The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-489-3494 or visit us at www.upmchealthplan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-489-3494 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Calendar year deductible Participating Provider**: $3,500 Person/ $7,000 Family** Non-Participating Provider: **$7,000 Person/ $14,000 Family**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Deductible does not apply to Preventive Care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment (copay) or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription Drug Coverage (Brand, Specialty): **$250 Person.** Pediatric Dental: **$50 Person/ $150 Family** Orthodontic care is subject to Medical Deductible**.** There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Participating Provider: **$7,900 Person/ $15,800 Family** Non-Participating Provider: **$10,000 Person/ $20,000 Family**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.upmchealthplan.com or call 1-855-489-3494 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment per visit	50% coinsurance	None
	Specialist visit	$75 copayment per visit	50% coinsurance	None
	Preventive care/screening/ immunization	No cost	50% coinsurance	Please see your Schedule of Benefits for details. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copayment per visit	50% coinsurance	Certain Diagnostic Services may have additional cost sharing. Please see your Schedule of Benefits for details.
	Imaging (CT/PET scans, MRIs)	$200 copayment per visit	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.upmchealthplan.com	Generic drugs	$25 copayment per prescription (Retail), $50 copayment per prescription (Mail order)	Not covered	None
	Preferred brand drugs	$50 copayment per prescription (Retail), $125 copayment per prescription (Mail order)	Not covered	None
	Non-preferred brand drugs	$100 copayment per prescription (Retail), $300 copayment per prescription (Mail order)	Not covered	None
	Specialty drugs	50% coinsurance	Not covered	Limit: for specialty medications with a maximum of $500 per prescription Please see your Prescription Medication Schedule of Benefits for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	None
	Physician/ surgeon fees	10% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$800 copayment per visit	$800 copayment per visit	Copayment waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$75 copayment per visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
	Physician/ surgeon fees	10% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 copayment per visit	50% coinsurance	None
	Inpatient services	10% coinsurance	50% coinsurance	Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
If you are pregnant	Office visits	$25 copayment per visit	50% coinsurance	Depending on the type of services, other cost shares may apply. Maternity
	Childbirth/delivery	10% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	professional services			care may include tests and services described elsewhere in the SBC (*i.e.*, ultrasound). Office visit cost share applies to first visit only.
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Covered up to 60 days per Benefit Period.
	Rehabilitation services	$40 copayment per visit	50% coinsurance	Physical and Occupational Therapies: Covered up to 30 visits per Benefit Period for both therapies combined. Speech Therapy: Covered up to 30 visits per Benefit Period.
	Habilitation services	$40 copayment per visit	50% coinsurance	Physical and Occupational Therapies: Covered up to 30 visits per Benefit Period for both therapies combined. Speech Therapy: Covered up to 30 visits per Benefit Period.
	Skilled nursing care	10% coinsurance	50% coinsurance	Covered up to 120 days per Benefit Period. Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
	Durable medical equipment	50% coinsurance	50% coinsurance	None
	Hospice services	10% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No cost	Full Cost. $30 Member Reimbursement	Limited to one exam per year.
	Children's glasses	No cost	Full Cost. $55-$75 Member Reimbursement	Limit of one pair of glasses per year.
	Children's dental check-up	No cost	20% coinsurance	Limit of two exams per year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)

- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture only covered for specific diagnosis
- Chiropractic care covered with limitations
- Infertility treatment (Limited to Artificial Insemination)
- Routine foot care only covered for specific diagnosis

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-877-881-6388 for the state insurance department, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the insurer at 1-855-489-3494. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-855-489-3494 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-489-3494.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-489-3494.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-489-3494.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-489-3494.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$3,500**
Specialist	**$75**
Hospital (facility)	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$910
Coinsurance	$1,140
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,610**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,500**
Specialist	**$75**
Hospital (facility)	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$4,120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,430**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,500**
Specialist	**$75**
Hospital (facility)	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$3,690**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$730
Copayments	$2,860
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$3,690**

Nondiscrimination Notice

UPMC Health Plan[1] complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UPMC Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UPMC Health Plan:

• Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact the Member Services phone number listed on the back of your member ID card.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint with:

Complaints and Grievances
PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-844-755-5611 (TTY: 1-800-361-2629)
Fax: 1-412-454-5964
Email: HealthPlanCompliance@upmc.edu

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

[1]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., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-489-3494 (TTY: 1-800-361-2629).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-489-3494
（TTY：1-800-361-2629）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-855-489-3494 (TTY: 1-800-361-2629).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-489-3494 (телетайп: 1-800-361-2629).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-489-3494
(TTY: 1-800-361-2629).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-489-3494 (TTY: 1-800-361-2629)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-489-3494 (TTY: 1-800-361-2629).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-558-984-4943 (رقم هاتف الصم والبكم: 2629-361-800-1).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-489-3494 (ATS : 1-800-361-2629).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-489-3494 (TTY: 1-800-361-2629).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-489-3494 (TTY: 1-800-361-2629).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-489-3494 (TTY: 1-800-361-2629).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-489-3494 (TTY: 1-800-361-2629).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-489-3494 (TTY: 1-800-361-2629)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-489-3494 (TTY: 1-800-361-2629).