UPMC HEALTH PLAN

Schedule of Benefits

Panther Basic
HSA PPO - Premium Network

Deductible: $1,500 / $3,000
Coinsurance: 30%
Total Annual Out-of-Pocket: $5,000 / $10,000

Primary Care Provider: 30% after Deductible
Specialist: 30% after Deductible

Emergency Department: 30% after Deductible
Rx: $16/$40/$80/$90 after Deductible

This document is your Schedule of Benefits. If you enroll in this plan, this Schedule of Benefits will be an important part of your Certificate of Coverage (COC). Your plan may also include a 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. An SPD either adds to or replaces your COC. 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	Non-Participating Provider
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Encouraged, but not required	
Pre-Certification Requirements	Provider Responsibility	Member Responsibility
		$500 penalty per incident for failure to pre-certify non emergency inpatient admissions.

Member Cost Sharing	Participating Provider	Non-Participating Provider
HSA: Health Savings Account annual allocation		
Please refer to your employer for details.		
Annual Deductible		
Individual	$1,500	$3,000
Family	$3,000	$6,000

Member Cost Sharing	Participating Provider	Non-Participating Provider
Your plan has an aggregate Deductible, which means that for family coverage, the entire family Deductible must be met by one or a combination of the covered family members before Covered Services are paid for any member on the plan.		
Deductible applies to all Covered Services you receive during the Benefit Period, unless that service is specifically excluded.		
Coinsurance		
	You pay 30% after Deductible.	You pay 50% after Deductible.
	Copayments may apply to certain Participating Provider services.	
Total Annual Out-of-Pocket Limit		
Individual	$5,000	$10,000
Family	$10,000	$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 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 will have Covered Services paid at 100% for the remainder of the Benefit Period.		
Out-of-Pocket costs such as Copayments, Coinsurance, and Deductibles apply toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits.		

Preventive Services	Participating Provider	Non-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 Care and Immunizations		
Preventive/health screening examination	Covered at 100%; you pay $0.	You pay 50% after Deductible.
Pediatric immunizations	Covered at 100%; you pay $0.	You pay 50%. Deductible does not apply.
Well-baby visits	Covered at 100%; you pay $0.	You pay 50% after Deductible.
Adult Care and Immunizations		
Preventive/health screening examination	Covered at 100%; you pay $0.	You pay 50% after Deductible.
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay $0.	You pay 50% after Deductible.
Age Specific Preventive Care screenings (colonoscopy, prostate cancer screenings, etc.)	Covered at 100%; you pay $0.	You pay 50% after Deductible.
Women's Care		
Screening Gynecological Exam and Pap Test	Covered at 100%; you pay $0.	You pay 50% after Deductible.
Screening Mammogram	Covered at 100%; you pay $0.	You pay 50%. Deductible does not apply.

Covered Services	Participating Provider	Non-Participating Provider
Hospital Services		
Semi-private room, private room (if Medically Necessary and appropriate), surgery, pre-admission testing	You pay 30% after Deductible.	You pay 50% after Deductible.
Outpatient/ambulatory surgery	You pay 30% after Deductible.	You pay 50% after Deductible.
Observation stay	You pay 30% after Deductible.	You pay 50% after Deductible.
Maternity	You pay 30% after Deductible.	You pay 50% after Deductible.
Emergency Services		
If you would like to speak to a registered nurse about a specific health concern, call our MyHealth Advice Line at 1-866-918-1591. Members may also submit email inquiries using the Web Nurse Request system available at www.upmchealthplan.com.		
Emergency department	You pay 30% after Deductible.	
Emergency transportation	You pay 30% after Deductible.	
Urgent care facility	You pay 30% after Deductible.	You pay 30% after Participating Provider Deductible.
Physician Surgical Services		
	You pay 30% after Deductible.	You pay 50% after Deductible.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay 30% after Deductible.	You pay 50% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 30% after Deductible.	You pay 50% after Deductible.
Primary care provider office visit	You pay 30% after Deductible.	You pay 50% after Deductible.
Specialist Office Visit - including OB/GYN	You pay 30% after Deductible.	You pay 50% after Deductible.
Convenience care visit	You pay 30% after Deductible.	You pay 50% after Deductible.
eVisit	You pay 30% after Deductible.	Not covered
Allergy Services		
Treatment, injections, and serum	You pay 30% after Deductible.	You pay 50% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI, etc.)	You pay 30% after Deductible.	You pay 50% after Deductible.
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 30% after Deductible.	You pay 50% after Deductible.
Lab	You pay 30% after Deductible.	You pay 50% after Deductible.
Diagnostic testing	You pay 30% after Deductible.	You pay 50% after Deductible.
Rehabilitation/Habilitation Therapy Services		
Physical, speech, and occupational therapy	You pay 30% after Deductible.	You pay 50% after Deductible.
	Covered up to 60 visits per Benefit Period for all three therapies combined.	
Cardiac rehabilitation	You pay 30% after Deductible.	You pay 50% after Deductible.
	Covered up to 12 weeks per Benefit Period.	
Pulmonary rehabilitation	You pay 30% after Deductible.	You pay 50% after Deductible.
	Covered up to 24 visits per Benefit Period.	

