

Panther Gold Plan - Enhanced Access HMO Applies to Bradford, Johnstown and Greensburg campuses only HMO**Deductible:** \$0 / \$0**Coinsurance:** 0%**Total Annual Out-of-Pocket:** \$1,800 / \$3,600**Primary Care Provider:** \$25 Copayment per visit**Specialist:** \$40 Copayment per visit**Emergency Department:** \$100 Copayment per visit for members 18 years and under. \$150 Copayment per visit for members 19 years old and over**Urgent Care Facility:** \$60 Copayment per visit**Rx:** \$16/\$45/\$90/\$100

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	Yes
Pre-Certification and Prior Authorization Requirements	Provider Responsibility

Member Cost Sharing	Participating Provider
Annual Deductible	
Individual	\$0
Family	\$0
Coinsurance	
	Covered at 100%; you pay \$0.
	Copayments may apply to certain Participating Provider services.
Total Annual Out-of-Pocket Limit	
Individual	\$1,800
Family	\$3,600

Member Cost Sharing	Participating Provider
Your plan has an aggregate Out-of-Pocket Limit, which means for family coverage, the entire family Out-of-Pocket Limit must be met by one or a combination of the covered family members before the plan pays at 100% for Covered Services 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.
Age Specific Preventive Care screenings (colonoscopy, prostate cancer screenings, etc.)	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.

Covered Services	Participating Provider
Hospital Services	
Hospital inpatient	You pay \$500 Copayment per inpatient stay.
	Limit of two Copayments per Benefit Period; you pay \$0 thereafter.
Outpatient surgery and Observation stay	You pay \$250 Copayment per visit.
	Limit of four Copayments per Benefit Period; you pay \$0 thereafter.
Outpatient care, medical services, ancillary services and supplies	Covered at 100%; you pay \$0.
Maternity - Non-preventive facility and professional services	You pay \$500 Copayment per inpatient stay.
	Limit of two Copayments per Benefit Period; you pay \$0 thereafter.
Emergency Services	
Emergency department	You pay \$100 Copayment per visit for members 18 years and under. You pay \$150 Copayment per visit for members 19 years old and over.
	Copayment waived if you are admitted to hospital.
Emergency transportation	Covered at 100%; you pay \$0.
Physician/Surgical Services	
Inpatient physician/surgical services	Covered at 100%; you pay \$0.
Outpatient physician/surgical services	Covered at 100%; you pay \$0.

Covered Services		Participating Provider
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care		Covered at 100%; you pay \$0.
Adult immunizations not required to be covered by the ACA		Covered at 100%; you pay \$0.
Primary care provider office visit		You pay \$25 Copayment per visit.
Specialist office visit		You pay \$40 Copayment per visit.
Convenience care visit		You pay \$25 Copayment per visit.
Urgent care facility		You pay \$60 Copayment per visit.
	Applies to both Participating and Non-Participating Providers.	
Virtual Visits		
Virtual visit - Virtual Urgent Care		You pay \$10 Copayment per visit.
Virtual visit - Scheduled (Primary Care)		You pay \$25 Copayment per visit.
Virtual visit - Scheduled (Specialist)		You pay \$20 Copayment per visit.
Virtual visit - eDermatology		You pay \$20 Copayment per visit.
UPMC MyHealth 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 MyHealth 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		Covered at 100%; you pay \$0.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)		You pay \$100 Copayment per visit.
	Limit of four Copayments per Benefit Period; you pay \$0 thereafter.	
Other imaging (e.g., x-ray, sonogram)		You pay \$25 Copayment per visit.
	Limit of four Copayments per Benefit Period; you pay \$0 thereafter.	
Lab		Covered at 100%; you pay \$0.
Diagnostic testing		Covered at 100%; you pay \$0.
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, speech, and occupational therapy		You pay \$25 Copayment per visit.
	Covered up to 60 visits per Benefit Period for all three therapies combined.	
Cardiac rehabilitation		Covered at 100%; you pay \$0.
	Covered up to 36 visits per Benefit Period.	
Pulmonary rehabilitation		You pay \$25 Copayment per visit.
	Covered up to 36 visits per Benefit Period.	
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, speech, and occupational therapy		You pay \$25 Copayment per visit.
	Covered up to 60 visits per Benefit Period for all three therapies combined.	
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy		Covered at 100%; you pay \$0.

