UPMC HEALTH PLAN

Schedule of Benefits

Advantage Panther Gold Plan - Enhanced Access HMO
Applies to Oakland and Titusville campuses
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 old and under. You pay $125 Copayment per visit for members 19 years old 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	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Yes	
Pre-Certification Requirements	Provider Responsibility	Provider Responsibility

Member Cost Sharing	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
Annual Deductible		
Individual	$0	$300
Family	$0	$600

Member Cost Sharing	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
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. - Amounts applied to the Level 1 Deductible will also apply to the Level 2 Deductible. - Amounts applied to the Level 2 Deductible will also apply to the Level 1 Deductible.		
Deductible applies to all Covered Services you receive during the Benefit Period, unless that service is specifically excluded.		
Coinsurance		
	Covered at 100%; you pay $0.	You pay 20% after Deductible (Where Deductible Applies).
	Copayments may apply to certain Participating Provider services.	
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. - Amounts applied to the Level 1 Out-of-Pocket Limit will also apply to the Level 2 Out-of-Pocket Limit. - Amounts applied to the Level 2 Out-of-Pocket Limit will also apply to the Level 1 Out-of-Pocket Limit.		
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	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
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	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
Hospital Services		
Inpatient care	You pay $500 Copayment per inpatient stay.	You pay 20% after Deductible.
	Limit of two Copayments per Benefit Period; you pay $0 thereafter.	
Outpatient surgery and observation stay	You pay $200 Copayment per visit.	You pay 20% after Deductible.
	Limit of four Copayments per Benefit Period; you pay $0 thereafter.	
Maternity	You pay $500 Copayment per inpatient stay.	You pay 20% after Deductible.
	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.	You pay 20% after Deductible.
Emergency Services		
If you would like to speak to a registered nurse about a specific health concern, call our UPMC *My*Health 24/7 Nurse Line at 1-866-918-1591. You may also send an email using the Web Nurse Request system at www.upmchealthplan.com.		
Emergency department	You pay $75 Copayment per visit for members 18 years old and under. You pay $125 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.	
Urgent care facility	You pay $60 Copayment per visit.	You pay $60 Copayment per visit.
	Applies to both Participating and Non-Participating Providers.	

Covered Services	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
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; including OB/GYN	You pay $40 Copayment per visit.	
Convenience care visit	You pay $25 Copayment per visit.	
Virtual visit – Level 1 (e.g., non-specialist)	You pay $10 Copayment per visit.	
Virtual visit – Level 2 (e.g., specialist)	You pay $20 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.	You pay 20% after Deductible.
	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.	You pay 20% after Deductible.
	Limit of four Copayments per Benefit Period; you pay $0 thereafter.	
Lab	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.	
Inpatient & Outpatient Hospital Services	Covered at 100%; you pay $0.	You pay 20% after Deductible.
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		
Physical, speech, and occupational therapy (Hospital and Non-hospital Outpatient)	You pay $25 Copayment per visit.	You pay 20% after Deductible.
	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.	

Covered Services	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
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		
Physical, speech, and occupational therapy (Hospital and Non-hospital Outpatient)	You pay $25 Copayment per visit.	You pay 20% 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 20% after Deductible.
	Non-Hospital services will be covered at the Level 1 cost-share for Participating Providers.	
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		
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 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.	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.	
Treatment for Infertility (Assisted Fertilization Procedures)	You pay $250 Deductible per member per Benefit Period.	
	Lifetime maximum of $10,000. Benefit limit does not apply to artificial insemination procedures.	

Covered Services	UPMC Advantage Network Level 1	Other Participating UPMC Facilities Level 2
Home health care	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Refer to the Certificate of Coverage for specific Benefit Limitations.	
Hospice care	Covered at 100%; you pay $0.	
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 six visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.	
Nutritional products	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Nutritional products for the treatment of PKU and related disorders are not subject to Deductible. Refer to the Certificate of Coverage for specific Benefit Limitations.	
Oral surgical services	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Refer to the Certificate of Coverage for specific Benefit Limitations.	
	Non-Hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Podiatry care	You pay $25 Copayment per visit.	
	Refer to the Certificate of Coverage for specific Benefit Limitations.	
Private duty nursing	Covered at 100%; you pay $0.	
	Refer to the Certificate of Coverage for specific Benefit Limitations.	
Skilled nursing facility	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Covered up to 120 days per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.	
	Non-Hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Therapeutic manipulation - Chiropractic Care	You pay $25 Copayment per visit. First visit you pay $40 Copayment.	
	Covered up to 25 visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.	
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 20% after Deductible.

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.

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., and/or UPMC Benefit Management Services Inc.

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