Covered Services	Participating Provider	Non-Participating Provider
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	You pay 30% after Deductible.	You pay 50% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 30% after Deductible.	You pay 50% after Deductible.
Pain Management		
Pain management program	You pay 30% after Deductible.	You pay 50% after Deductible.
Behavioral Health and Substance Abuse Services Contact UPMC Health Plan Behavioral Health Services at 1-877-461-8610		
Inpatient (e.g., detoxification, etc.)	You pay 30% after Deductible.	You pay 50% after Deductible.
Inpatient non-hospital residential services	You pay 30% after Deductible.	You pay 50% after Deductible.
Outpatient (e.g., rehabilitation, therapy, etc.)	You pay 30% after Deductible.	You pay 50% after Deductible.
Other Medical Services		
Acupuncture	You pay 30% after Deductible.	You pay 50% after Deductible.
	Covered up to 12 visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.	
Corrective appliances	You pay 30% after Deductible.	You pay 50% after Deductible.
Dental services related to accidental injury	You pay 30% after Deductible.	You pay 50% after Deductible.
Durable medical equipment	You pay 30% after Deductible.	You pay 50% after Deductible.
Fertility testing	You pay 30% after Deductible.	You pay 50% after Deductible.
Treatment for Infertility (Assisted Fertilization Procedures)	You pay 30% after Deductible.	You pay 50% after Deductible.
	Lifetime maximum of $10,000 for Participating and Non-Participating Provider.	Lifetime maximum of $10,000 for Participating and Non-Participating Provider.
Home health care	You pay 30% after Deductible.	You pay 50% after Deductible.
Hospice care	You pay 30% after Deductible.	You pay 50% after Deductible.
Medical nutrition therapy	You pay 30% after Deductible.	You pay 50% after Deductible.
	Refer to the Certificate of Coverage for specific Benefit Limitations.	
Nutritional counseling	You pay 30% after Deductible.	You pay 50% after Deductible.
	Limited to two visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.	
Nutritional products	You pay 30% after Deductible.	You pay 50% after Deductible.
	Refer to the Certificate of Coverage for specific Benefit Limitations.	
Oral surgical services	You pay 30% after Deductible.	You pay 50% after Deductible.
Podiatry care	You pay 30% after Deductible.	You pay 50% after Deductible.
Private duty nursing	You pay 30% after Deductible.	You pay 50% after Deductible.
Skilled nursing facility	You pay 30% after Deductible.	You pay 50% after Deductible.
	Benefit Limit of 90 days per Benefit Period.	
Therapeutic manipulation	You pay 30% after Deductible.	You pay 50% after Deductible.
	Covered up to 25 visits per Benefit Period. Prior Authorization must be obtained for dependent children 13 years of age or younger.	

Covered Services	Participating Provider	Non-Participating Provider
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 Participating Pharmacy. See applicable pharmacy rider for coverage information.	
Diabetic education	You pay 30% after Deductible.	You pay 50% after Deductible.

Prescription Drug Coverage

For additional information on your pharmacy benefits, please reference your Prescription Drug Rider.
The Your Choice pharmacy program will apply (mandatory generic).
Subject to Plan Deductible

Retail prescription drug • Prescriptions must be dispensed by a participating pharmacy • 30-day supply	You pay $16 Copayment after Deductible for generic drugs. You pay $40 Copayment after Deductible for preferred brand drugs. You pay $80 Copayment after Deductible for non-preferred brand drugs. 90-day maximum retail supply available for 3 copayments
Specialty prescription drug • Specialty medications are limited to a 30-day supply • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request)	You pay $90 Copayment after Deductible for specialty drugs. 30-day maximum supply
Mail-order prescription drug • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy	You pay $32 Copayment after Deductible for generic drugs. You pay $80 Copayment after Deductible for preferred brand drugs. You pay $160 Copayment after Deductible for non-preferred brand drugs. 90-day maximum mail-order supply
If a physician demonstrates that the brand-name drug is medically necessary and appropriate, the member will pay only the non-preferred brand-name drug copayment.	

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 (SBC). You'll find your documents at **www.upmchealthplan.com**. If you have questions, call Member Services.

In this document, the term "UPMC Health Plan" refers to benefit plans offered by UPMC Health Network, Inc., UPMC Health Options, Inc., UPMC Health Coverage, Inc. and/or UPMC Health Plan, Inc.

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