SCHEDULE OF BENEFITS PANTHER PLUS PLAN

The following Schedule of Benefits is part of your Certificate of Coverage. It sets forth benefit limits and cost-sharing amounts for specific Covered Services during a Benefit Period. A Benefit Period is the 12-month period that begins on the effective date of your coverage. Capitalized words and phrases used in this Schedule of Benefits have the same meaning as set forth in the Certificate of Coverage. The headings under the Covered Services set forth below correspond with sections of your Certificate of Coverage that further describe the terms and conditions of coverage for each class of services. Remember, in order to be covered at the level set forth in this Schedule of Benefits, all services must be Medically Necessary and meet all other criteria set forth in your Certificate of Coverage, including, but not limited to, Prior Authorization, when applicable. This managed care plan may not cover all your health care expenses[1]. **Please read your Certificate of Coverage carefully for complete information about benefits and exclusions. To locate a Participating Provider near you, please visit www.upmchealthplan.com; and look for the Find a Doctor button. If you have questions about your benefits or to determine if a provider is in the UPMC Health Plan network, please contact UPMC Health Plan Member Services at 1-888-499-6885.**

BENEFIT PERIOD		
Plan Year- July 1 to June 30		
LIFETIME BENEFIT LIMIT	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**
	Unlimited	Unlimited
ANNUAL DEDUCTIBLE	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**
All amounts are based on the Allowed Amount. **For Non-Participating Providers, member is liable for any amounts above the Allowed Amount.**		
Individual	You pay $750 per Benefit Period	You pay $1,500 per Benefit Period
Family	You pay $1,500 per Benefit Period	You pay $3,000 per Benefit Period
For family policies, the entire family Deductible must be met by one or a combination of the covered family members before the plan pays for covered benefits for anyone on the Policy.		
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The Deductible does apply towards satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits.		
ANNUAL OUT-OF-POCKET LIMIT **This limit includes the deductible.**	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**
All amounts are based on the Reasonable and Customary Charge		
Individual	After the member incurs $2,250 in Coinsurance expense for Covered Services in a single Benefit Period, payable benefits for Participating Provider care will increase to 100% for the remaining Benefit Period.	After the member incurs $4,500 in Coinsurance expense for Covered Services in a single Benefit Period, payable benefits for Non-Participating Provider care will increase to 100% for the remaining Benefit Period.
Family	After the family (under the same family coverage) incurs $4,500 in Coinsurance expense for Covered Services in a Benefit Period, the family's payable benefits for Participating Provider care will increase to 100% for the remaining Benefit Period.	After the family (under the same family coverage) incurs $9,000 in Coinsurance expense for Covered Services in a Benefit Period, the family's payable benefits for Non-Participating Provider care will increase to 100% for the remaining Benefit Period.
PLAN PAYMENT LEVEL	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**
Plan Payment Level – percent of the Reasonable and Customary Charge that UPMC Health Plan will pay		
	You pay 20% after Deductible (Where Deductible Applies)	You pay 40% after Deductible (Where Deductible Applies)
The Plan Payment Level shall apply to all Covered Services unless specifically excluded.		
PRE-EXISTING CONDITION LIMITATIONS	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**
	None	None

PRIMARY CARE PROVIDER (PCP) REQUIRED	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	No	No
PRE-CERTIFICATION REQUIREMENTS	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**
	Provider responsibility	Member responsibility - $500 penalty per incident for failure to pre-certify non-emergency inpatient admissions.

COVERED SERVICES

Benefits for Covered Services are based upon the Reasonable and Customary Charge (R&C) and include, but are not limited to, those Services listed in this schedule.

COVERED SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
HOSPITAL SERVICES		
Semiprivate Room, Private Room (if Medically Necessary and Appropriate), Surgery, Pre-Admission Testing	You pay 20% after Deductible	You pay 40% after Deductible
Outpatient/Ambulatory Surgery	You pay 20% after Deductible	You pay 40% after Deductible
Observation Stay	You pay 20% after Deductible	You pay 40% after Deductible
EMERGENCY SERVICES		
Emergency Services Coverage	You pay 20% after In-Network Deductible	
Urgent Care Facility	You pay 20% after In-Network Deductible	
Convenience Care Clinic	You pay 20% after Deductible	You pay 40% after Deductible
PHYSICIAN SURGICAL SERVICES		
	You pay 20% after Deductible	You pay 40% after Deductible
PROVIDER MEDICAL SERVICES — Preventive Services will be covered in compliance with requirements under the Patient Protection and Affordable Care Act.		
Inpatient Medical Care Visits and Intensive Medical Care, Consultation, Newborn Care	You pay 20% after Deductible	You pay 40% after Deductible
Pediatric Care and Immunizations:		
Preventive/Health Screening Examination	Covered at 100%. You pay $0	You pay 40% after Deductible
Pediatric Immunizations	Covered at 100%. You pay $0	You pay 40% — Deductible does not apply
Well-baby Visits	Covered at 100%. You pay $0	You pay 40% after Deductible
Adult Care and Immunizations:[2]		
Preventive/Health Screening Examination	Covered at 100%. You pay $0	You pay 40% after Deductible
Age Specific Preventive Care screenings (colonoscopy, prostate cancer screening, etc.)	Covered at 100%. You pay $0	You pay 40% after Deductible
Adult Immunizations required to be covered at no cost-sharing by the Patient Protection and Affordable Care Act	Covered at 100%. You pay $0	You pay 40% after Deductible
Adult Immunizations not required to be covered by PPACA	Covered at 100%. You pay $0	You pay 40% after Deductible
Women's Care:		
Screening Gynecological Exam and Pap test	Covered at 100%. You pay $0	You pay 40% after Deductible
Screening Mammogram	Covered at 100%. You pay $0	You pay 40% — Deductible does not apply
Provider Office Visit — for treatment of medical disease or injury	You pay 20% after Deductible	You pay 40% after Deductible
Specialist Office Visit; including ob-gyn	You pay 20% after Deductible	You pay 40% after Deductible

