UPMC HEALTH PLAN

Schedule of Benefits

Duquesne University - HealthyU
Healthy U HIA EPO - Premium Network
Deductible: $400 / $800
Coinsurance: 15%
Total Annual Out-of-Pocket: $3,000 / $6,000

Primary Care Provider: $25 Copayment per visit
Specialist: $45 Copayment per visit
Emergency Department: $150 Copayment per visit
Urgent Care Facility: $45 Copayment per visit

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
Benefit Period	Plan Year
Primary Care Provider (PCP) Required	Encouraged, but not required
Pre-Certification and Prior Authorization Requirements	Provider Responsibility

Member Cost Sharing	Participating Provider
HIA: Health incentive account (HIA) annual dollar maximum	
Individual/Family – Please visit *My*Health OnLine to see earning limits and account status.	
Earn HIA reward dollars by completing approved healthy activities. You can find a list of customized activities on *My*Health OnLine or by contacting Member Services at 1-877-563-0301. Funds are deposited into the HIA.	
Annual Deductible	
Individual	$400
Family	$800

Member Cost Sharing	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 15% after Deductible.
	Copayments may apply to certain Participating Provider services.
Total Annual Out-of-Pocket Limit	
Individual	$3,000
Family	$6,000
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 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.	

Preventive Services	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.
Pediatric immunizations	Covered at 100%; you pay $0.
Well-baby visits	Covered at 100%; you pay $0.
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.
Diagnostic services and procedures required by the ACA	Covered at 100%; you pay $0.

Covered Services	Participating Provider
Hospital Services	
Hospital inpatient	You pay 15% after Deductible.

Covered Services	Participating Provider
Hospital outpatient (includes ambulatory surgery)	You pay 15% after Deductible.
Observation stay	You pay 15% after Deductible.
Maternity - Non-preventive facility and professional services	You pay 15% after Deductible.
Emergency Services	
Emergency department	You pay $150 Copayment per visit.
	Copayment waived if you are admitted as inpatient.
Emergency transportation	You pay 15% after Deductible.
Physician/Surgical Services	
Inpatient physician/surgical services	You pay 15% after Deductible.
Provider Medical Services	
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay 15% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 15% after Deductible.
Primary care provider office visit	You pay $25 Copayment per visit.
Specialist office visit, including OB/GYN	You pay $45 Copayment per visit.
Convenience care visit	You pay $25 Copayment per visit.
Urgent care facility	You pay $45 Copayment per visit.
Virtual Visits	
UPMC AnywhereCare - Virtual Urgent Care and Children's AnywhereCare	You pay $5 Copayment per visit.
Virtual visit – Primary Care	You pay $25 Copayment per visit.
Virtual visit - Specialist	You pay $45 Copayment per visit.
Virtual visit – Behavioral Health	You pay $25 Copayment per visit.
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 15% after Deductible.
Diagnostic Services	
Advanced imaging (e.g., PET, MRI)	You pay 15% after Deductible.
Other imaging (e.g., x-ray, sonogram)	You pay 15% after Deductible.
Lab	You pay 15% after Deductible.
Diagnostic testing	You pay 15% 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 $45 Copayment per visit.
	Covered up to 30 visits per Benefit Period for both therapies combined.
Speech therapy	You pay $45 Copayment per visit.
	Covered up to 30 visits per Benefit Period.

Covered Services	Participating Provider
Cardiac rehabilitation	You pay $45 Copayment per visit.
	Covered up to 12 weeks per Benefit Period.
Pulmonary rehabilitation	You pay $45 Copayment per visit.
	Covered up to 24 visits per Benefit Period.
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 $45 Copayment per visit.
	Covered up to 30 visits per Benefit Period for both therapies combined.
Speech therapy	You pay $45 Copayment per visit.
	Covered up to 30 visits per Benefit Period.
Medical Therapy Services	
Chemotherapy, radiation therapy, dialysis therapy	You pay 15% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 15% after Deductible.
Pain Management	
Pain management program	You pay $45 Copayment per visit.
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 15% after Deductible.
Outpatient – Office visits and outpatient therapy	You pay $25 Copayment per visit.
Outpatient – Other services (includes intensive outpatient and partial hospitalization programs)	You pay 15% 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 15% after Deductible.
	Covered up to 12 visits per Benefit Period.
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay 15% after Deductible.
Corrective appliances	You pay 15% after Deductible.
Dental services related to accidental injury	You pay 15% after Deductible.
Durable medical equipment	You pay 15% after Deductible.
Fertility testing	You pay 15% after Deductible.
Home health care	You pay 15% after Deductible.
Hospice care	You pay 15% after Deductible.
Medical nutrition therapy	You pay 15% after Deductible.
Nutritional counseling	You pay 15% after Deductible.

Covered Services	Participating Provider
	Covered up to two visits per Benefit Period.
Nutritional products	You pay 15%. Deductible does not apply.
	Nutritional products for the treatment of PKU and related disorders are not subject to Deductible.
Oral surgical services	You pay 15% after Deductible.
Podiatry care	You pay $45 Copayment per visit.
Private duty nursing	You pay 15% after Deductible.
Skilled nursing facility	You pay 15% after Deductible.
	Covered up to 100 days per Benefit Period.
Therapeutic manipulation	You pay $45 Copayment per visit.
	Covered up to 25 visits per Benefit Period.
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.

Wellness Disclaimer

We are committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all members. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-855-395-8762, and we will work with you and your doctor to find a wellness program with the same reward that is right for you in light of your health status.

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

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