UPMC Small Business Advantage Platinum PPO $10/$25 - Premium Network Deductible: $0 / $0 Coinsurance: 0%	Primary Care Provider: $10 Specialists: $25 Rx: $8/$38/$76/$95

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	Non-Participating Provider
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	No	
Pre-Certification Requirements	Provider responsibility	Member responsibility $500 penalty per incident for failure to pre-certify non-emergency inpatient admissions.

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 Care and Immunizations		
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

Preventive Services	Participating Provider	Non-Participating Provider
Adult Care and Immunizations		
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%. Deductible does not apply
Women's Care		
Screening gynecological exam	Covered at 100%; you pay $0	You pay 40%. Deductible does not apply
Screening Pap test and screening mammogram	Covered at 100%; you pay $0	You pay 40%. Deductible does not apply

Member Cost Sharing	Participating Provider	Non-Participating Provider
Annual Deductible		
Individual	$0	$1,000
Family	$0	$2,000
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 on the plan 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 that service is specifically excluded.		
Annual Out-of-Pocket Limit		
Individual	$1,250	$10,000
Family	$2,500	$20,000
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 will have Covered Services paid at 100% for the remainder of the Benefit Period.		
Copayments, Coinsurance, and Deductibles apply toward satisfaction of the Out-of-Pocket Limits specified in this Schedule of Benefits.		
Coinsurance		
	Covered at 100%; you pay $0	You pay 40% after Deductible
	Copayments may apply to certain services.	

Covered Services	Participating Provider	Non-Participating Provider
Hospital Services		
Semi-private room, private room (if Medically Necessary and appropriate), surgery, pre-admission testing	Covered at 100%; you pay $0	You pay 40% after Deductible
Outpatient/ambulatory surgery	Covered at 100%; you pay $0	You pay 40% after Deductible

Covered Services	Participating Provider	Non-Participating Provider
Observation stay	Covered at 100%; you pay $0	You pay 40% after Deductible
Maternity	Covered at 100%; you pay $0	You pay 40% after Deductible
Emergency Services		
Emergency department	You pay $175 Copayment per visit. Copayment waived if you are admitted to hospital.	
Emergency transportation	Covered at 100%; you pay $0	
Urgent care facility	You pay $25 Copayment per visit	You pay 40% after Deductible
Physician Surgical Services		
	Covered at 100%; you pay $0	You pay 40% after Deductible
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	Covered at 100%; you pay $0	You pay 40% after Deductible
Adult immunizations not required to be covered by the ACA	Covered at 100%; you pay $0	You pay 40% after Deductible
Primary care provider office visit	You pay $10 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 $10 Copayment per visit	You pay 40% after Deductible
eVisit	You pay $5 Copayment per visit	You pay 40% after Deductible
Pediatric Dental and Vision Services	Pediatric Dental and Vision Services are covered in compliance with requirements under the Affordable Care Act (ACA) for members of group plans with 50 or fewer employees. Find eligibility and benefit details in your Summary of Benefits and Coverage (SBC) and Dental and Vision Essential Health Benefits Rider at MyHealth OnLine or call Member Services.	
Allergy Services		
Treatment, injections, and serum	You pay $10 Copayment per visit	You pay 40% after Deductible
Diagnostic Services		
Advanced imaging (e.g., PET, MRI, etc.)	You pay $150 Copayment per visit	You pay 40% after Deductible
Other imaging (e.g., x-ray, sonogram, etc.)	You pay $25 Copayment per visit	You pay 40% after Deductible
Lab	You pay $25 Copayment per visit	You pay 40% after Deductible
Diagnostic testing	Covered at 100%; you pay $0	You pay 40% after Deductible
Rehabilitation/Habilitation Therapy Services		
Physical and occupational therapy	You pay $25 Copayment per visit	You pay 40% after Deductible
	Covered up to 30 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay $25 Copayment per visit	You pay 40% after Deductible
	Covered up to 30 visits per Benefit Period.	
Cardiac rehabilitation	You pay $25 Copayment per visit	You pay 40% after Deductible
	Covered up to 12 weeks per Benefit Period.	
Pulmonary rehabilitation	You pay $25 Copayment per visit	You pay 40% after Deductible
	Covered up to 24 visits per Benefit Period.	
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	You pay $25 Copayment per visit	You pay 40% after Deductible

Covered Services	Participating Provider	Non-Participating Provider
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 10%	You pay 40% after Deductible
Pain Management Program		
	You pay $25 Copayment per visit	You pay 40% after Deductible
Behavioral Health and Substance Abuse services – Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083		
Inpatient (e.g. detoxification, etc.)	Covered at 100%; you pay $0	You pay 40% after Deductible
Inpatient non-hospital residential services	Covered at 100%; you pay $0	You pay 40% after Deductible
Outpatient (e.g. rehabilitation, therapy, etc.)	You pay $25 Copayment per visit	You pay 40% after Deductible
Other Medical Services		
Acupuncture	You pay $25 Copayment per visit	You pay 40% after Deductible
	Refer to the Certificate of Coverage for specific Benefit Limitations.	
Corrective appliances	You Pay 40%	You pay 40% after Deductible
Durable medical equipment	You Pay 40%	You pay 40% after Deductible
Dental services related to accidental injury	You pay $175 Copayment per visit	You pay $175 Copayment per visit
Fertility testing	You pay $25 Copayment per visit	You pay 40% after Deductible
Home health care	You pay $25 Copayment per visit	You pay 40% after Deductible
	Benefit Limit of 60 days per Benefit Period.	
Hospice care	Covered at 100%; you pay $0	You pay 40% after Deductible
Medical nutritional therapy	You pay $25 Copayment per visit	You pay 40% after Deductible
	Refer to the Certificate of Coverage for specific Benefit Limitations.	
Nutritional counseling	You pay $25 Copayment	You pay 40% after Deductible
	Limited to two visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.	
Nutritional supplements	You pay $25 Copayment	You pay 40% after Deductible
	Refer to the Certificate of Coverage for specific Benefit Limitations.	
Oral surgical services	Covered at 100%; you pay $0	You pay 40% after Deductible
Podiatry care	You pay $25 Copayment per visit	You pay 40% after Deductible
Skilled nursing facility	Covered at 100%; you pay $0	You pay 40% after Deductible
	Benefit Limit of 120 days per Benefit Period.	
Therapeutic manipulation	You pay $15 Copayment per visit	You pay 40% after Deductible
	Covered up to 20 visits per Benefit Period Prior Authorization must be obtained for dependent children 13 years of age or younger.	
Diabetic Equipment, Supplies, and Education		
Diabetic equipment and supplies		
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 Drug Coverage For additional information on your pharmacy benefits, please reference your Prescription Drug Rider. The Advantage Choice pharmacy program will apply (mandatory generic). Not Subject to plan Deductible UPMC Health Plan has determined that your prescription drug benefit plan constitutes Creditable coverage.	
Retail prescription drug • Prescriptions must be dispensed by a participating pharmacy • 30-day supply	You pay $8 Copayment for generic drugs You pay $38 Copayment for preferred brand drugs You pay $76 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 $95 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 $16 Copayment for generic drugs You pay $76 Copayment for preferred brand drugs You pay $152 Copayment for non-preferred brand drugs 90-day maximum mail-order supply
If the brand-name drug is dispensed instead of the generic equivalent, you must pay the copayment associated with the brand-name drug as well as the retail price difference between the brand-name drug and the generic drug.	

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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