UPMC Health Options, Inc. Schedule of Benefits

UPMC First Care	
EPO HRA - Partner Network	
Deductible	$2,500 /$5,000
Coinsurance	10%
Total Annual Out-of-Pocket	$8,150 /$16,300
Primary care provider	First visit Covered at 100%; you pay $0 Then, you pay $20 Copayment per visit.
Specialist office visit	First visit Covered at 100%; you pay $0 Then, you pay $40 Copayment per visit.
Emergency Department	You pay $150 Copayment per visit
Urgent Care Facility	You pay $75 Copayment per visit
Rx	$0 /$15 /$40 /$80 /$95

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.

UPMC First Care covers certain services without cost share, including your first in-person PCP visit, first virtual PCP visit, first in-person Specialist visit, and first virtual Specialist visit. These $0 visits are in addition to your Preventive Services, as described below.

In addition, all virtual Urgent Care visits via UPMC AnywhereCare, and all Behavioral Health visits, in-person and virtual, will be covered without cost share. Note that if you are visiting certain facilities (such as hospital clinics) or your provider orders other services (such as, drug injections, lab tests), additional facility charges and any charges for services other than your office visit will be subject to normal cost sharing under your COC and Schedule of Benefits.

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
Benefit Period	Plan Year

Primary Care Provider (PCP) Required	Encouraged, but not required
Prior Authorization Requirements	Provider Responsibility

Member Cost Sharing	Participating Provider
HRA: Health reimbursement arrangement (HRA) annual allocation	
Ask your employer for details	
Employer funds are allocated into the HRA.	
Annual Deductible	
Individual	$2,500
Family	$5,000
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.	
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.	
Coinsurance	
	You pay 10% 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	$8,150
Family	$16,300
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.	
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	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.
Pediatric immunizations	Covered at 100%; you pay $0.

Member Cost Sharing	Participating Provider
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.
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 10% after Deductible.
Outpatient/Ambulatory surgery	You pay 10% after Deductible.
Observation stay	You pay 10% after Deductible.
Maternity - facility services associated with delivery	You pay 10% after Deductible.
Emergency Services	
Emergency department	You pay $150 Copayment per visit.
Copayment waived if you are admitted to hospital.	
Emergency transportation	You pay 10% after Deductible.
Surgical Services	
Surgical services (professional provider services)	You pay 10% after Deductible.
Provider Medical Services	
Inpatient medical care visits, intensive medical care, and consultation	You pay 10% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 10% after Deductible.
Primary care provider office visit	First visit Covered at 100%; you pay $0. Then, you pay $20 Copayment per visit.
Specialist office visit	First visit Covered at 100%; you pay $0. Then, you pay $40 Copayment per visit.
Convenience care visit	You pay $20 Copayment per visit.
Urgent care facility	You pay $75 Copayment per visit.
Virtual Visits	
UPMC AnywhereCare - Virtual Urgent Care and Children's AnywhereCare	Covered at 100%; you pay $0.
Virtual visit - Primary Care	First visit Covered at 100%; you pay $0. Then, you pay $10 Copayment per visit.

Member Cost Sharing	Participating Provider
Virtual visit – Specialist	First visit Covered at 100%; you pay $0. Then, you pay $20 Copayment per visit.
Virtual visit – Behavioral Health	Covered at 100%; you pay $0.
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	You pay 10% after Deductible.
Diagnostic Services	
Advanced imaging (e.g., PET, MRI)	You pay 10% after Deductible.
Other imaging (e.g., x-ray, sonogram,)	You pay 10% after Deductible.
Laboratory services	You pay 10% after Deductible.
Diagnostic testing	You pay 10% 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 and occupational therapy	You pay $40 Copayment per visit.
Covered up to 30 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay $40 Copayment per visit.
Covered up to 30 visits per Benefit Period.	
Cardiac rehabilitation	You pay 10% after Deductible.
Covered up to 36 visits per Benefit Period.	
Pulmonary rehabilitation	You pay $40 Copayment per visit.
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 and occupational therapy	You pay $40 Copayment per visit.
Covered up to 30 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay $40 Copayment per visit.
Covered up to 30 visits per Benefit Period.	
Medical Therapy Services	
Chemotherapy, radiation therapy, dialysis therapy	You pay 10% after Deductible.
Medical Therapy Services-Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 10% after Deductible.

Member Cost Sharing	Participating Provider
Pain management	
Pain management program	You pay $40 Copayment per visit.
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)	You pay 10% after Deductible.
Office visits, including psychotherapy, counseling, and urgent care	Covered at 100%; you pay $0.
Outpatient Services (includes intensive outpatient, partial hospitalization, and other medically necessary outpatient services)	You pay 10% after Deductible.
Laboratory services related to a Behavioral Health condition	You pay 10% after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health Condition	Covered at 100%; you pay $0.
Visit limits do not apply.	
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay 10% 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	You pay $40 Copayment per visit.
Covered up to 12 visits per Benefit Period.	
Corrective appliances	You pay 10% after Deductible.
Dental services related to accidental injury	You pay 10% after Deductible.
Durable medical equipment	You pay 10% after Deductible.
Home health care	You pay 10% after Deductible.
Covered up to 60 days per Benefit Period.	
Hospice care	You pay 10% after Deductible.
Medical nutrition therapy	You pay 10% after Deductible.
Nutritional counseling	You pay 10% after Deductible.
Covered up to 6 visits per Benefit Period.	
Nutritional formulas	You pay 10%. Deductible does not apply.

Member Cost Sharing	Participating Provider
Nutritional formulas for the treatment of PKU and related disorders are not subject to Deductible.	
Oral surgical services	You pay 10% after Deductible.
Podiatry services	You pay $40 Copayment per visit.
Skilled nursing facility	You pay 10% after Deductible.
Covered up to 120 days per Benefit Period.	
Therapeutic manipulation/chiropractic care	You pay $40 Copayment per visit.
Covered up to 20 visits per Benefit Period.	
Private duty nursing	You pay 10% 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 Prescription Schedule of Benefits for coverage information.
Diabetic education	Covered at 100%; you pay $0.

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.	
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 $40 Copayment for preferred brand medications and generic medications (brand and generic).
Nonpreferred Medications (Brand and Generic) Tier	You pay $80 Copayment for nonpreferred medications (brand and generic).

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	
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.	
Specialty Medications (Brand and Generic) Tier	You pay $95 Copayment for specialty medications (brand and generic).
Oral Chemotherapy Medications (Brand and Generic)	You pay $0 Copayment for oral chemotherapy medications (brand and generic).
30-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 $30 Copayment for preferred generic medications.
Preferred Brand Medications and Generic Medications (Brand and Generic) Tier	You pay $80 Copayment for preferred brand medications and generic medications (brand and generic).
Nonpreferred Medications (Brand and Generic) Tier	You pay $160 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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