UPMC Consumer *Advantage*
HRA PPO - Premium Network
Deductible: $1,000 / $2,000
Coinsurance: 20%
Total Annual Out-of-Pocket: $7,150 / $14,300

Primary Care Provider: $15 Copayment per visit
Specialist: $25 Copayment per visit
Emergency Department: $100 Copayment per visit
Urgent Care Facility: $25 Copayment per visit
Rx: $8/$25/$50/$50

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
HRA: Health reimbursement arrangement (HRA) annual allocation		
Ask your employer for details.		
Employer funds are allocated into the HRA.		
Annual Deductible		
Individual	$1,000	$2,000
Family	$2,000	$4,000

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 20% after Deductible.	You pay 40% after Deductible.
	Copayments may apply to certain Participating Provider services.	
Annual Coinsurance Limit		
Individual	$300	$2,500
Family	$600	$5,000
The Annual Coinsurance Limit is the maximum amount you will have to pay in Coinsurance before your benefits are covered without a Coinsurance cost share. Any amount paid in Coinsurance during the plan year will be applied towards the satisfaction of your plan's Total Annual Out-of-Pocket Limit.		
Total Annual Out-of-Pocket Limit		
Individual	$7,150	Not applicable
Family	$14,300	Not applicable
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. NOTE: For Covered Services rendered by Non-Participating Providers, only Coinsurance applies toward this Limit.		

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 40%. Deductible does not apply.
Well-baby visits	Covered at 100%; you pay $0.	Not Covered
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 40% after Deductible.
Screening gynecological exam, including a Pap test	Covered at 100%; you pay $0.	You pay 40%. Deductible does not apply.

Preventive Services	Participating Provider	Non-Participating Provider
Mammograms, annual routine and medically necessary	Covered at 100%; you pay $0.	You pay 40% after Deductible.
Diagnostic services and procedures required by the ACA	Covered at 100%; you pay $0.	You pay 40% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Hospital Services		
Hospital inpatient	You pay 20% after Deductible.	You pay 40% after Deductible.
Hospital outpatient (includes ambulatory surgery)	You pay 20% after Deductible.	You pay 40% after Deductible.
Observation stay	You pay 20% after Deductible.	You pay 40% after Deductible.
Maternity - Non-preventive facility and professional services	You pay 20% after Deductible.	You pay 40% after Deductible.
Emergency Services		
Emergency department	You pay $100 Copayment per visit. Copayment waived if you are admitted to hospital.	
Emergency transportation	You pay 20% after Deductible.	
Physician/Surgical Services		
Inpatient physician/surgical services	You pay 20% after Deductible.	You pay 40% after Deductible.
Outpatient physician/surgical services	You pay 20% after Deductible.	You pay 40% after Deductible.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay 20% after Deductible.	You pay 40% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 20% after Deductible.	You pay 40% after Deductible.
Primary care provider office visit	You pay $15 Copayment per visit.	You pay 40% after Deductible.
Specialist office visit	You pay $25 Copayment per visit.	You pay 40% after Deductible.
Convenience care visit	You pay $15 Copayment per visit.	You pay 40% after Deductible.
Urgent care facility	You pay $25 Copayment per visit.	You pay 40% after Deductible.
Virtual Visits		
UPMC AnywhereCare - Virtual Urgent Care and Children's AnywhereCare	You pay $5 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Primary Care	You pay $8 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Specialist	You pay $13 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Behavioral Health	You pay $8 Copayment per visit.	You pay 40% 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	You pay 20% after Deductible.	You pay 40% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	You pay 20% after Deductible.	You pay 40% after Deductible.
Other imaging (e.g., x-ray, sonogram)	You pay 20% after Deductible.	You pay 40% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Lab	You pay 20% after Deductible.	You pay 40% after Deductible.
Diagnostic testing	You pay 20% after Deductible.	You pay 40% 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 and occupational therapy	You pay $25 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 40 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay $25 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Cardiac rehabilitation	You pay 20% after Deductible.	You pay 40% after Deductible.
Pulmonary rehabilitation	You pay 20% after Deductible.	You pay 40% after Deductible.
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 and occupational therapy	You pay $25 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 40 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay $25 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 20% after Deductible.	You pay 40% after Deductible.
Respiratory therapy	You pay 20% after Deductible.	
Pain Management		
Pain management program	You pay $25 Copayment per visit.	You pay 40% 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)	You pay 20% after Deductible.	You pay 40% after Deductible.
Outpatient – Office visits and outpatient therapy	You pay $15 Copayment per visit.	You pay 40% after Deductible.
Outpatient – Other services (includes intensive outpatient and partial hospitalization programs)	You pay 20% after Deductible.	You pay 40% 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	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 12 visits per benefit period.	
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay 20% after Deductible.	You pay 40% after Deductible.
Corrective appliances	You pay 20% after Deductible.	You pay 40% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Dental services related to accidental injury	You pay 20% after Deductible.	You pay 40% after Deductible.
Durable medical equipment	You pay 20% after Deductible.	You pay 40% after Deductible.
Fertility testing	You pay 20% after Deductible.	You pay 40% after Deductible.
Home health care	You pay 20% after Deductible.	You pay 40% after Deductible.
Hospice care	You pay 20% after Deductible.	You pay 40% after Deductible.
Medical nutrition therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Nutritional counseling	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to six visits per Benefit Period.	
Nutritional products	You pay 20%. Deductible does not apply.	You pay 40%. Deductible does not apply.
	Nutritional products for the treatment of PKU and related disorders are not subject to Deductible.	
Oral surgical services	You pay 20% after Deductible.	You pay 40% after Deductible.
Podiatry care	You pay $15 Copayment per visit.	You pay 40% after Deductible.
Private duty nursing	You pay 20% after Deductible.	
Skilled nursing facility	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 100 days per Benefit Period for Non-Participating Providers.	
Therapeutic manipulation	You pay $25 Copayment per visit.	You pay 40% after Deductible.
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 pharmacy rider for coverage information.	
Diabetic education	Covered at 100%; you pay $0.	You pay 40% 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. • 31-day supply.	Tier 1: You pay $8 Copayment for preferred generic medications. Tier 2: You pay $25 Copayment for preferred medications. Tier 3: You pay $50 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 31-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 $50 Copayment for specialty medications (brand and generic). You pay $0 Copayment for oral chemotherapy medications. 31-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 $16 Copayment for preferred generic medications. Tier 2: You pay $50 Copayment for preferred medications. Tier 3: You pay $100 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive 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 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