COVERED SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
ALLERGY SERVICES		
Diagnostic Testing	You pay 20% after Deductible	You pay 40% after Deductible
Treatment, including Injections and Serum	You pay 20% after Deductible	You pay 40% after Deductible
DIAGNOSTIC SERVICES		
Advanced Imaging (e.g. PET, MRI, etc.)	You pay 20% after Deductible	You pay 40% after Deductible
Other Imaging (e.g. X-ray, sonogram, etc.)	You pay 20% after Deductible	You pay 40% after Deductible
Lab and Other Services	You pay 20% after Deductible	You pay 40% after Deductible
REHABILITATION THERAPY SERVICES		
Physical, Speech, and Occupational Therapy	You pay 20% after Deductible	You pay 40% after Deductible
	Limit of 60 days per Benefit Period for all three therapies combined	
Cardiac Rehabilitation	You pay 20% after Deductible	You pay 40% after Deductible
	Covered up to 12 weeks per Benefit Period	
Pulmonary Rehabilitation	You pay 20% after Deductible	You pay 40% after Deductible
	Covered up to 24 visits per Benefit Period	
MEDICAL THERAPY SERVICES		
Chemotherapy, Radiation Therapy, Dialysis Therapy, Infusion Therapy	You pay 20% after Deductible	You pay 40% after Deductible
PAIN MANAGEMENT PROGRAM		
	You pay 20% after Deductible	You pay 40% after Deductible
BEHAVIORAL HEALTH SERVICES — Contact UPMC Health Plan Behavioral Health Services at 1-877-461-8610		
Mental Illness		
Inpatient	You pay 20% after Deductible	You pay 40% after Deductible
Outpatient	You pay 20% after Deductible	You pay 40% after Deductible
SUBSTANCE ABUSE SERVICES — Contact UPMC Health Plan Behavioral Health Services at 1-877-461-8610		
Inpatient Detoxification	You pay 20% after Deductible	You pay 40% after Deductible
Inpatient Non-Hospital Residential Alcohol or Other Drug Services	You pay 20% after Deductible	You pay 40% after Deductible
Outpatient Rehabilitation	You pay 20% after Deductible	You pay 40% after Deductible

COVERED SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
OTHER MEDICAL SERVICES		
Private Duty Nursing Services	You pay 20% after Deductible	You pay 40% after Deductible
Skilled Nursing Facility	You pay 20% after Deductible	You pay 40% after Deductible
	Limit of 90 days per Benefit Period	
Home Health Care	You pay 20% after Deductible	You pay 40% after Deductible
Hospice Care	You pay 20% after Deductible	You pay 40% after Deductible
Dental Services Related to Accidental Injury	You pay 20% after Deductible	You pay 40% after Deductible
Oral Surgical Services	You pay 20% after Deductible	You pay 40% after Deductible
Blood and Blood Products	You pay 20% after Deductible	You pay 40% after Deductible
Clinical Trials	You pay 20% after Deductible	You pay 40% after Deductible
Durable Medical Equipment	You pay 20% after Deductible	You pay 40% after Deductible
Corrective Appliances	You pay 20% after Deductible	You pay 40% after Deductible
Transplantation Services	You pay 20% after Deductible	You pay 40% after Deductible
Therapeutic Manipulation-Chiropractic Care	You pay 20% after Deductible	You pay 40% after Deductible
	Limit of 25 visits per Benefit Period	
Acupuncture	You pay 20% after Deductible	You pay 40% after Deductible
	Refer to the Certificate of Coverage for Specific Benefit Limits	
Podiatry Care	You pay 20% after Deductible	You pay 40% after Deductible
Fertility Testing	You pay 20% after Deductible	You pay 40% after Deductible
Nutritional Supplements	You pay 20% after Deductible	You pay 40% after Deductible
	Refer to the Certificate of Coverage for specific Benefit Limits	
Nutritional Counseling	You pay 20% after Deductible	You pay 40% after Deductible
	Limited to two visits per Benefit Period Refer to the Certificate of Coverage for specific Benefit Limits	
Medical Nutritional Therapy	You pay 20% after Deductible	You pay 40% after Deductible
	Limited to Medically Necessary services directly related to specific medical conditions and subject to the specific Benefit Limits set forth in the Certificate of Coverage	
Ambulance	You pay 20% after Deductible	You pay 40% after Deductible
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, Lancets, Insulin, and Syringes	Must be obtained at Participating Pharmacy. See applicable pharmacy rider for coverage information.	
Diabetic Education	You pay 20% after Deductible	You pay 40% after Deductible

[1]UPMC Health Plan maintains that the coverage described in this document is at all times administered in compliance with applicable laws and regulations, including, but not limited to, the Patient Protection and Affordable Care Act of 2010. If at any time any part or provision of this Statement of Benefits is in conflict with any applicable law, regulation, or other controlling authority, the requirements of that authority shall prevail.

[2] Contact UPMC Health Plan Member Services for more information.

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