UPMC Health Plan

# Schedule of Benefits

**RMU Student Health Plan**
**PPO - Premium Network**
**Deductible:** $500 / $1,000
**Coinsurance:** 20%
**Total Annual Out-of-Pocket:** $6,000 / $12,000

**Primary Care Provider:** $20 Copayment per visit
**Specialist:** $40 Copayment per visit
**Emergency Department:** $125 Copayment per visit
**Urgent Care Facility:** $40 Copayment per visit
**Rx:** $15/$50/$75/$75

This document is your Schedule of Benefits. If you enroll in this plan, this Schedule of Benefits will be an important part of your Policy. Your Policy describes in detail the services your plan covers, while 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 Policy. 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 Policy. You may also have Service Area documents 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 | Encouraged, but not required | |
| Pre-Certification and 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 | $500 | $1,000 |
| Family | $1,000 | $2,000 |
| Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios — whichever comes first:<br><br>*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<br>*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. | | |

| Member Cost Sharing | Participating Provider | Non-Participating Provider |
|---|---|---|
| Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded. | | |
| **Coinsurance** | | |
| | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Copayments may apply to certain Participating Provider services. | |
| **Total Annual Out-of-Pocket Limit** | | |
| Individual | $6,000 | $10,000 |
| Family | $12,000 | $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:<br><br>*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<br>*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 | 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 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 |
| Adult 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% after Deductible. |
| Routine gynecological exam, including a Pap test | Covered at 100%; you pay $0. | You pay 40%. Deductible does not apply. |
| Mammograms, annual routine and medically necessary | Covered at 100%; you pay $0. | You pay 40% after Deductible. |
| Diagnostic services and procedures required by the ACA | Covered at 100%; you pay $0. | You pay 40% after Deductible. |
| Pediatric dental and vision services | For coverage information, log in to *My*Health OnLine or call Member Services at the number on the back of your Member ID card. | |

| Covered Services | Participating Provider | Non-Participating Provider |
|---|---|---|
| **Hospital Services** | | |
| Hospital inpatient | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Hospital outpatient (includes ambulatory surgery) | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Observation stay | You pay 20% after Deductible. | You pay 40% after Deductible. |

| Covered Services | Participating Provider | Non-Participating Provider |
|---|---|---|
| Maternity - Non-preventive facility and professional services | You pay 20% after Deductible. | You pay 40% after Deductible. |
| **Emergency Services** | | |
| Emergency department | You pay $125 Copayment per visit. | |
| | Copayment waived if you are admitted to hospital. | |
| Emergency transportation | You pay 20% after Deductible. | |
| **Physician/Surgical Services** | | |
| Inpatient physician/surgical services | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Outpatient physician/surgical services | You pay 20% after Deductible. | You pay 40% after Deductible. |
| **Provider Medical Services** | | |
| Inpatient medical care visits, intensive medical care, consultation, and newborn care | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Adult immunizations not required to be covered by the ACA | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Primary care provider office visit | You pay $20 Copayment per visit. | You pay 40% after Deductible. |
| Specialist office visit | You pay $40 Copayment per visit. | You pay 40% after Deductible. |
| Convenience care visit | You pay $20 Copayment per visit. | You pay 40% after Deductible. |
| Urgent care facility | You pay $40 Copayment per visit. | You pay 40% after Deductible. |
| **Virtual Visits** | | |
| Virtual visit – Virtual Urgent Care | You pay $10 Copayment per visit. | You pay 40% after Deductible. |
| Virtual visit – Scheduled (Primary Care) | You pay $20 Copayment per visit. | You pay 40% after Deductible. |
| Virtual visit – Scheduled (Specialist) | You pay $40 Copayment per visit. | You pay 40% after Deductible. |
| Virtual visit – eDermatology | You pay $40 Copayment per visit. | You pay 40% after Deductible. |
| **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 20% after Deductible. | You pay 40% after Deductible. |
| **Diagnostic Services** | | |
| Advanced imaging (e.g., PET, MRI) | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Other imaging (e.g., x-ray, sonogram) | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Lab | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Diagnostic testing | You pay 20% after Deductible. | You pay 40% after Deductible. |
| **Rehabilitation Therapy Services**<br>**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 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to 60 visits per Benefit Period for both therapies combined. | |
| Speech therapy | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to 30 visits per Benefit Period. | |
| Cardiac rehabilitation | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to 36 visits per Benefit Period. | |
| Pulmonary rehabilitation | You pay 20% after Deductible. | You pay 40% after Deductible. |

