UPMC Health Plan Schedule of Benefits

Advantage Panther Gold Plan – Enhanced Access HMO Applies to Oakland and Titusville campuses	
HMO	
Deductible	$0 /$0
Coinsurance	Covered at 100%; you pay $0
Total Annual Out-of-Pocket	$1,800 /$3,600
Primary care provider	You pay $25 Copayment per visit
Specialist office visit	You pay $40 Copayment per visit
Emergency Department	You pay $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	You pay $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. 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. 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 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	
Prior Authorization Requirements	Provider Responsibility	

Member Cost Sharing	UPMC *Advantage* Network Level 1	Other Participating UPMC Facilities Level 2
Level 1 means you receive the highest level of benefits and have the lowest Out-of-Pocket costs. Level 1 includes all UPMC providers and UPMC-owned facilities along with many community based providers and facilities. At Level 2 your Out-of-Pocket costs may increase. If you have questions regarding your Benefit Levels, contact Member Services at the phone number on your member ID card.		

Member Cost Sharing	UPMC *Advantage* Network Level 1	Other Participating UPMC Facilities Level 2
Annual Deductible		
Individual	$0	$300
Family	$0	$600
Your plan has an aggregate Deductible, which means that for family coverage, any one or a combination of covered family members must 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.		
If you receive services at Benefit Level 1 providers or facilities, amounts applied to the Deductible listed at Benefit Level 1 will also apply to the Deductible listed at Benefit Level 2. If you receive services at Benefit Level 2 providers or facilities, amounts applied to the Deductible listed at Benefit Level 2 will also apply to Benefit Level 1.		
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.		
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	$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.		
If you receive services at Benefit Level 1 providers or facilities, amounts applied to the Out-of-Pocket listed at Benefit Level 1 will also apply to the Out-of-Pocket listed at Benefit Level 2. If you receive services at Benefit Level 2 providers or facilities, amounts applied to the Out-of-Pocket listed at Benefit Level 2 will also apply to Benefit Level 1.		
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.		

Member Cost Sharing	UPMC *Advantage* Network Level 1	Other Participating UPMC Facilities Level 2
Preventive Services 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.	

Member Cost Sharing	UPMC *Advantage* Network Level 1	Other Participating UPMC Facilities Level 2
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.	
Screening services and procedures required by the ACA	Covered at 100%; you pay $0.	
Hospital Services		
Hospital inpatient	You pay $500 Copayment per inpatient stay	You pay 20% after Deductible.
Limit of two Copayments per Benefit Period; you pay $0 thereafter.		
Outpatient/Ambulatory surgery and Observation stay	You pay $250 Copayment per visit.	You pay 20% after Deductible.
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.	You pay 20% after Deductible.
Maternity - hospital services associated with delivery	You pay $500 Copayment per inpatient stay	You pay 20% 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.	
Surgical Services		
Surgical services (professional provider services)	Covered at 100%; you pay $0.	Covered at 100%; you pay $0.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	Covered at 100%; you pay $0.	Covered at 100%; you pay $0.
Adult immunizations not required to be covered by the ACA	Covered at 100%; you pay $0.	Covered at 100%; you pay $0.
Primary care provider office visit	You pay $25 Copayment per visit.	You pay $25 Copayment per visit.

Member Cost Sharing	UPMC *Advantage* Network Level 1	Other Participating UPMC Facilities Level 2
Specialist office visit	You pay $40 Copayment per visit.	You pay $40 Copayment per visit.
Convenience care visit	You pay $25 Copayment per visit.	You pay $25 Copayment per visit.
Urgent care facility	You pay $60 Copayment per visit.	You pay $60 Copayment per visit.
Applies to both Participating and Non-Participating Providers.		
Virtual Visits		
UPMC AnywhereCare - Virtual Urgent Care and Children's AnywhereCare	You pay $10 Copayment per visit.	
Virtual visit – (Primary Care)	You pay $25 Copayment per visit.	You pay $25 Copayment per visit.
Virtual visit – Scheduled (Specialist)	You pay $20 Copayment per visit.	You pay $20 Copayment per visit.
Virtual visit – Behavioral Health	You pay $25 Copayment per visit.	You pay $25 Copayment per visit.
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) 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	Covered at 100%; you pay $0.	Covered at 100%; you pay $0.
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,) (Free standing and hospital)	You pay $25 Copayment per visit.	You pay 20% after Deductible.
Limit of four Copayments per Benefit Period; you pay $0 thereafter.		
Laboratory services	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:** See the Behavioral Health Services section below for Rehabilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical, Speech and Occupational Therapy (Hospital and Non-hospital Outpatient)	You pay $25 Copayment per visit.	You pay $25 Copayment per visit.

