



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 see 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.healthcare.gov/sbc-glossary 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 : \$7,000 Individual/ \$14,000 Family Non-Participating Provider : \$14,000 Individual/ \$28,000 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 , Primary Care provider office visit, Specialist office visit. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. Pediatric Dental: \$50 Individual/ \$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 : \$9,200 Individual/ \$18,400 Family Non-Participating Provider : \$15,000 Individual/ \$30,000 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 limit until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums , balance-billing charges (unless balanced billing is prohibited), and health care this plan does not 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. | \$50 copayment per visit. Deductible does not apply. | 50% coinsurance | None. |
| | Specialist visit | \$80 copayment per visit. Deductible does not apply. | 50% coinsurance | None. |
| | Preventive care/screening /immunization | No cost. Deductible does not apply. | 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 needed are preventive . Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$60 copayment per visit. Deductible does not apply. | 50% coinsurance | Certain Diagnostic Services may have additional cost sharing. Please see your Schedule of Benefits for details. |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | 50% coinsurance | None. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.upmchealthplan.com | Generic drugs | \$10 copayment per prescription. (Retail) \$20 copayment per prescription. (Mail Order) | Not covered | Please see your Prescription Medication Schedule of Benefits for details. |
| | Preferred brand drugs | \$50 copayment per prescription. (Retail) \$100 copayment per prescription. (Mail Order) | Not covered | Please see your Prescription Medication Schedule of Benefits for details. |
| | Non-preferred brand drugs | \$100 copayment per prescription. (Retail) \$200 copayment per prescription. (Mail Order) | Not covered | Please see your Prescription Medication Schedule of Benefits for details. |

| 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) | |
| | Specialty drugs | 50% coinsurance . (Retail) | Not covered | Limit: for specialty medications (brand and generic) 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) | 40% coinsurance | 50% coinsurance | None. |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | None. |
| If you need immediate medical attention | Emergency room care | 40% coinsurance | 40% coinsurance | None. |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance | None. |
| | Urgent care | \$80 copayment per visit. Deductible does not apply. | 50% coinsurance | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% coinsurance | 50% coinsurance | Preauthorization may be required. If preauthorization is not obtained, benefits could be denied. |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | None. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$50 copayment per visit. Deductible does not apply. | 50% coinsurance | Office visit and outpatient therapy. Other services (including intensive outpatient and partial hospitalization) may have additional cost sharing. Please see your Schedule of Benefits for details. |
| | Inpatient services | 40% coinsurance | 50% coinsurance | Preauthorization may be required. If preauthorization is not obtained, benefits could be denied. |
| If you are pregnant | Office visits | \$50 copayment per visit. Deductible does not apply. | 50% coinsurance | |
| | Childbirth/delivery professional services | 40% 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) | |
| | Childbirth/delivery facility services | 40% coinsurance | 50% coinsurance | Depending on the type of services, other cost shares may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Office visit cost share applies to first visit only. |
| If you need help recovering or have other special health needs | Home health care | 40% coinsurance | 50% coinsurance | Covered up to 60 days per Benefit Period. |
| | Rehabilitation services | \$60 copayment per visit. Deductible does not apply. | 50% coinsurance | Physical and Occupational Therapies: Covered up to 30 visits per Benefit Period. Speech Therapy: Covered up to 30 visits per Benefit Period. Visit limits do not apply for mental and behavioral health services. |
| | Habilitation services | \$60 copayment per visit. Deductible does not apply. | 50% coinsurance | Physical and Occupational Therapies: Covered up to 30 visits per Benefit Period. Speech Therapy: Covered up to 30 visits per Benefit Period. Visit limits do not apply for mental and behavioral health services. |
| | Skilled nursing care | 40% 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 | 40% coinsurance | 50% coinsurance | None. |
| If your child needs dental or eye care | Children's eye exam | No cost. Deductible does not apply. | Full Cost. \$30 Member Reimbursement. | Limited to 1 exams per benefit period. |

| 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) | |
| | Children's glasses | No cost. Deductible does not apply. | Full Cost. \$55-\$75 Member Reimbursement. | Limited to 1 items per benefit period. |
| | Children's dental check-up | No cost. Deductible does not apply. | 20% coinsurance | Limited to 1 exams per 6 months. |

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 | • Routine Eye Care (Adult) | |
| • Bariatric surgery | • Long-term care | • Weight loss programs | |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | | |
| • Dental care (Adult) | • Private-duty nursing | | |

| 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 | • Infertility Treatment (Limited to Artificial Insemination) | | |
| • Chiropractic care covered with limitations | • Routine foot care only covered for specific diagnoses | | |

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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or the insurer at 1-855-489-3494. Other options to continue coverage are 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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. Additionally, a consumer assistance program can help you file your appeal. Contact 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Not Applicable

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, kwijigo holne' 1-855-489-3494.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 | \$7,000 |
| ■ Specialist copayment | \$80 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$7,000 |
| Copayments | \$200 |
| Coinsurance | \$1,800 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$9,060 |

Managing Joe's type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$7,000 |
| ■ Specialist copayment | \$80 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,900 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$40 |
| The total Joe would pay is | \$1,940 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$7,000 |
| ■ Specialist copayment | \$80 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,100 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,400 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

UPMC Health Plan¹, on behalf of itself and its affiliates, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

UPMC Health Plan provides free aids and services to people with disabilities so they can communicate effectively with us. Aids and services may include:

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

UPMC Health Plan provides free language services to people whose primary language is not English. Language services may include:

- 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: 711)

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.

¹UPMC 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.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-489-3494

(TTY: 711).

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 : 711) 。

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: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-489-3494 (телетайп: 711).

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: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-489-3494 (TTY: 711)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: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-489-3494 (رقم هاتف الصم والبكم:711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-489-3494 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-489-3494 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો િન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-489-3494 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-489-3494 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele
1-855-489-3494 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-855-489-3494
(TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para
1-855-489-3494 (TTY: 711).