

UPMC Consumer <i>Advantage</i>	
HSA HMO - Standard Network	
Deductible	\$3,000 /\$6,000
Coinsurance	20%
Total Annual Out-of-Pocket	\$6,450 /\$12,900
Primary care provider	You pay 20% after Deductible
Specialist office visit	You pay 20% after Deductible
Emergency Department	You pay 20% after Deductible
Urgent Care Facility	You pay 20% after Deductible
Rx	\$8 /\$38 /\$76 /\$76 after Deductible

This Schedule of Benefits will be an important part of your Certificate of Coverage (COC) or your Summary Plan Description (SPD). If your plan has an SPD, it is issued by your employer or labor trust fund. It is not issued by UPMC Health Plan. It is important that you review and understand your COC and/or SPD because they describe in detail the services your plan covers. 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 COC. 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 COC. You may also have Riders and Amendments 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 your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider
Benefit Period	Plan Year
Primary Care Provider (PCP) Required	Yes
Referral Requirement	A PCP referral is required for certain specialist visits and services. Those specialists include: Acupuncture, Chiropractic, Gastroenterology, Neurology, Pain Management, Podiatry, Pulmonary, Reproductive, Rheumatology, Sleep Medicine, Sports Medicine, Physical Therapy, Occupational Therapy, Speech Therapy. Referrals are not required for Pediatric Specialist visits (children under 21), Ob-gyns, Mental Health or Substance Use Services, and Virtual Visits. If you are unsure if a visit or service requires a referral, please call Member Services.
Prior Authorization Requirements	Provider Responsibility

Member Cost Sharing		Participating Provider
HSA: Health savings account (HSA) annual allocation		
Employer/Employee Determined; this is a qualified high deductible health plan.		
Annual Deductible		
Individual		\$3,000
Family		\$6,000
Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios - whichever comes first: *When an individual within a family reaches his or her individual Deductible. At this point, only that person is considered to have met the Deductible; OR *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.		
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.		
Coinsurance		
		You pay 20% after Deductible
Copayments may apply to certain Participating Provider services.		
Any Covered Services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.		
Total Annual Out-of-Pocket Limit		
Individual		\$6,450
Family		\$12,900
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: *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 *When a combination of a family member's 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.		

Member Cost Sharing		Participating Provider
Preventive Services		
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.
Pediatric immunizations		Covered at 100%; you pay \$0.

Member Cost Sharing	Participating Provider
Well-baby visits	Covered at 100%; you pay \$0.
Adult preventive/health screening examination	Covered at 100%; you pay \$0.
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay \$0.
Screening gynecological exam	Covered at 100%; you pay \$0.
Breast cancer and cervical cancer screening	Covered at 100%; you pay \$0.
Screening services and procedures required by the ACA	Covered at 100%; you pay \$0.
Hospital Services	
Hospital inpatient	You pay 20% after Deductible.
Outpatient/Ambulatory	You pay 20% after Deductible.
Observation stay	You pay 20% after Deductible.
Maternity - hospital services associated with delivery	You pay 20% after Deductible.
Emergency Services	
Emergency department	You pay 20% after Deductible.
Emergency transportation	You pay 20% after Deductible.
Surgical Services	
Surgical services (professional provider services)	You pay 20% after Deductible.
Provider Medical Services	
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay 20% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 20% after Deductible.
Primary care provider office visit	You pay 20% after Deductible.
Specialist office visit	You pay 20% after Deductible.
Convenience care visit	You pay 20% after Deductible.
Urgent care facility	You pay 20% after Deductible.
Virtual Visits	
UPMC AnywhereCare - Virtual Urgent Care and Children's AnywhereCare	You pay 20% after Deductible.
Virtual visit - (Primary Care)	You pay 20% after Deductible.
Virtual visit - Scheduled (Specialist)	You pay 20% after Deductible.
Virtual visit - Behavioral Health	You pay 20% after Deductible.

Member Cost Sharing	Participating Provider
UPMC MyHealth 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 MyHealth 24/7 Nurse Line at 1-866-918-1591(TTY:711) 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at www.upmchealthplan.com and a nurse will respond within 24 hours.	
Allergy Services	
Treatment, injections, and serum	You pay 20% after Deductible.
Diagnostic Services	
Advanced imaging (e.g., PET, MRI)	You pay 20% after Deductible.
Other imaging (e.g., x-ray, sonogram,) (Free standing and hospital)	You pay 20% after Deductible.
Laboratory services	You pay 20% after Deductible.
Diagnostic testing	You pay 20% after Deductible.
Rehabilitation Therapy Services	
Note: See the Behavioral Health Services section below for Rehabilitation Therapy services prescribed for the treatment of a Behavioral Health condition.	
Physical and occupational therapy	You pay 20% after Deductible.
Covered up to 30 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay 20% after Deductible.
Covered up to 30 visits per Benefit Period.	
Cardiac rehabilitation	You pay 20% after Deductible.
Covered up to 36 visits per Benefit Period.	
Pulmonary rehabilitation	You pay 20% after Deductible.
Covered up to 36 visits per Benefit Period.	
Habilitation Therapy Services	
Note: See the Behavioral Health Services section below for Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.	
Physical and occupational therapy	You pay 20% after Deductible.
Covered up to 30 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay 20% after Deductible.
Covered up to 30 visits per Benefit Period.	
Medical Therapy Services	
Chemotherapy, radiation therapy, dialysis therapy	You pay 20% after Deductible.
Medical Therapy Services-Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 20% after Deductible.
Pain management program	
Pain management program	You pay 20% after Deductible.

