UPMC Health Options, Inc.

Schedule of Benefits

Panther Blue - General Student Health Plan
PPO - Premium Network
Deductible: $250 / $500
Coinsurance: 10%
Total Annual Out-of-Pocket: $4,200 / $8,400

Primary Care Provider: $30 Copayment per visit
Specialist: $40 Copayment per visit
Emergency Department: $75 Copayment per visit
Urgent Care Facility: $40 Copayment per visit
Rx: $15/$35/$70/$70

This document is your Schedule of Benefits. If you enroll in this plan, this Schedule of Benefits will be an important part of your Policy. Your Policy describes in detail the services your plan covers, while 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 Policy. 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 Policy. You may also have Service Area documents 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	
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	$250	$500
Family	$500	$1,000

Member Cost Sharing	Participating Provider	Non-Participating Provider
Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios — whichever comes first: *When an individual family member reaches his or her individual Deductible. At this point, only that person is considered to have met the Deductible; OR *When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible.		
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.		
Coinsurance		
	You pay 10% after Deductible.	You pay 30% after Deductible.
	Copayments may apply to certain Participating Provider services.	
Any covered services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.		
Total Annual Out-of-Pocket Limit		
Individual	$4,200	$10,000
Family	$8,400	$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 Covered Services will be paid at 100% 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.	Not Covered
Pediatric immunizations	Covered at 100%; you pay $0.	You pay 30%. Deductible does not apply.
Well-baby visits	Covered at 100%; you pay $0.	Not Covered
Adult flu vaccine	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Adult preventive/health screening examination	Covered at 100%; you pay $0.	Not Covered
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay $0.	You pay 30% after Deductible.
Screening gynecological exam	Covered at 100%; you pay $0.	You pay 30%. Deductible does not apply.
Breast cancer and cervical cancer screening	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.

Preventive Services	Participating Provider	Non-Participating Provider
Pediatric dental and vision services	For coverage information, log in to *My*Health OnLine or call Member Services at the number on the back of your Member ID card.	

