Schedule of Benefits

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: $75 Copayment per visit for members 18 years and under. You pay $125 Copayment per visit for members 19 years and over
Rx: $16/$40/$80/$90

This document is your Schedule of Benefits. If you enroll in this plan, this Schedule of Benefits will be an important part of your Certificate of Coverage (COC). Your plan may also include a 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. An SPD either adds to or replaces your COC. 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 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 such as Copayments, Coinsurance, and Deductibles apply toward satisfaction of the Out-of-Pocket Limits 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 Care and Immunizations	
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 Care and Immunizations	
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.
Women's Care	
Screening gynecological exam	Covered at 100%; you pay $0.
Screening Pap test and screening mammogram	Covered at 100%; you pay $0.

Covered Services	Participating Provider
Hospital Services	
Semi-private room, private room (if Medically Necessary and appropriate), surgery, pre-admission testing	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 $200 Copayment per visit.
	Limit of four Copayments per Benefit Period; you pay $0 thereafter.
Maternity	You pay $500 Copayment per inpatient stay.
	Limit of two Copayments per Benefit Period; you pay $0 thereafter.
Outpatient care, medical services, ancillary services and supplies	Covered at 100%; you pay $0.
Emergency Services	
If you would like to speak to a registered nurse about a specific health concern, call our MyHealth Advice Line at 1-866-918-1591. Members may also submit email inquiries using the Web Nurse Request system available at www.upmchealthplan.com.	
Emergency department	You pay $75 Copayment per visit for members 18 years and under. You pay $125 Copayment per visit for members 19 years and over.
	Copayment waived if you are admitted to hospital.

Covered Services	Participating Provider
Emergency transportation	Covered at 100%; you pay $0.
Urgent care facility	You pay $60 Copayment per visit.
	Applies to both Participating and Non-Participating Providers.
Physician Surgical Services	
	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.
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.
eVisit	You pay $10 Copayment per visit.
Allergy Services	
Treatment, injections, and serum	Covered at 100%; you pay $0.
Diagnostic Services	
Advanced imaging (e.g., PET, MRI, etc.)	You pay $80 Copayment per visit.
	Limit of four Copayments per Benefit Period; you pay $0 thereafter.
Other imaging (e.g., x-ray, sonogram, etc.)	You pay $20 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/Habilitation Therapy Services	
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 12 weeks per Benefit Period.
Pulmonary rehabilitation	You pay $25 Copayment per visit.
	Covered up to 24 visits per Benefit Period.

Covered Services	Participating Provider
Medical Therapy Services	
Chemotherapy, radiation therapy, dialysis therapy	Covered at 100%; you pay $0.
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.
Behavioral Health and Substance Abuse Services Contact UPMC Health Plan Behavioral Health Services at 1-877-461-8610	
Inpatient (e.g., detoxification, etc.)	Covered at 100%; you pay $0.
Inpatient non-hospital residential services	Covered at 100%; you pay $0.
Outpatient (e.g. rehabilitation, etc.)	Covered at 100%; you pay $0.
Outpatient (e.g. therapy)	You pay $25 Copayment per visit.
Other Medical Services	
Acupuncture	Covered at 100%; you pay $0.
	Covered up to 12 visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.
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.
Treatment for Infertility (Assisted Fertilization Procedures)	You pay $250 Deductible per member per Benefit Period.
	Lifetime maximum of $10,000.
Home health care	Covered at 100%; you pay $0.
Hospice care	Covered at 100%; you pay $0.
Medical nutrition therapy	Covered at 100%; you pay $0.
	Refer to the Certificate of Coverage for specific Benefit Limitations.
Nutritional counseling	Covered at 100%; you pay $0.
	Limited to two visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.
Nutritional products	Covered at 100%; you pay $0.
	Refer to the Certificate of Coverage for specific Benefit Limitations.
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.
	Benefit Limit of 90 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. Prior Authorization must be obtained for dependent children 13 years of age or younger.

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 Drug Coverage **For additional information on your pharmacy benefits, please reference your Prescription Drug Rider.** **The Your Choice pharmacy program will apply (mandatory generic).** **Not subject to Plan Deductible**	
Retail prescription drug • Prescriptions must be dispensed by a participating pharmacy • 30-day supply	You pay $16 Copayment for generic drugs. You pay $40 Copayment for preferred brand drugs. You pay $80 Copayment for non-preferred brand drugs. 90-day maximum retail supply available for 3 copayments
Specialty prescription drug • Specialty medications are limited to a 30-day supply • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request)	You pay $90 Copayment for specialty drugs. 30-day maximum supply
Mail-order prescription drug • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy	You pay $32 Copayment for generic drugs. You pay $80 Copayment for preferred brand drugs. You pay $160 Copayment for non-preferred brand drugs. 90-day maximum mail-order supply
If a physician demonstrates that the brand-name drug is medically necessary and appropriate, the member will pay only the non-preferred brand-name drug 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 (SBC). You'll find your documents at **www.upmchealthplan.com**. If you have questions, call Member Services.

In this document, the term "UPMC Health Plan" refers to benefit plans offered by UPMC Health Network, Inc., UPMC Health Options, Inc., UPMC Health Coverage, Inc. and/or UPMC Health Plan, Inc.

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