

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-499-6885 or visit us at www.upmchealthplan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-499-6885 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other <u>deductibles</u> for specific services?	Yes. Infertility services: \$250/Person . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Participating <u>Provider</u> : \$1,800 Person/ \$3,600 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , balance-billed charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.upmchealthplan.com or call 1-888-499-6885 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copayment</u> per visit	Not covered	None
	<u>Specialist visit</u>	\$40 <u>copayment</u> per visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No cost	Not covered	Please see your Schedule of Benefits for details. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No cost	Not covered	Certain Diagnostic Services may have additional cost sharing. Please see your Schedule of Benefits for details. Other imaging (including X-rays and sonograms) are covered with a \$20 <u>copayment</u> . Limit of four <u>copayments</u> per Benefit Period; 100% coverage thereafter.
	Imaging (CT/PET scans, MRIs)	\$80 <u>copayment</u> per visit	Not covered	Limit of four <u>copayments</u> per Benefit Period; 100% coverage thereafter.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at	Generic drugs	\$16 <u>copayment</u> per prescription (Retail), \$32 <u>copayment</u> per prescription (Mail order)	Not covered	None
	Preferred brand drugs	\$40 <u>copayment</u> per prescription (Retail), \$80 <u>copayment</u> per prescription (Mail order)	Not covered	None
	Non-preferred brand drugs	\$80 <u>copayment</u> per prescription (Retail), \$160 <u>copayment</u> per prescription (Mail order)	Not covered	None
	<u>Specialty drugs</u>	\$90 <u>copayment</u> per prescription	Not covered	Please see your Prescription Medication Rider for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 <u>copayment</u> per visit	Not covered	Limit of four <u>copayments</u> per Benefit Period; 100% coverage thereafter.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Physician/surgeon fees	No cost	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$75 <u>copayment</u> for members 18 years and under; \$125 <u>copayment</u> for members 19 years old and over	\$75 <u>copayment</u> for members 18 years and under; \$125 <u>copayment</u> for members 19 years old and over	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	No cost	No cost	None
	<u>Urgent care</u>	\$60 <u>copayment</u> per visit	Not covered	Applies to both Participating and Non-Participating Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copayment</u> per inpatient stay	Not covered	Limit of two <u>copayments</u> per Benefit Period; 100% coverage thereafter. <u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
	Physician/surgeon fees	No cost	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copayment</u> per visit	Not covered	Please see your Schedule of Benefits for details.
	Inpatient services	No cost	Not covered	<u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
If you are pregnant	Office visits	\$25 <u>copayment</u> per visit	Not covered	Limit of two <u>copayments</u> per Benefit Period; 100% coverage thereafter. Depending on the type of services, other <u>cost shares</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Office visit <u>cost share</u> applies to first visit only.
	Childbirth/delivery professional services	No cost	Not covered	
	Childbirth/delivery facility services	\$500 <u>copayment</u> per inpatient stay	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No cost	Not covered	None
	<u>Rehabilitation services</u>	\$25 <u>copayment</u> per visit	Not covered	Physical, Occupational and Speech Therapy: Covered up to 60 visits per Benefit Period for all three therapies combined.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (You will pay the most)	
	<u>Habilitation services</u>	\$25 <u>copayment</u> per visit	Not covered	Physical, Occupational and Speech Therapy: Covered up to 60 visits per Benefit Period for all three therapies combined.
	<u>Skilled nursing care</u>	No cost	Not covered	Covered up to 120 days per Benefit Period. <u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
	<u>Durable medical equipment</u>	No cost	Not covered	None
	<u>Hospice services</u>	No cost	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture only covered for specific diagnosis • Bariatric surgery subject to medical review • Chiropractic care covered with limitations 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment 	<ul style="list-style-type: none"> • Private-duty nursing subject to medical review • Routine foot care only covered for specific diagnosis

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-877-881-6388 for the state insurance department, or the insurer at 1-888-499-6885. Other coverage options may be available to you too, including

buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-888-499-6885. Additionally, a consumer assistance program can help you file your appeal. Contact 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-499-6885.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-499-6885.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-499-6885.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-499-6885.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist \$40
- Hospital (facility) \$500
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,840
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$630
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$690

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist \$40
- Hospital (facility) \$500
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,460
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,860

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist \$40
- Hospital (facility) \$500
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,010
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$670
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$670

Nondiscrimination Notice

UPMC Health Plan¹ complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UPMC Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UPMC Health Plan:

- Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:
 - Qualified sign language interpreters.
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters.
 - Information written in other languages.

If you need these services, contact the Member Services phone number listed on the back of your member ID card.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint with:

Complaints and Grievances
PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-844-755-5611 (TTY: 711)
Fax: 1-412-454-5964
Email: HealthPlanCompliance@upmc.edu

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

¹UPMC 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., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-420-9589

(TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-420-9589
(TTY : 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-866-420-9589 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-420-9589 (телетайп: 711).

Wann du Deitsch (Pennsylvania German / Dutch)] schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-420-9589
(TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-866-420-9589 (TTY: 711)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-420-9589
(TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-420-9589 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-420-9589 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-420-9589 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો િન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-420-9589 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-420-9589 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-420-9589 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-866-420-9589 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-420-9589 (TTY: 711).