UPMC Health Plan

Schedule of Benefits

University of Pittsburgh PA Child Welfare Resource PPO - Out of Area
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	Participating Provider	Non-Participating Provider
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Encouraged, but not required	
Pre-Certification and Prior Authorization Requirements	Provider Responsibility	Member Responsibility
		If you fail to obtain Prior Authorization for certain services, you may not be eligible for reimbursement under your plan. Please see additional information below.

Member Cost Sharing	Participating Provider	Non-Participating Provider
Annual Deductible		
Individual	$0	$500
Family	$0	$1,000

Member Cost Sharing	Participating Provider	Non-Participating Provider
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.		
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 30% after Deductible.
	Copayments may apply to certain Participating Provider services.	
Total Annual Out-of-Pocket Limit		
Individual	$1,800	$3,000
Family	$3,600	$6,000
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	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 preventive/health screening examination	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Pediatric immunizations	Covered at 100%; you pay $0.	You pay 30%. Deductible does not apply.
Well-baby visits	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Adult preventive/health screening examination	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Age Specific Preventive Care screenings (colonoscopy, prostate cancer screenings, etc.)	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Screening Gynecological Exam and Pap Test	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Screening Mammogram	Covered at 100%; you pay $0.	You pay 30%. Deductible does not apply.
Diagnostic services and procedures required by the ACA	Covered at 100%; you pay $0.	You pay 30% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Hospital Services		
Hospital inpatient	You pay $500 Copayment per inpatient stay.	You pay 30% after Deductible.
	Limit of two Copayments per Benefit Period; you pay $0 thereafter.	
	You pay $250 Copayment per visit.	You pay 30% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Hospital outpatient (includes ambulatory surgery)	Limit of four Copayments per Benefit Period; you pay $0 thereafter.	
Observation stay	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Maternity - Non-preventive facility and professional services	You pay $500 Copayment per inpatient stay.	You pay 30% after Deductible.
	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 old 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.	You pay 30% after Deductible.
Outpatient physician/surgical services	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Adult immunizations not required to be covered by the ACA	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Primary care provider office visit	You pay $25 Copayment per visit.	You pay 30% after Deductible.
Specialist Office Visit - including OB-GYN	You pay $40 Copayment per visit.	You pay 30% after Deductible.
Convenience care visit	You pay $25 Copayment per visit.	You pay 30% after Deductible.
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.	You pay 30% after Deductible.
Virtual visit – Scheduled (Primary Care)	You pay $25 Copayment per visit.	You pay 30% after Deductible.
Virtual visit – Scheduled (Specialist)	You pay $20 Copayment per visit.	You pay 30% after Deductible.
Virtual visit – eDermatology	You pay $20 Copayment per visit.	You pay 30% after Deductible.
UPMC *My*Health 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 *My*Health 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.	You pay 30% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	You pay $100 Copayment per visit.	You pay 30% 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 30% after Deductible.
	Limit of four Copayments per Benefit Period; you pay $0 thereafter.	
Lab	Covered at 100%; you pay $0.	You pay 30% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Diagnostic testing	Covered at 100%; you pay $0.	You pay 30% 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	You pay $25 Copayment per visit.	You pay 30% after Deductible.
	Covered up to 60 visits per Benefit Period for all three therapies combined.	
Cardiac rehabilitation	Covered at 100%; you pay $0.	You pay 30% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Pulmonary rehabilitation	You pay $25 Copayment per visit.	You pay 30% 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	You pay $25 Copayment per visit.	You pay 30% 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 30% after Deductible.
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 30% after Deductible.
Pain Management		
Pain management program	You pay $40 Copayment per visit.	You pay 30% after Deductible.
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.	You pay 30% after Deductible.
Outpatient (e.g., rehabilitation)	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Outpatient (e.g., therapy)	You pay $25 Copayment per visit.	You pay 30% after Deductible.
Outpatient – Other services (includes intensive outpatient and partial hospitalization programs)	Covered at 100%; you pay $0.	You pay 30% after Deductible.
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.	You pay 30% after Deductible.
	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 30% after Deductible.
Corrective appliances	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Dental services related to accidental injury	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Durable medical equipment	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Fertility testing	Covered at 100%; you pay $0.	You pay 30% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Home health care	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Hospice care	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Treatment for Infertility (Assisted Fertilization Procedures)	You pay $250 Deductible per Member per Benefit Period.	You pay 30% after Deductible.
	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 30% after Deductible.
Nutritional counseling	Covered at 100%; you pay $0.	You pay 30% after Deductible.
	Covered up to six visits per Benefit Period.	
Nutritional products	Covered at 100%; you pay $0.	You pay 30%. 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 30% after Deductible.
Podiatry care	You pay $25 Copayment per visit.	You pay 30% after Deductible.
Private duty nursing	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Skilled nursing facility	Covered at 100%; you pay $0.	You pay 30% after Deductible.
	Covered up to 120 days per Benefit Period.	
Therapeutic manipulation - Chiropractic Care	You pay $25 Copayment per visit. First visit you pay $40 Copayment.	You pay 30% after Deductible.
	Covered up to 25 visits per Benefit Period.	
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.	You pay 30% after Deductible.

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.	

Prior Authorization for out-of-network services

Certain out-of-network non-emergent care must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan and obtain Prior Authorization before receiving services. A list of services that must be Prior Authorized is available 24/7 on our website at www.upmchealthplan.com. You can also contact Member Services by calling the phone number on the back of your member ID card. Your out-of-network provider may also access this list at www.upmchealthplan.com or your provider may call Provider Services at 1-866-918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of your receiving services in order for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that require Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date

of service.

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.

UPMC Health Plan
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com