios - whichever comes first: *When an individual within a family reaches his or her individual Deductible. At this point, only that person is considered to have met the Deductible; OR *When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible.		
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.		
Coinsurance		
	You pay $0 after Deductible	You pay 30% after Deductible
Copayments may apply to certain Participating Provider services.		
Any Covered Services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.		
Total Annual Out-of-Pocket Limit		
Individual	$6,600	$10,000
Family	$13,200	$20,000
Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit is satisfied in one of two ways-whichever comes first: *When an individual within a family reaches his or her individual Out-of-Pocket Limit. At this point, only that person will have Covered Services paid at 100% for the remainder of the Benefit Period; OR *When a combination of a family member's expenses reaches the family Out-of-Pocket Limit. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and Covered Services will be paid at 100% for the remainder of the Benefit Period.		
Out-of-Pocket costs (Copayments, Coinsurance, and Deductibles) for Covered Services apply toward satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits.		

Member Cost Sharing	Participating Provider	Non-Participating Provider
Preventive Services Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.		
Pediatric preventive/health screening examination	Covered at 100%; you pay $0.	Not Covered
Pediatric immunizations	Covered at 100%; you pay $0.	You pay 30%. Deductible does not apply.
Well-baby visits	Covered at 100%; you pay $0.	Not Covered
Adult preventive/health screening examination	Covered at 100%; you pay $0.	Not Covered

Member Cost Sharing	Participating Provider	Non-Participating Provider
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Screening gynecological exam	Covered at 100%; you pay $0.	You pay 30%. Deductible does not apply.
Breast cancer and cervical cancer screening	Covered at 100%; you pay $0.	You pay 30%. Deductible does not apply.
Screening services and procedures required by the ACA	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Hospital Services		
Hospital inpatient	You pay $0 after Deductible.	You pay 30% after Deductible.
Outpatient/Ambulatory surgery	You pay $0 after Deductible.	You pay 30% after Deductible.
Observation stay	You pay $0 after Deductible.	You pay 30% after Deductible.
Maternity - hospital services associated with delivery	You pay $0 after Deductible.	You pay 30% after Deductible.
Emergency Services		
Emergency department	You pay $50 Copayment per visit.	
Copayment waived if you are admitted to hospital.		
Emergency transportation	You pay $0 after Deductible.	
Surgical Services		
Surgical services (professional provider services)	You pay $0 after Deductible.	You pay 30% after Deductible.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay $0 after Deductible.	You pay 30% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay $0 after Deductible.	You pay 30% after Deductible.
Primary care provider office visit	You pay $20 Copayment per visit.	You pay 30% after Deductible.
Specialist office visit	You pay $20 Copayment per visit.	You pay 30% after Deductible.
Convenience care visit	You pay $20 Copayment per visit.	You pay 30% after Deductible.
Urgent care facility	You pay $20 Copayment per visit.	You pay 30% after Deductible.
Virtual Visits		
UPMC AnywhereCare - Virtual Urgent Care and Children's AnywhereCare	You pay $5 Copayment per visit.	
Virtual visit - Primary Care	You pay $10 Copayment per visit.	You pay 30% after Deductible.
Virtual visit – Specialist	You pay $10 Copayment per visit.	You pay 30% after Deductible.
Virtual visit – Behavioral Health	Covered at 100%; you pay $0.	You pay 30% after Deductible.

Member Cost Sharing	Participating Provider	Non-Participating Provider
UPMC *My*Health 24/7 Nurse Line		
If you would like to speak to a registered nurse about a specific health concern or when to seek treatment, call our UPMC *My*Health 24/7 Nurse Line at 1-866-918-1591(TTY:711) 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at www.upmchealthplan.com and a nurse will respond within 24 hours.		
Allergy Services		
Treatment, injections, and serum	You pay $0 after Deductible.	You pay 30% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	You pay $0 after Deductible.	You pay 30% after Deductible.
Other imaging (e.g., x-ray, sonogram,)	You pay $0 after Deductible.	You pay 30% after Deductible.
Laboratory services	You pay $0 after Deductible.	You pay 30% after Deductible.
Diagnostic testing	You pay $0 after Deductible.	You pay 30% after Deductible.
Rehabilitation/Habilitation Therapy Services Note: See the Behavioral Health Services section below for Rehabilitation/Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical, Speech and Occupational Therapy	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Cardiac rehabilitation	You pay $0 after Deductible.	You pay 30% after Deductible.
Covered up to 12 weeks per Benefit Period.		
Pulmonary rehabilitation	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Covered up to 24 visits per Benefit Period.		
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	You pay $0 after Deductible.	You pay 30% after Deductible.
Medical Therapy Services-Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay $0 after Deductible.	You pay 30% after Deductible.
Pain management		
Pain management program	You pay $20 Copayment per visit.	You pay 30% after Deductible.
Behavioral Health (Mental Health and Substance Use Disorder) Services (Rehabilitative or Habilitative) Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.		
Inpatient services (including inpatient hospital services, inpatient rehabilitation, detoxification, non-hospital residential treatment)	You pay $0 after Deductible.	You pay 30% after Deductible.
Office visits, including psychotherapy and counseling	Covered at 100%; you pay $0.	You pay 30% after Deductible.

