Schedule of Benefits

Advantage Panther Gold Plan - Enhanced Access HMO
Applies to Oakland and Titusville campuses
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 old 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	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Yes	
Pre-Certification and Prior Authorization Requirements	Provider Responsibility	

Member Cost Sharing	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
Annual Deductible		
Individual	$0	$300
Family	$0	$600

Member Cost Sharing	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
Your family plan has an aggregate Deductible, which means that, any covered member and any combination of covered family members can meet the family Deductible before Covered Services are paid for any member on the plan. The individual Deductible does not apply if you are enrolled in family coverage. -Amounts applied to the Level 1 Deductible will also apply to the Level 2 Deductible -Amounts applied to the Level 2 Deductible will also apply to the Level 1 Deductible		
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.		
Coinsurance		
	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Copayments may apply to certain Participating Provider services.	
Total Annual Out-of-Pocket Limit		
Individual	$1,800	
Family	$3,600	
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. -Amounts applied to the Level 1 Out-of-Pocket will also apply to the Level 2 Out-of-Pocket -Amounts applied to the Level 2 Out-of-Pocket will also apply to the Level 1 Out-of-Pocket		
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	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
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.	

<table>
<tr><th>Covered Services</th><th>UPMC Advantage Network Level 1</th><th>Other Participating UPMC Facilities Level 2</th></tr>
<tr><td colspan="3">Hospital Services</td></tr>
<tr><td rowspan="2">Hospital inpatient</td><td>You pay $500 Copayment per inpatient stay.</td><td>You pay 20% after Deductible.</td></tr>
<tr><td>Limit of two Copayments per Benefit Period; you pay $0 thereafter.</td><td></td></tr>
<tr><td rowspan="2">Outpatient surgery and Observation stay</td><td>You pay $250 Copayment per visit.</td><td>You pay 20% after Deductible.</td></tr>
<tr><td>Limit of four Copayments per Benefit Period; you pay $0 thereafter.</td><td></td></tr>
<tr><td>Outpatient care, medical services, ancillary services and supplies</td><td>Covered at 100%; you pay $0.</td><td>You pay 20% after Deductible.</td></tr>
<tr><td rowspan="2">Maternity - Non-preventive facility and professional services</td><td>You pay $500 Copayment per inpatient stay.</td><td>You pay 20% after Deductible.</td></tr>
<tr><td>Limit of two Copayments per Benefit Period; you pay $0 thereafter.</td><td></td></tr>
<tr><td colspan="3">Emergency Services</td></tr>
<tr><td rowspan="2">Emergency department</td><td colspan="2">You pay $100 Copayment per visit for members 18 years old and under. You pay $150 Copayment per visit for members 19 years old and over.</td></tr>
<tr><td colspan="2">Copayment waived if you are admitted to hospital.</td></tr>
<tr><td>Emergency transportation</td><td colspan="2">Covered at 100%; you pay $0.</td></tr>
<tr><td colspan="3">Physician/Surgical Services</td></tr>
<tr><td>Inpatient physician/surgical services</td><td colspan="2">Covered at 100%; you pay $0.</td></tr>
<tr><td>Outpatient physician/surgical services</td><td colspan="2">Covered at 100%; you pay $0.</td></tr>
<tr><td colspan="3">Provider Medical Services</td></tr>
<tr><td>Inpatient medical care visits, intensive medical care, consultation, and newborn care</td><td colspan="2">Covered at 100%; you pay $0.</td></tr>
<tr><td>Adult immunizations not required to be covered by the ACA</td><td colspan="2">Covered at 100%; you pay $0.</td></tr>
<tr><td>Primary care provider office visit</td><td colspan="2">You pay $25 Copayment per visit.</td></tr>
<tr><td>Specialist Office Visit; including OB/GYN</td><td colspan="2">You pay $40 Copayment per visit.</td></tr>
<tr><td>Convenience care visit</td><td colspan="2">You pay $25 Copayment per visit.</td></tr>
<tr><td rowspan="2">Urgent care facility</td><td colspan="2">You pay $60 Copayment per visit.</td></tr>
<tr><td colspan="2">Applies to both Participating and Non-Participating Providers.</td></tr>
<tr><td colspan="3">Virtual Visits</td></tr>
<tr><td>Virtual visit – Virtual Urgent Care</td><td colspan="2">You pay $10 Copayment per visit.</td></tr>
<tr><td>Virtual visit – Scheduled (Primary Care)</td><td colspan="2">You pay $25 Copayment per visit.</td></tr>
<tr><td>Virtual visit – Scheduled (Specialist)</td><td colspan="2">You pay $20 Copayment per visit.</td></tr>
<tr><td>Virtual visit – eDermatology</td><td colspan="2">You pay $20 Copayment per visit.</td></tr>
<tr><td colspan="3">UPMC MyHealth 24/7 Nurse Line</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="3">Allergy Services</td></tr>
<tr><td>Treatment, injections, and serum</td><td colspan="2">Covered at 100%; you pay $0.</td></tr>
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Covered Services	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	You pay $100 Copayment per visit.	You pay 20% after Deductible.
	Limit of four Copayments per Benefit Period; you pay $0 thereafter.	
Other imaging (e.g., x-ray, sonogram)	You pay $25 Copayment per visit.	You pay 20% after Deductible.
	Limit of four Copayments per Benefit Period; you pay $0 thereafter.	
Lab	Covered at 100%; you pay $0.	You pay 20% after Deductible.
Inpatient & Outpatient Hospital Services	Covered at 100%; you pay $0.	You pay 20% after Deductible.
Diagnostic testing	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Hospital and Non-hospital Outpatient Mammogram (based on age guidelines)	Covered at 100%; you pay $0.	You pay 20% after Deductible.
Non-hospital Outpatient Facility	Covered at 100%; you pay $0.	You pay 20% 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, speech, and occupational therapy (Hospital and Non-hospital Outpatient)	You pay $25 Copayment per visit.	You pay 20% after Deductible.
	Covered up to 60 visits per Benefit Period for all three therapies combined.	
Cardiac Rehabilitation (Hospital Outpatient)	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Pulmonary Rehabilitation (Hospital Outpatient)	You pay $25 Copayment per visit.	You pay 20% after Deductible.
	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 (Hospital and Non-hospital Outpatient)	You pay $25 Copayment per visit.	You pay 20% after Deductible.
	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.	You pay 20% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
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.	You pay 20% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Pain Management		
Pain management program	You pay $40 Copayment per visit.	You pay 20% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	

