

UPMC Business Advantage	
PPO - Premium Network	
Deductible	\$0 /\$0
Coinsurance	Covered at 100%; you pay \$0
Total Annual Out-of-Pocket	\$9,100 /\$18,200
Primary care provider	You pay \$15 Copayment per visit
Specialist office visit	You pay \$30 Copayment per visit
Emergency Department	You pay \$75 Copayment per visit
Urgent Care Facility	You pay \$15 Copayment per visit
Rx	\$0 /\$15 /\$25 /\$45 /\$45

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. Please note that UPMC Health Plan reserves the right to reduce or waive your cost-sharing for certain services, if necessary for compliance with the Mental Health Parity and Addiction Equity Act.

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	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	\$0	\$1,000

Member Cost Sharing	Participating Provider	Non-Participating Provider
Family	\$0	\$2,000
<p>Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios - whichever comes first: *When an individual within a family 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.</p>		
<p>Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.</p>		
Coinsurance		
	Covered at 100%; you pay \$0	You pay 25% after Deductible
<p>Copayments may apply to certain Participating Provider services.</p>		
<p>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.</p>		
Annual Coinsurance Limit		
Individual	\$0	\$3,000
Family	\$0	\$6,000
<p>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.</p>		
Total Annual Out-of-Pocket Limit		
Individual	\$9,100	Not Applicable
Family	\$18,200	Not Applicable
<p>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 a family member's 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.</p>		
<p>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.</p>		

Member Cost Sharing	Participating Provider	Non-Participating Provider
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.	You pay 25% after Deductible.
Pediatric immunizations	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Adult preventive/health screening examination	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Screening gynecological exam	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Breast cancer and cervical cancer screening	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Screening services and procedures required by the ACA	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Hospital Services		
Hospital inpatient	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Outpatient/Ambulatory surgery	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Observation stay	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Maternity - facility services associated with delivery	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Emergency Services		
Emergency department	You pay \$75 Copayment per visit.	
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.	You pay 25% after Deductible.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, and consultation	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Adult immunizations not required to be covered by the ACA	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Primary care provider office visit	You pay \$15 Copayment per visit.	You pay 25% after Deductible.
Specialist office visit	You pay \$30 Copayment per visit.	You pay 25% after Deductible.
Convenience care visit	You pay \$15 Copayment per visit.	You pay 25% after Deductible.
Urgent care facility	You pay \$15 Copayment per visit.	You pay 25% after Deductible.
Virtual Visits		
UPMC AnywhereCare - Virtual Care and Children's AnywhereCare	You pay \$5 Copayment per visit.	

Member Cost Sharing	Participating Provider	Non-Participating Provider
Virtual visit - Primary Care	You pay \$15 Copayment per visit.	You pay 25% after Deductible.
Virtual visit – Specialist	You pay \$30 Copayment per visit.	You pay 25% after Deductible.
Virtual visit – Behavioral Health	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
UPMC MyHealth 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 MyHealth 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.	You pay 25% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Other imaging (e.g., x-ray, sonogram)	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Laboratory services	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Diagnostic testing	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Rehabilitation/Habilitation Therapy Services		
Note: See the Behavioral Health Services section below for Rehabilitation/Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical, Speech and Occupational Therapy	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Cardiac rehabilitation	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Pulmonary rehabilitation	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
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 25% after Deductible.
Pain management		
Pain management program	You pay \$30 Copayment per visit.	You pay 25% after Deductible.
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.	You pay 25% after Deductible.

Member Cost Sharing	Participating Provider	Non-Participating Provider
Office visits, including psychotherapy, counseling, and urgent care	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Outpatient Services (includes intensive outpatient, partial hospitalization, and other medically necessary outpatient services)	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Laboratory services related to a Behavioral Health condition	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health Condition	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Visit limits do not apply.		
Applied behavior analysis for the treatment of Autism Spectrum Disorder	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Other Medical Services Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below. Visit limits do not apply for medically necessary services provided for treatment of a Behavioral Health condition.		
Acupuncture	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Covered up to 12 visits per Benefit Period.		
Corrective appliances	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Dental services related to accidental injury	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Durable medical equipment	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Home health care	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Hospice care	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Infertility services	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Please see your Infertility rider for specific benefit information.		
Medical nutrition therapy	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Nutritional counseling	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Covered up to 2 visits per Benefit Period.		
Oral surgical services	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Podiatry services	You pay \$30 Copayment per visit.	You pay 25% after Deductible.
Skilled nursing facility	Covered at 100%; you pay \$0.	You pay 25% after Deductible.
Therapeutic manipulation/chiropractic care	You pay \$20 Copayment per visit.	You pay 25% after Deductible.
Private duty nursing	Covered at 100%; you pay \$0.	You pay 25% after Deductible.

Member Cost Sharing	Participating Provider	Non-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 a Participating Pharmacy. See applicable Prescription Schedule of Benefits for coverage information.	
Diabetic education	Covered at 100%; you pay \$0.	You pay 25% 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.
- 34-day supply.

Select Generic Medications Tier	You pay \$0 Copayment for select generic medications.
Preferred Generic Medications Tier	You pay \$15 Copayment for preferred generic medications.
Preferred Brand Medications and Generic Medications (Brand and Generic) Tier	You pay \$25 Copayment for preferred brand medications and generic medications (brand and generic).
Nonpreferred Medications (Brand and Generic) Tier	You pay \$45 Copayment for nonpreferred medications (brand and generic).

90-day maximum retail supply available for three copayments

Specialty prescription medication

- Specialty medications are limited to a 34-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.

Specialty Medications (Brand and Generic) Tier	You pay \$45 Copayment for specialty medications (brand and generic).
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34-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.**

Select Generic Medications Tier	You pay \$0 Copayment for select generic medications.
Preferred Generic Medications Tier	You pay \$15 Copayment for preferred generic medications.

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

Preferred Brand Medications and Generic Medications (Brand and Generic) Tier	You pay \$25 Copayment for preferred brand medications and generic medications (brand and generic).
Nonpreferred Medications (Brand and Generic) Tier	You pay \$45 Copayment for nonpreferred medications (brand and generic).

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.

Services that require Prior Authorization

Certain services and items 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 your member ID card. Your 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 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, and, if applicable, subject to approval by the Pennsylvania Insurance Department. 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 and UPMC Health Plan reserves the right to update this document accordingly.

Your plan documents will always include the Schedule of Benefits, the COC, and the Summary of Benefits and Coverage. You can log into the UPMC Health Plan member site 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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