Covered Services	Participating Provider	Non-Participating Provider
Hospital Services		
Hospital inpatient	You pay 10% and $250 Copayment per inpatient stay. Deductible does not apply.	You pay 30% after Deductible.
Outpatient/Ambulatory surgery	You pay 10% after Deductible.	You pay 30% after Deductible.
Observation stay	You pay 10% after Deductible.	You pay 30% after Deductible.
Maternity – hospital services associated with delivery	You pay 10% and $250 Copayment per inpatient stay. Deductible does not apply.	You pay 30% after Deductible.
Emergency Services		
Emergency department	You pay $75 Copayment per visit.	
	Copayment waived if you are admitted to hospital.	
Emergency transportation	You pay 10% after Deductible.	
Surgical Services		
Surgical services (professional provider services)	You pay 10% after Deductible.	You pay 30% after Deductible.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay 10% after Deductible.	You pay 30% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 10% after Deductible.	You pay 30% after Deductible.
Primary care provider office visit	You pay $30 Copayment per visit.	You pay 30% after Deductible.
Specialist office visit	You pay $40 Copayment per visit.	You pay 30% after Deductible.
Convenience care visit	You pay $30 Copayment per visit.	You pay 30% after Deductible.
Urgent care facility	You pay $40 Copayment per visit.	You pay 30% after Deductible.
Virtual Visits		
UPMC AnywhereCare – Virtual Urgent Care and Children's AnywhereCare	You pay $15 Copayment per visit.	You pay 30% after Deductible.
Virtual visit – Primary Care	You pay $30 Copayment per visit.	You pay 30% after Deductible.
Virtual visit – Specialist	You pay $40 Copayment per visit.	You pay 30% after Deductible.
Virtual visit – Behavioral Health	You pay $15 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) for care 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at **www.upmchealthplan.com** and a nurse will respond within 24 hours.		
Allergy Services		
Treatment, injections, and serum	You pay 10% after Deductible.	You pay 30% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	You pay 10% after Deductible.	You pay 30% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Other imaging (e.g., x-ray, sonogram)	You pay 10% after Deductible.	You pay 30% after Deductible.
Laboratory services	You pay 10% after Deductible.	You pay 30% after Deductible.
Diagnostic testing	You pay 10% after Deductible.	You pay 30% after Deductible.
Rehabilitation Therapy Services **Note:** See the Behavioral Health Services section below for Rehabilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical and occupational therapy	You pay $30 Copayment per visit.	You pay 30% after Deductible.
	Covered up to 30 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay $30 Copayment per visit.	You pay 30% after Deductible.
	Covered up to 30 visits per Benefit Period.	
Cardiac rehabilitation	You pay 10% after Deductible.	You pay 30% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Pulmonary rehabilitation	You pay $30 Copayment per visit.	You pay 30% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Habilitation Therapy Services **Note**: See the Behavioral Health Services section below for Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical and occupational therapy	You pay $30 Copayment per visit.	You pay 30% after Deductible.
	Covered up to 30 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay $30 Copayment per visit.	You pay 30% after Deductible.
	Covered up to 30 visits per Benefit Period.	
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	You pay 10% after Deductible.	You pay 30% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 10% after Deductible.	You pay 30% after Deductible.
Pain Management		
Pain management program	You pay $40 Copayment per visit.	You pay 30% after Deductible.
Behavioral Health (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)	You pay 10% and $250 Copayment per inpatient stay. Deductible does not apply.	You pay 30% after Deductible.
Office visits, including psychotherapy and counseling	You pay $30 Copayment per visit.	You pay 30% after Deductible.
Outpatient services (includes intensive outpatient and partial hospitalization programs)	You pay 10% after Deductible.	You pay 30% after Deductible.
Laboratory services related to a Behavioral Health condition	You pay 10% after Deductible.	You pay 30% after Deductible.
	You pay $30 Copayment per visit.	You pay 30% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Physical, occupational, or speech therapy related to a Behavioral Health condition	Visit limits do not apply.	
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay 10% after Deductible.	You pay 30% after Deductible.
Other Medical Services Refer to the Policy for specific Benefit Limitations that may apply to the services listed below.		
Abortion	You pay 10% after Deductible.	You pay 30% after Deductible.
Acupuncture	You pay 10% after Deductible.	You pay 30% after Deductible.
	Covered up to 12 visits per Benefit Period.	
Corrective appliances	You pay 10% after Deductible.	You pay 30% after Deductible.
Dental services related to accidental injury	You pay 10% after Deductible.	You pay 30% after Deductible.
Durable medical equipment	You pay 10% after Deductible.	You pay 30% after Deductible.
Fertility testing	You pay 10% after Deductible.	You pay 30% after Deductible.
Home health care	You pay 10% after Deductible.	You pay 30% after Deductible.
Hospice care	You pay 10% after Deductible.	You pay 30% after Deductible.
Infertility Services	You pay 10% after Deductible.	You pay 30% after Deductible.
	Limited to artificial insemination.	
Medical nutrition therapy	You pay 10% after Deductible.	You pay 30% after Deductible.
Nutritional counseling	You pay 10% after Deductible.	You pay 30% after Deductible.
	Covered up to six visits per Benefit Period.	
Nutritional formulas	You pay 10%. Deductible does not apply.	You pay 30%. Deductible does not apply.
	Nutritional formulas for the treatment of PKU and related disorders are not subject to Deductible.	
Oral surgical services	You pay 10% after Deductible.	You pay 30% after Deductible.
Podiatry care	You pay $30 Copayment per visit.	You pay 30% after Deductible.
Private duty nursing	You pay 10% after Deductible.	You pay 30% after Deductible.
Repatriation and Medical Evacuation	You pay 10% after Deductible.	
Skilled nursing facility	You pay 10% after Deductible.	You pay 30% after Deductible.
	Covered up to 120 days per Benefit Period.	
Therapeutic manipulation	You pay $30 Copayment per visit.	You pay 30% after Deductible.
	Covered up to 25 visits per Benefit Period.	
Diabetic Equipment, Supplies, and Education		
Diabetic equipment and supplies		
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at a Participating Pharmacy. See applicable Pharmacy Schedule of Benefits 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 Schedule of Benefits.** **Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.** **The Advantage Choice pharmacy program will apply (mandatory generic).** **Not subject to Plan Deductible** **UPMC Health Plan has determined that your prescription medication benefit plan constitutes Creditable Coverage.**	
Retail prescription medication • Prescriptions must be dispensed by a participating pharmacy. • 30-day supply.	Tier 1: You pay $15 Copayment for preferred generic medications. Tier 2: You pay $35 Copayment for preferred brand medications. Tier 3: You pay $70 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. Tier 7: You pay $0 Copayment for select generic 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 Schedule of Benefits for additional information. • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request). You may pay a higher amount for specialty medications when filled at a retail pharmacy.	Tier 4: You pay $70 Copayment for specialty medications (brand and generic). Tier 6: You pay 10% for oral chemotherapy medications with a maximum of $70 per prescription. 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 $30 Copayment for preferred generic medications. Tier 2: You pay $70 Copayment for preferred brand medications. Tier 3: You pay $140 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. Tier 7: You pay $0 Copayment for select generic medications. 90-day maximum mail-order supply
If the brand-name medication is dispensed instead of the generic equivalent, you must pay the Copayment associated with the brand-name medication as well as the price difference between the brand-name medication and the generic medication.	

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 Policy. Also, the headings under the Covered Services section are the same as those in your Policy.

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 Policy, 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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