

SCHEDULE OF BENEFITS UPMC HEALTH PLAN - POINT PARK UNIVERSITY STUDENT HEALTH PLAN

Covered Services, which may be subject to a Deductible and Coinsurance, are provided during a Benefit Period as outlined in this Schedule of Benefits. All services must meet UPMC Health Network, Inc. definition of "Medical Necessary and Appropriate" in order to be Covered Services and some services may require Precertification from UPMC Health Network, Inc. This managed care plan may not cover all your health care expenses. Please read your Certificate of Coverage carefully for complete information about benefits and exclusions. If you have questions, please contact UPMC Health Network, Inc. Member Services at 1-877-381-3764.

BENEFIT PERIOD		
Plan Year		

LIFETIME BENEFIT LIMIT	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	Unlimited	Unlimited

ANNUAL OUT-OF-POCKET LIMIT	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
All amounts are based on the Reasonable & Customary Charge		
Individual	None	None
Family	None	None

ANNUAL DEDUCTIBLE	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Individual	\$50 per Benefit Period	\$50 per Benefit Period
Deductible applies to all Covered Services furnished to a Member per Benefit Period, unless specifically excluded.		

MAXIMUM PER INJURY OR ILLNESS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
All amounts are based on the Reasonable & Customary Charge		
Individual	\$100,000 per Injury or Sickness	

PLAN PAYMENT LEVEL	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Plan Coinsurance – percent of the Reasonable and Customary Charge that UPMC Health Network, Inc. will pay		
	80% after deductible	60% after deductible
The Plan Coinsurance shall apply to all Covered Services unless specifically excluded.		

PREEXISTING CONDITION LIMITATIONS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	None	None

PRIMARY CARE PROVIDER (PCP) REQUIRED	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	No	No

PRECERTIFICATION REQUIREMENTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	Provider Responsibility	Member Responsibility - \$500 penalty per incident for failure to pre-certify non emergency inpatient admissions.

COVERED SERVICES

Benefits for Covered Services are based upon the Reasonable & Customary Charge (R&C) and include, but are not limited to those Services listed in this schedule.

COVERED SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
HOSPITAL SERVICES		
Semi-Private Room, Private Room (if Medically Necessary and Appropriate), Surgery, Pre-Admission Testing	80% after Deductible	60% after Deductible
Outpatient care	80% after Deductible	60% after Deductible
EMERGENCY SERVICES		
Emergency Care Coverage	100% after a \$50 Copayment per Visit	100% after a \$50 Copayment per Visit
	Copayment waived if admitted	
PHYSICIAN SURGICAL SERVICES		
	80% after Deductible	60% after Deductible
PHYSICIAN MEDICAL SERVICES		
Inpatient Medical Care Visits and Intensive Medical Care, Consultation, Newborn Care	80% after Deductible	60% after Deductible
PHYSICIAN SERVICES		
Pediatric Care and Immunizations:		
Routine Physical Examination	80% after Deductible	Not covered
Pediatric Immunizations	100% - Deductible does not apply	60% - Deductible does not apply
	Child immunization services are exempt from Deductible or dollar limit provisions	
Well Baby Visits	80% after Deductible	Not covered
Adult Care:		
Routine Physical Examination	80% after Deductible	Not covered
Women's Care:		
Routine Gynecological Exam	80% - Deductible does not apply	60% - Deductible does not apply
Routine Pap test and routine mammogram	80% - Deductible does not apply	60% - Deductible does not apply
Physician Office Visit – for treatment of medical disease or injury	80% after Deductible	60% after Deductible
ALLERGY SERVICES:		
Diagnostic Testing	80% after Deductible	60% after Deductible
Treatment including Injections and Serum	80% after Deductible	60% after Deductible

COVERED SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
OUTPATIENT DIAGNOSTIC SERVICES		
Advanced imaging (e.g. PET, MRI, etc.)	80% after Deductible	60% after Deductible
Other imaging (X-ray, Sonogram, etc.)	80% after Deductible	60% after Deductible
Labs Services	80% after Deductible	60% after Deductible
Other Diagnostic Services	80% after Deductible	60% after Deductible
REHABILITATION THERAPY SERVICES		
Physical and Occupational	80% after Deductible	60% after Deductible
MEDICAL THERAPY SERVICES		
Chemotherapy, Radiation Therapy, Dialysis Treatment, Infusion Therapy	80% after Deductible	60% after Deductible
PAIN MANAGEMENT PROGRAM		
	80% after Deductible	60% after Deductible
Behavioral Health Services– Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083		
General Mental Illness		
Inpatient	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
Serious Mental Illness Services		
Inpatient	80% after Deductible	60% after Deductible
	Up to 30 days per Benefit Period No Lifetime Maximum	
	Thirty (30) Inpatient days may be exchanged on a 1:2 basis to secure up to 60 transitional partial hospitalization days.	
Outpatient	80% after Deductible	60% after Deductible
	Up to 60 Visits per Benefit Period	
Substance Abuse Services - Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083		
Inpatient Detoxification	80% after Deductible	60% after Deductible
	Benefit Limit of seven days per admission - Lifetime maximum of four admissions	
Inpatient Non-hospital Residential Alcohol or Other Drug Services	80% after Deductible	60% after Deductible
	Benefit Limit of 30 days per Benefit Period - Lifetime Maximum 90 days	
Outpatient Rehabilitation	80% after Deductible	60% after Deductible
	Benefit Limit of 60 full-session visits (or equivalent partial visits) per Benefit Period, 30 of which may be exchanged on a 2:1 basis to secure up to an additional 15 inpatient non-hospital residential alcohol treatment days. Benefit Limit of 120 full-session visits or equivalent partial visits per lifetime.	

COVERED SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
OTHER MEDICAL SERVICES		
Ambulance Service	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Hospice Care	80% after Deductible	60% after Deductible
Dental Services Related to Accidental Injury to sound and natural teeth	80% after Deductible	60% after Deductible
	Services must be provided within 72 hours of accident	
Oral Surgical Services	80% after Deductible	60% after Deductible
Blood and Blood Products	80% after Deductible	60% after Deductible
Transplantation Services	80% after Deductible	60% after Deductible
Nutritional Supplements	80% after Deductible	60% after Deductible
	Nutritional supplements for PKU, branched-chain ketonuria, galactosemia and homocystinuria are exempt from Deductible provisions.	
Nutritional Counseling	80% after Deductible	60% after Deductible
	Limited to two visits per Benefit Period	
Medical Nutritional Therapy	80% after Deductible	60% after Deductible
	Limited to Medically Necessary services directly related to specific medical conditions and subject to the specific Benefit Limits set forth in the Certificate of Coverage	
Diabetic Equipment, Supplies and Education:		
Glucometer, Test Strips, Lancets Insulin and Syringes	Must be obtained at Participating Pharmacy. 100% after copayment, per item, if applicable	
Education	80% after Deductible	60% after Deductible
PRESCRIPTION DRUG COVERAGE		
	See Prescription Drug Rider	
REPATRIATION AND MEDICAL EVACUATION		
	100%	