UPMC Health Plan

Schedule of Benefits

UPMC Small Business *Advantage*
Silver EPO $3,000 $40/$60 - Premium Network
Deductible: $3,000 / $6,000
Coinsurance: 0%
Total Annual Out-of-Pocket: $8,400 / $16,800

Primary Care Provider: $40 Copayment per visit
Specialist: $60 Copayment per visit
Emergency Department: $750 Copayment per visit
Urgent Care Facility: $60 Copayment per visit
Rx: $15/$40/$75/$95

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 and/or SPD. 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 and/or SPD. You may also have Riders and Amendments that expand or restrict your benefits.

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 the back of your member ID card.

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

Plan Information	Participating Provider
Benefit Period	Plan Year
Primary Care Provider (PCP) Required	Encouraged, but not required
Pre-Certification and Prior Authorization Requirements	Provider Responsibility

Member Cost Sharing	Participating Provider
Annual Deductible	
Individual	$3,000
Family	$6,000
Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios — whichever comes first: *When an individual family member 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.	

Member Cost Sharing	Participating Provider
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.	
Coinsurance	
	You pay $0 after Deductible.
	Copayments may apply to certain Participating Provider services.
Total Annual Out-of-Pocket Limit	
Individual	$8,400
Family	$16,800
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 family members' 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.	

Preventive Services	Participating Provider
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.
Pediatric immunizations	Covered at 100%; you pay $0.
Well-baby visits	Covered at 100%; you pay $0.
Adult preventive/health screening examination	Covered at 100%; you pay $0.
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay $0.
Screening gynecological exam	Covered at 100%; you pay $0.
Breast cancer and cervical cancer screening	Covered at 100%; you pay $0.
Diagnostic services and procedures required by the ACA	Covered at 100%; you pay $0.
Pediatric dental and vision services	For coverage information, log in to *My*Health OnLine or call Member Services at the number on the back of your Member ID card.

Covered Services	Participating Provider
Hospital Services	
Hospital inpatient	You pay $600 Copayment per day after Deductible for a maximum of 5 days per Benefit Period.
Hospital outpatient (includes ambulatory surgery)	You pay $500 Copayment per visit after Deductible.
Observation stay	You pay $0 after Deductible.
Maternity - Non-preventive facility and professional services	You pay $600 Copayment per day after Deductible for a maximum of 5 days per Benefit Period.

Covered Services	Participating Provider
Emergency Services	
Emergency department	You pay $750 Copayment per visit. Copayment waived if you are admitted to hospital.
Emergency transportation	You pay $0 after Deductible.
Physician/Surgical Services	
Inpatient physician/surgical services	You pay $0 after Deductible.
Outpatient physician/surgical services	You pay $150 Copayment per visit after Deductible.
Provider Medical Services	
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay $0 after Deductible.
Adult immunizations not required to be covered by the ACA	You pay $0 after Deductible.
Primary care provider office visit	You pay $40 Copayment per visit.
Specialist office visit	You pay $60 Copayment per visit.
Convenience care visit	You pay $40 Copayment per visit.
Urgent care facility	You pay $60 Copayment per visit.
Virtual Visits	
Virtual visit – Virtual Urgent Care	You pay $5 Copayment per visit.
Virtual visit – Scheduled (Primary Care)	You pay $40 Copayment per visit.
Virtual visit – Scheduled (Specialist)	You pay $60 Copayment per visit.
Virtual visit – eDermatology	You pay $60 Copayment per visit.
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). You may also send an email using the web nurse request system at **www.upmchealthplan.com**.	
Allergy Services	
Treatment, injections, and serum	You pay $60 Copayment per visit.
Diagnostic Services	
Advanced imaging (e.g., PET, MRI)	You pay $300 Copayment per visit after Deductible.
Other imaging (e.g., x-ray, sonogram)	You pay $60 Copayment per visit after Deductible.
Lab	You pay $60 Copayment per visit after Deductible.
Diagnostic testing	You pay $60 Copayment per visit after Deductible.
Rehabilitation Therapy Services **Note:** Visit limits on Rehabilitative Therapy Services are not applied if those services are prescribed for treatment of a mental health condition or substance use disorder.	
Physical and occupational therapy	You pay $60 Copayment per visit. Covered up to 30 visits per Benefit Period for both therapies combined.
Speech therapy	You pay $60 Copayment per visit. Covered up to 30 visits per Benefit Period.
Cardiac rehabilitation	You pay $0 after Deductible. Covered up to 36 visits per Benefit Period.
Pulmonary rehabilitation	You pay $60 Copayment per visit. Covered up to 36 visits per Benefit Period.