| Covered Services | Participating Provider | Non-Participating Provider |
|---|---|---|
| | Covered up to 36 visits per Benefit Period. | |
| **Habilitation Therapy Services**<br>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 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to 60 visits per Benefit Period for both therapies combined. | |
| Speech therapy | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to 30 visits per Benefit Period. | |
| **Medical Therapy Services** | | |
| Chemotherapy, radiation therapy, dialysis therapy | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting | You pay 20% after Deductible. | You pay 40% after Deductible. |
| **Pain Management** | | |
| Pain management program | You pay $40 Copayment per visit. | You pay 40% after Deductible. |
| **Mental Health and Substance Use Disorder Services**<br>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 20% after Deductible. | You pay 40% after Deductible. |
| Outpatient – Office visits and outpatient therapy | You pay $20 Copayment per visit. | You pay 40% after Deductible. |
| Outpatient – Other services (includes intensive outpatient and partial hospitalization programs) | You pay 20% after Deductible. | You pay 40% after Deductible. |
| **Other Medical Services**<br>Refer to the Policy for specific Benefit Limitations that may apply to the services listed below. | | |
| Acupuncture | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to 12 visits per Benefit Period. | |
| Applied behavior analysis for the treatment of Autism Spectrum Disorder | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Corrective appliances | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Dental services related to accidental injury | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Durable medical equipment | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Fertility testing | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Home health care | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Hospice care | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Infertility Services | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Limited to artificial insemination. | |
| Medical nutrition therapy | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Nutritional counseling | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to six visits per Benefit Period. | |

| Covered Services | Participating Provider | Non-Participating Provider |
|---|---|---|
| Nutritional products | You pay 20%. Deductible does not apply. | You pay 40%. Deductible does not apply. |
| | Nutritional products for the treatment of PKU and related disorders are not subject to Deductible. | |
| Oral surgical services | You pay 20% after Deductible. | You pay 40% after Deductible. |
| Podiatry care | You pay $40 Copayment per visit. | You pay 40% after Deductible. |
| Private duty nursing | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to 30 visits per Benefit Period. | |
| Skilled nursing facility | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to 100 days per Benefit Period for Non-Participating Provider. | |
| Therapeutic manipulation | You pay 20% after Deductible. | You pay 40% after Deductible. |
| | Covered up to 25 visits per Benefit Period. | |
| **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 Medication Coverage**<br>**For additional information on your pharmacy benefits, refer to your Prescription Medication Schedule of Benefits.**<br>**Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.**<br>**The Advantage Choice pharmacy program will apply (mandatory generic).**<br>**Not subject to Plan Deductible**<br>**UPMC Health Plan has determined that your prescription medication benefit plan constitutes Creditable coverage** | |
|---|---|
| Retail prescription medication<br>• Prescriptions must be dispensed by a participating pharmacy.<br>• 31-day supply. | Tier 1: You pay $15 Copayment for preferred generic medications.<br>Tier 2: You pay $50 Copayment for preferred brand medications.<br>Tier 3: You pay $75 Copayment for nonpreferred medications (brand and generic).<br>Tier 5: You pay $0 Copayment for preventive medications.<br>Tier 7: You pay $0 Copayment for select generic medications.<br><br>90-day maximum retail supply available for three copayments |
| Specialty prescription medication<br>• Specialty medications are limited to a 31-day supply. See Prescription Medication Schedule of Benefits for additional information.<br>• Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request). You may pay a higher amount for specialty medications when filled at a retail pharmacy. | Tier 4: You pay $75 Copayment for specialty medications (brand and generic).<br>Tier 6: You pay 20% for oral chemotherapy medications with a maximum of $75 per prescription.<br><br>31-day maximum supply |
| Mail-order prescription medication<br>• A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy. | Tier 1: You pay $30 Copayment for preferred generic medications.<br>Tier 2: You pay $100 Copayment for preferred brand medications.<br>Tier 3: You pay $150 Copayment for nonpreferred (brand and generic).<br>Tier 5: You pay $0 Copayment for preventive medications.<br>Tier 7: You pay $0 Copayment for select generic medications.<br><br>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. | |

In order to ensure compliance with the Mental Health Parity and Addiction Equity Act, member cost-sharing may be reduced for certain services when received for the diagnosis or treatment of a mental health or substance use disorder

condition.

### Prior Authorization for out-of-network services

Certain out-of-network non-emergent care 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 the back of your member ID card. Your out-of-network 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 Policy. Also, the headings under the Covered Services section are the same as those in your Policy.

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 Policy, 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 Management Services Inc.

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