Covered Services	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
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.	You pay 20% after Deductible.
Corrective appliances	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Physician Services will be covered at the Level 1 cost-share for Participating Providers.	
Dental services related to accidental injury	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Durable medical equipment	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Physician Services will be covered at the Level 1 cost-share for Participating Providers.	
Fertility testing	Covered at 100%; you pay $0.	
Home health care	Covered at 100%; you pay $0.	You pay 20% after Deductible.
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.	You pay 20% 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.	
Nutritional counseling	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Covered up to six visits per Benefit Period.	
Nutritional products	Covered at 100%; you pay $0.	You pay 20%. Deductible does not apply.
	Nutritional products for the treatment of PKU and related disorders are not subject to Deductible.	
Oral surgical services	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	

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<tr><td>Podiatry care</td><td colspan="2">You pay $25 Copayment per visit.</td></tr>
<tr><td>Private duty nursing</td><td colspan="2">Covered at 100%; you pay $0.</td></tr>
<tr><td rowspan="3">Skilled nursing facility</td><td>Covered at 100%; you pay $0.</td><td>You pay 20% after Deductible.</td></tr>
<tr><td colspan="2">Covered up to 120 days per Benefit Period.</td></tr>
<tr><td colspan="2">Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.</td></tr>
<tr><td rowspan="2">Therapeutic manipulation - Chiropractic Care</td><td colspan="2">You pay $25 Copayment per visit. First visit you pay $40 Copayment.</td></tr>
<tr><td colspan="2">Covered up to 25 visits per Benefit Period.</td></tr>
<tr><td colspan="3">Diabetic Equipment, Supplies, and Education</td></tr>
<tr><td colspan="3">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.)</td></tr>
<tr><td>Glucometer, test strips, and lancets, insulin and syringes</td><td colspan="2">Must be obtained at Participating Pharmacy. See applicable pharmacy rider for coverage information.</td></tr>
<tr><td>Diabetic education</td><td>Covered at 100%; you pay $0.</td><td>You pay 20% after Deductible.</td></tr>
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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 • 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 • 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 • 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 *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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