SCHEDULE OF BENEFITS UPMC HEALTH NETWORK, INC. UNIVERSITY OF PITTSBURGH STUDENT HEALTH PLAN

The following Schedule of Benefits is part of your University of Pittsburgh Student Health Plan. It sets forth benefit limits and cost-sharing amounts for specific Covered Services during a Benefit Period. A Benefit Period is the 12-month period that begins on the effective date of your coverage. Capitalized words and phrases used in this Schedule of Benefits have the same meaning as set forth in the University of Pittsburgh Student Health Plan. The headings under the Covered Services set forth below correspond with sections of your University of Pittsburgh Student Health Plan that further describe the terms and conditions of coverage for each class of services. Remember, in order to be covered at the level set forth in this Schedule of Benefits, all services must be Medically Necessary and meet all other criteria set forth in your benefit plan, including, but not limited to, Prior Authorization, when applicable. This managed care plan may not cover all your health care expenses. **To locate a Participating Provider near you, please visit www.upmchealthplan.com; and look for the Find a Provider button. If you have questions about your benefits or to determine if a provider is in UPMC Health Plan's network, please contact UPMC Health Plan Member Services at 1-888-499-6885.**

BENEFIT PERIOD
Plan Year

LIFETIME BENEFIT LIMIT	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	$250,000	$50,000

ANNUAL OUT-OF-POCKET LIMIT	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
All amounts are based on the Reasonable & Customary Charge		
Individual	After the member incurs $5,000 in Coinsurance expense for Covered Services in a single Benefit Period, payable benefits for participating provider care will increase to 100% for the remaining Benefit Period.	After the member incurs $10,000 in Coinsurance expense for Covered Services in a single Benefit Period, payable benefits for non-participating provider care will increase to 100% for the remaining Benefit Period.
Family	After the family (under the same family coverage) incurs $10,000 in Coinsurance expense for Covered Services in a single Benefit Period, the family's payable benefits for participating provider care will increase to 100% for the remaining Benefit Period.	After the family (under the same family coverage) incurs $20,000 in Coinsurance expense for Covered Services in a single Benefit Period, the family's payable benefits for non-participating provider care will increase to 100% for the remaining Benefit Period.

ANNUAL DEDUCTIBLE	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Individual	$100 per Benefit Period	$200 per Benefit Period
Deductible applies to all Covered Services furnished to a member per Benefit Period, unless specifically excluded. The Deductible does not apply towards satisfaction of the Out-of-Pocket Limit, specified in this Schedule of Benefits.		

PLAN PAYMENT LEVEL	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Plan Payment Level – percent of the Reasonable and Customary Charge that UPMC Health Plan will pay		
	80% after deductible	60% after deductible
The Plan Payment Level 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 required for select services, $500 financial penalty per incident for failure to pre-notify

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), Surgery, Pre-Admission Testing	100% after $500 Copayment per inpatient stay	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
	Covered up to $6,000 per Benefit Period (includes both physician and facility charges) Copayment waived if member admitted as inpatient	
PHYSICIAN SURGICAL SERVICES		
	80% after Deductible	60% after Deductible
	These dollar limits apply to outpatient surgical services – 1) Covered up to $12,000 per Benefit Period for surgeon 2) Covered up to $2,400 per Benefit Period for assistant surgeon 3) Covered up to $2,400 per Benefit Period for anesthetist	
	No dollar limits on medical services per Benefit Period	
PHYSICIAN MEDICAL SERVICES		
Inpatient Medical Care Visits and Intensive Medical Care, Consultation and Newborn Care	80% after Deductible	60% after Deductible
PHYSICIAN SERVICES		
Pediatric Care and Immunizations:		
Routine Physical Examination	100% after $25 Copayment per visit	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	100% after $25 Copayment per visit	Not covered
Adult Care:		
Routine Physical Examination	100% after $25 Copayment per visit	Not covered
Adult immunizations	80% after Deductible	60% after Deductible
Flu vaccine	100% - Deductible does not apply	60% after Deductible
Women's Care:		
Routine Gynecological Exam, including Breast Exam	100% after $25 Copayment per visit	60% - Deductible does not apply
Routine Mammogram and Pap Test	100% - Deductible does not apply	60% - Deductible does not apply
Abortion	Abortion covered up to $250 per Benefit Period	
Physician Office Visit – for treatment of medical disease or injury	100% after $25 Copayment per visit	60% after Deductible
Specialist Office Visit	100% after $25 Copayment per visit	60% after Deductible

COVERED SERVICES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
DIAGNOSTIC SERVICES		
Advanced Imaging (e.g. PET, MRI, etc.)	80% after Deductible	60% after Deductible
Other Imaging (e.g. X-ray, Sonogram, etc.)	80% after Deductible	60% after Deductible
Labs and other services	80% after Deductible	60% after Deductible
	Outpatient Lab and Imaging Services limited to $1,500 per Benefit Period	
REHABILITATION THERAPY SERVICES		
Physical and Occupational Therapy	100% after $25 Copayment per visit	60% after Deductible
	Covered up to 60 visits per Benefit Period for all three therapies combined	
MEDICAL THERAPY SERVICES		
Chemotherapy, Radiation Therapy, Dialysis Treatment, Infusion Therapy	80% after Deductible	60% after Deductible
PAIN MANAGEMENT PROGRAM		
	100% after $25 Copayment per visit	60% after Deductible
BEHAVIORAL HEALTH SERVICES – Contact UPMC Health Plan Behavioral Health Services at 1-877-461-8610		
General Mental Illness		
Inpatient	100% after $500 Copayment per inpatient stay	60% after Deductible
	Up to 30 days per Benefit Period	Lifetime Maximum 90 days
Outpatient	100% after $25 Copayment per visit	50% after Deductible
	Up to 20 visits per Benefit Period	
	Group visits and 15 minute medication visits count as ½ visit	
Serious Mental Illness Services		
Inpatient	100% after $500 Copayment per inpatient stay	60% after Deductible
	Up to 30 days per Benefit Period	No Lifetime Maximum
	The 30 inpatient days set forth above may be exchanged on a 1:2 basis to secure up to 60 additional outpatient visits.	
Outpatient	100% after $25 Copayment per visit	50% after Deductible
	Up to 60 visits per Benefit Period	
	Group visits and 15 minute medication visits count as ½ visit	
SUBSTANCE ABUSE SERVICES – Contact UPMC Health Plan Behavioral Health Services at 1-877-461-8610		
Inpatient Detoxification	100% after $500 Copayment per inpatient stay	50% after Deductible
	Benefit Limit of seven days per admission - Lifetime Maximum of four admissions	
Inpatient Non-hospital Residential Alcohol or Other Drug Services	100% after $500 Copayment per inpatient stay	50% after Deductible
	Benefit Limit of 30 days per Benefit Period - Lifetime Maximum 90 days	
Outpatient Rehabilitation	80% after Deductible	50% 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
OTHER MEDICAL SERVICES		
Ambulance Service	80% after Deductible	60% after Deductible
	Covered up to $1,200 per Benefit Period	
Home Health Care	80% after Deductible	60% after Deductible
Hospice Care	80% after Deductible	60% after Deductible
Dental Services Related to Accidental Injury	80% after Deductible	60% after Deductible
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
Acupuncture	80% after Deductible	60% after Deductible
	Please reference your Student Health Plan Policy or call Member Services for details	
Nutritional Supplements	80% after Deductible	60% after Deductible
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
Orthopedic Shoes and Shoe Inserts	80% after Deductible	60% after Deductible
REPATRIATION AND MEDICAL EVACUATION		
	100%	