Member Cost Sharing	Participating Provider	Non-Participating Provider
Outpatient Services (includes intensive outpatient, partial hospitalization and, other medically necessary outpatient services)	You pay $0 after Deductible.	You pay 30% after Deductible.
Laboratory services related to a Behavioral Health condition	You pay $0 after Deductible.	You pay 30% after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health Condition	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay $0 after Deductible.	You pay 30% after Deductible.
Other Medical Services Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below. Visit limits do not apply for medically necessary services provided for treatment of a Behavioral Health condition.		
Acupuncture	You pay $0 after Deductible.	You pay 30% after Deductible.
Covered up to 12 visits per Benefit Period.		
Corrective appliances	You pay $0 after Deductible.	You pay 30% after Deductible.
Dental services related to accidental injury	You pay $0 after Deductible.	You pay 30% after Deductible.
Durable medical equipment	You pay $0 after Deductible.	You pay 30% after Deductible.
Fertility testing	You pay $0 after Deductible.	You pay 30% after Deductible.
Home health care	You pay $0 after Deductible.	You pay 30% after Deductible.
Hospice care	You pay $0 after Deductible.	You pay 30% after Deductible.
Medical nutrition therapy	You pay $0 after Deductible.	You pay 30% after Deductible.
Nutritional counseling	You pay $0 after Deductible.	You pay 30% after Deductible.
Covered up to 2 visits per Benefit Period.		
Nutritional formulas	Covered at 100%; you pay $0.	You pay 30%. Deductible does not apply.
Nutritional formulas for the treatment of PKU and related disorders are not subject to Deductible.		
Oral surgical services	You pay $0 after Deductible.	You pay 30% after Deductible.
Podiatry care	You pay $20 Copayment per visit.	You pay 30% after Deductible.
Skilled nursing facility	You pay $0 after Deductible.	You pay 30% after Deductible.
Therapeutic manipulation/chiropractic care	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Private duty nursing	You pay $0 after Deductible.	You pay 30% after Deductible.
Diabetic Equipment, Supplies, and Education		
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts, Inc., that plan will pay for diabetic supplies and equipment first.)		
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at a Participating Pharmacy. See applicable Prescription Schedule of Benefits for coverage information.	

Member Cost Sharing	Participating Provider	Non-Participating Provider
Diabetic education	You pay $0 after Deductible.	You pay 30% after Deductible.

Prescription Medication Coverage For additional information on your pharmacy benefits, refer to your Prescription Medication Schedule of Benefits. Tier names describe the most common type(s) of medication (such as brands and generics) within that tier. The Your Choice pharmacy program will apply (mandatory generic). Subject to Plan Deductible	
Pharmacy deductible Individual: $15 Family: $25	
Retail prescription medication • Prescriptions must be dispensed by a participating pharmacy. • 30-day supply.	
Tier 1: Preferred Generic Medications	You pay $0 Copayment after Deductible for preferred generic medications.
Tier 2: Preferred Brand Medications and Generic Medications (Brand and Generic)	You pay $15 Copayment after Deductible for preferred brand medications and generic medications (brand and generic).
Tier 3: Nonpreferred Medications (Brand and Generic)	You pay $30 Copayment after Deductible for nonpreferred medications (brand and generic).
Tier 5: Select Generic Medications	You pay $0 Copayment after Deductible for select generic medications.
90-day maximum retail supply available for three copayments	
Specialty prescription medication • Specialty medications are limited to a 30-day supply. See Prescription Medication Schedule of Benefits for additional information. • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request). • Your prescription medication benefit includes coverage of certain specialty medications in the SaveOnSP program. See Prescription Medication Schedule of Benefits for additional information.	
Tier 4: Specialty Medications (Brand and Generic)	You pay $30 Copayment after Deductible for specialty medications (brand and generic).
30-day maximum supply	
Mail-order prescription medication • **A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy.**	
Tier 1: Preferred Generic Medications	You pay $0 Copayment after Deductible for preferred generic medications.
Tier 2: Preferred Brand Medications and Generic Medications (Brand and Generic)	You pay $15 Copayment after Deductible for preferred brand medications and generic medications (brand and generic).
Tier 3: Nonpreferred Medications (Brand and Generic)	You pay $30 Copayment after Deductible for nonpreferred medications (brand and generic).

Prescription Medication Coverage For additional information on your pharmacy benefits, refer to your Prescription Medication Schedule of Benefits. Tier names describe the most common type(s) of medication (such as brands and generics) within that tier. The Your Choice pharmacy program will apply (mandatory generic). Subject to Plan Deductible	
Tier 5: Select Generic Medications	You pay $0 Copayment after Deductible for select generic medications.
90-day maximum mail-order supply	
If the brand-name medication is dispensed instead of the generic equivalent, you must pay the Copayment associated with the brand-name medication as well as the price difference between the brand-name medication and the generic medication.	

Services that require Prior Authorization

Certain services and items must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan and obtain Prior Authorization before receiving services. A list of services that must be Prior Authorized is available 24/7 on our website at www.upmchealthplan.com. You can also contact Member Services by calling the phone number on your member ID card. Your provider may also access this list at www.upmchealthplan.com or your provider may call Provider Services at 1-866-918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of your receiving services in order for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that require Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date of service.

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your COC. Also, the headings under the Covered Services section are the same as those in your COC.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations, and, if applicable, subject to approval by the Pennsylvania Insurance Department. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail and UPMC Health Plan reserves the right to update this document accordingly.

Your plan documents will always include the Schedule of Benefits, the COC, and the Summary of Benefits and Coverage. You can log into *My*Health OnLine to view these documents. If you have questions, call Member Services.

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

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