Covered Services	Participating Provider
Habilitation Therapy Services Note: Visit limits on Habilitative Therapy Services are not applied if those services are prescribed for treatment of a mental health condition or substance use disorder.	
Physical and occupational therapy	You pay $60 Copayment per visit.
	Covered up to 30 visits per Benefit Period for both therapies combined.
Speech therapy	You pay $60 Copayment per visit.
	Covered up to 30 visits per Benefit Period.
Medical Therapy Services	
Chemotherapy, radiation therapy, dialysis therapy	You pay $60 Copayment per visit.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay $0 after Deductible.
Pain Management	
Pain management program	You pay $60 Copayment per visit.
Mental Health and Substance Use Disorder Services 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 $600 Copayment per day after Deductible for a maximum of 5 days per Benefit Period.
Outpatient – Office visits and outpatient therapy	You pay $40 Copayment per visit.
Outpatient – Other services (includes intensive outpatient and partial hospitalization programs)	You pay $0 after Deductible.
Other Medical Services Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below.	
Acupuncture	You pay $60 Copayment per visit.
	Covered up to 12 visits per Benefit Period.
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay $0 after Deductible.
Corrective appliances	You pay 50% after Deductible.
Dental services related to accidental injury	You pay $750 Copayment per visit.
Durable medical equipment	You pay 50% after Deductible.
Fertility testing	You pay $60 Copayment per visit.
Home health care	You pay $0 after Deductible.
	Covered up to 60 days per Benefit Period.
Hospice care	You pay $0 after Deductible.
Infertility services	You pay $60 Copayment per visit.
	Limited to artificial insemination.
Medical nutrition therapy	You pay $0 after Deductible.
Nutritional counseling	You pay $0 after Deductible.
	Covered up to six visits per Benefit Period.
Nutritional products	Covered at 100%; you pay $0.

Covered Services	Participating Provider
	Nutritional products for the treatment of PKU and related disorders are not subject to Deductible.
Oral surgical services	You pay $0 after Deductible.
Podiatry care	You pay $60 Copayment per visit.
Skilled nursing facility	You pay $600 Copayment per day after Deductible for a maximum of 5 days per Benefit Period.
	Covered up to 120 days per Benefit Period.
Therapeutic manipulation	You pay $60 Copayment per visit.
	Covered up to 20 visits per Benefit Period.
Diabetic Equipment, Supplies, and Education	
Diabetic equipment and supplies	
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at Participating Pharmacy. See applicable Prescription Schedule of Benefits for coverage information.
Diabetic education	Covered at 100%; you pay $0.

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 Advantage Choice pharmacy program will apply (mandatory generic).** **Not subject to Plan Deductible** **UPMC Health Plan has determined that your prescription medication benefit plan constitutes Creditable coverage**	
Retail prescription medication • Prescriptions must be dispensed by a participating pharmacy. • 30-day supply.	Tier 1: You pay $15 Copayment for preferred generic medications. Tier 2: You pay $40 Copayment for preferred brand medications. Tier 3: You pay $75 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. Tier 7: You pay $0 Copayment 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). You may pay a higher amount for specialty medications when filled at a retail pharmacy.	Tier 4: You pay $95 Copayment for specialty medications (brand and generic). Tier 6: You pay $0 Copayment for oral chemotherapy medications. 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: You pay $30 Copayment for preferred generic medications. Tier 2: You pay $80 Copayment for preferred brand medications. Tier 3: You pay $150 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. Tier 7: You pay $0 Copayment 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.	

In order to ensure compliance with the Mental Health Parity and Addiction Equity Act, member cost-sharing may be reduced for certain services when received for the diagnosis or treatment of a mental health or substance use disorder condition.

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your Certificate of

Coverage (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. 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.

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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