Member Cost Sharing	UPMC *Advantage* Network Level 1	Other Participating UPMC Facilities Level 2
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:** See the Behavioral Health Services section below for Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical, Speech and Occupational Therapy (Hospital and Non-hospital Outpatient)	You pay $25 Copayment per visit.	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.	You pay 20% after Deductible.
Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.		
Medical Therapy Services-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 program		
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.		
Behavioral Health (Mental Health and Substance Use Disorder) Services (Rehabilitative or Habilitative) 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.	Covered at 100%; you pay $0.
Outpatient (e.g. rehabilitation, etc.)	Covered at 100%; you pay $0.	Covered at 100%; you pay $0.
Outpatient – Services (includes intensive outpatient and partial hospitalization programs)	Covered at 100%; you pay $0.	Covered at 100%; you pay $0.

Member Cost Sharing	UPMC *Advantage* Network Level 1	Other Participating UPMC Facilities Level 2
Laboratory services related to a Behavioral Health condition	Covered at 100%; you pay $0.	Covered at 100%; you pay $0.
Physical, occupational, or speech therapy related to a Behavioral Health Condition	Covered at 100%; you pay $0.	Covered at 100%; you pay $0.
Visit limits do not apply.		
Outpatient (e.g., therapy, etc.)	You pay $25 Copayment per visit.	You pay $25 Copayment per visit.
Applied behavior analysis for the treatment of Autism Spectrum Disorder	Covered at 100%; you pay $0.	You pay 20% 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.	Covered at 100%; you pay $0.
Covered up to 12 visits per Benefit Period.		
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.	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.	Covered at 100%; you pay $0.
Treatment for Infertility (Assisted Fertilization Procedures)	You pay $250 Deductible per Member per Benefit Period.	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 6 visits per Benefit Period.		
Nutritional formulas	Covered at 100%; you pay $0.	You pay 20%. Deductible does not apply.
Nutritional formulas 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.		
Podiatry care	You pay $25 Copayment per visit.	You pay $25 Copayment per visit.
Skilled nursing facility	Covered at 100%; you pay $0.	You pay 20% after Deductible.

Member Cost Sharing	UPMC *Advantage* Network Level 1	Other Participating UPMC Facilities Level 2
Covered up to 120 days per Benefit Period.		
Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.		
Therapeutic manipulation	You pay $25 Copayment per visit. First visit you pay $40 Copayment.	You pay $25 Copayment per visit. First visit you pay $40 Copayment.
Covered up to 25 visits per Benefit Period.		
Private duty nursing	Covered at 100%; you pay $0.	Covered at 100%; you pay $0.
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 a Participating Pharmacy. See applicable Prescription Schedule of Benefits for coverage information.	
Diabetic education	Covered at 100%; you pay $0.	You pay 20% 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 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: Preferred Generic Medications	You pay $16 Copayment for preferred generic medications.
Tier 2: Preferred Brand Medications and Generic Medications (Brand and Generic)	You pay $45 Copayment for preferred brand medications and generic medications (brand and generic).
Tier 3: Nonpreferred Medications (Brand and Generic)	You pay $90 Copayment for nonpreferred medications (brand and generic).
Tier 5: Preventive Medications	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 Schedule of Benefits for additional information. • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request). • Your prescription medication benefit includes coverage of certain specialty medications in the SaveOnSP program. See Prescription Medication Schedule of Benefits for additional information.	
Tier 4: Specialty Medications (Brand and Generic)	You pay $100 Copayment for specialty medications (brand and generic).
30-day maximum supply	

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 Your Choice pharmacy program will apply (mandatory generic). Not subject to Plan Deductible	
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: Preferred Generic Medications	You pay $32 Copayment for preferred generic medications.
Tier 2: Preferred Brand Medications and Generic Medications (Brand and Generic)	You pay $90 Copayment for preferred brand medications and generic medications (brand and generic).
Tier 3: Nonpreferred Medications (Brand and Generic)	You pay $180 Copayment for nonpreferred medications (brand and generic).
Tier 5: Preventive Medications	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 COC. Also, the headings under the Covered Services section are the same as those in your Policy.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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