Covered Services	Participating Provider
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	Covered at 100%; you pay \$0.
Pain Management	
Pain management program	You pay \$40 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)	Covered at 100%; you pay \$0.
Outpatient (e.g., rehabilitation)	Covered at 100%; you pay \$0.
Outpatient (e.g., therapy)	You pay \$25 Copayment per visit.
Outpatient - Other services (includes intensive outpatient and partial hospitalization programs)	Covered at 100%; you pay \$0.
Other Medical Services	
Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below.	
Acupuncture	Covered at 100%; you pay \$0.
	Covered up to 12 visits per Benefit Period.
Applied behavior analysis for the treatment of Autism Spectrum Disorder	Covered at 100%; you pay \$0.
Corrective appliances	Covered at 100%; you pay \$0.
Dental services related to accidental injury	Covered at 100%; you pay \$0.
Durable medical equipment	Covered at 100%; you pay \$0.
Fertility testing	Covered at 100%; you pay \$0.
Home health care	Covered at 100%; you pay \$0.
Hospice care	Covered at 100%; you pay \$0.
Treatment for Infertility (Assisted Fertilization Procedures)	You pay \$250 Deductible per Member per Benefit Period.
	Lifetime maximum of \$10,000. Benefit limit does not apply to artificial insemination procedures.
Medical nutrition therapy	Covered at 100%; you pay \$0.
Nutritional counseling	Covered at 100%; you pay \$0.
	Covered up to six visits per Benefit Period.
Nutritional products	Covered at 100%; you pay \$0.
Oral surgical services	Covered at 100%; you pay \$0.
Podiatry care	You pay \$25 Copayment per visit.
Private duty nursing	Covered at 100%; you pay \$0.
Skilled nursing facility	Covered at 100%; you pay \$0.
	Covered up to 120 days per Benefit Period.
Therapeutic manipulation - Chiropractic Care	You pay \$25 Copayment per visit. First visit you pay \$40 Copayment.
	Covered up to 25 visits per Benefit Period.

Covered Services	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	Covered at 100%; you pay \$0.

Prescription Medication Coverage	
For additional information on your pharmacy benefits, refer to your Prescription Medication Rider. 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). Not subject to Plan Deductible	
Retail prescription medication <ul style="list-style-type: none"> • Prescriptions must be dispensed by a participating pharmacy. • 30-day supply. 	Tier 1: You pay \$16 Copayment for preferred generic medications. Tier 2: You pay \$45 Copayment for preferred brand medications. Tier 3: You pay \$90 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay \$0 Copayment for preventive medications. 90-day maximum retail supply available for three copayments
Specialty prescription medication <ul style="list-style-type: none"> • Specialty medications are limited to a 30-day supply. See Prescription Medication Rider for additional information. • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request). 	Tier 4: You pay \$100 Copayment for specialty medications (brand and generic). 30-day maximum supply
Mail-order prescription medication <ul style="list-style-type: none"> • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy. 	Tier 1: You pay \$32 Copayment for preferred generic medications. Tier 2: You pay \$90 Copayment for preferred brand medications. Tier 3: You pay \$180 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay \$0 Copayment for preventive medications. 90-day maximum mail-order supply
If a provider demonstrates that the brand-name medication is Medically Necessary and appropriate, you will pay only the nonpreferred brand-name medication 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. You can log into *MyHealth OnLine* to view these documents. If you have questions, call Member Services.

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