Member Cost Sharing	Participating Provider
Behavioral Health (Mental Health and Substance Use Disorder) Services (Rehabilitative or Habilitative) 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.
Visits, including psycho and outpatient therapy and counseling	You pay 20% after Deductible.
Outpatient - Services (includes intensive outpatient and partial hospitalization programs)	You pay 20% after Deductible.
Laboratory services related to a Behavioral Health condition	You pay 20% after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health Condition	You pay 20% after Deductible.
Visit limits do not apply.	
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay 20% after Deductible.
Other Medical Services Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below.	
Acupuncture	You pay 20% after Deductible.
Covered up to 12 visits per Benefit Period.	
Corrective appliances	You pay 20% after Deductible.
Dental services related to accidental injury	You pay 20% after Deductible.
Durable medical equipment	You pay 20% after Deductible.
Fertility testing	You pay 20% after Deductible.
Home health care	You pay 20% after Deductible.
Covered up to 60 days per Benefit Period.	
Hospice care	You pay 20% after Deductible.
Medical nutrition therapy	You pay 20% after Deductible.
Nutritional counseling	You pay 20% after Deductible.
Covered up to 6 visits per Benefit Period.	
Nutritional formulas	You pay 20%. Deductible does not apply.
Nutritional formulas for the treatment of PKU and related disorders are not subject to Deductible.	
Oral surgical services	You pay 20% after Deductible.
Podiatry care	You pay 20% after Deductible.
Skilled nursing facility	You pay 20% after Deductible.
Covered up to 120 days per Benefit Period.	
Therapeutic manipulation	You pay 20% after Deductible.

Member Cost Sharing		Participating Provider
Covered up to 20 visits per Benefit Period.		
Private duty nursing	You pay 20% after Deductible.	
Diabetic Equipment, Supplies, and Education		
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts, Inc., that plan will pay for diabetic supplies and equipment first.)		
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at a Participating Pharmacy. See applicable Prescription Schedule of Benefits for coverage information.	
Diabetic education	You pay \$0 after Deductible.	

Prescription Medication Coverage

For additional information on your pharmacy benefits, refer to your Prescription Medication Schedule of Benefits. Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.

The Your Choice pharmacy program will apply (mandatory generic).
Subject to Plan Deductible

Retail prescription medication

- Prescriptions must be dispensed by a participating pharmacy.
- 30-day supply.

Tier 1: Preferred Generic Medications	You pay \$8 Copayment after Deductible for preferred generic medications.
Tier 2: Preferred Brand Medications and Generic Medications (Brand and Generic)	You pay \$38 Copayment after Deductible for preferred brand medications and generic medications (brand and generic).
Tier 3: Nonpreferred Medications (Brand and Generic)	You pay \$76 Copayment after Deductible for nonpreferred medications (brand and generic).
Tier 5: Preventive Medications	You pay \$0 Copayment for preventive medications.

90-day maximum retail supply available for three copayments

Specialty prescription medication

- Specialty medications are limited to a 30-day supply. See Prescription Medication Rider for additional information.
- Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request).

Tier 4: Specialty Medications (Brand and Generic)	You pay \$76 Copayment after Deductible for specialty medications (brand and generic).
Tier 6: Oral Chemotherapy Medications (Brand and Generic)	You pay \$0 Copayment after Deductible for oral chemotherapy medications (brand and generic).

30-day maximum supply

Mail-order prescription medication

- **A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy.**

Tier 1: Preferred Generic Medications	You pay \$16 Copayment after Deductible for preferred generic medications.
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Prescription Medication Coverage

For additional information on your pharmacy benefits, refer to your Prescription Medication Schedule of Benefits. Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.

The Your Choice pharmacy program will apply (mandatory generic).

Subject to Plan Deductible

Tier 2: Preferred Brand Medications and Generic Medications (Brand and Generic)	You pay \$76 Copayment after Deductible for preferred brand medications and generic medications (brand and generic).
Tier 3: Nonpreferred Medications (Brand and Generic)	You pay \$152 Copayment after Deductible for nonpreferred medications (brand and generic).
Tier 5: Preventive Medications	You pay \$0 Copayment for preventive medications.
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.	


The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your COC. Also, the headings under the Covered Services section are the same as those in your COC.

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 COC, and the Summary of Benefits and Coverage. You can log into *MyHealth* 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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 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 1-888-876-2756 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 1-888-876-2756 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Policy period <u>deductible</u> Participating <u>Provider</u> : \$3,000 Person / \$6,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Deductible</u> does not apply to <u>Preventive Care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> (copay) or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Participating <u>Provider</u> : \$6,450 Person/ \$12,900 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premium</u> , balance-billed charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.upmchealthplan.com or call 1-888-876-2756 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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	20% <u>coinsurance</u>	Not covered	None
	Specialist visit	20% <u>coinsurance</u>	Not covered	None
	Preventive care/screening/immunization	No cost. <u>Deductible</u> does not apply.	Not covered	Please see your Schedule of Benefits for details. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	Certain Diagnostic Services may have additional cost sharing. Please see your Schedule of Benefits for details.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.upmchealthplan.com	Generic drugs	\$8 <u>copayment</u> per prescription (Retail), \$16 <u>copayment</u> per prescription (Mail order)	Not covered	Please see your Prescription Medication Rider for details.
	Preferred brand drugs	\$38 <u>copayment</u> per prescription (Retail), \$76 <u>copayment</u> per prescription (Mail order)	Not covered	Please see your Prescription Medication Rider for details.
	Non-preferred brand drugs	\$76 <u>copayment</u> per prescription (Retail), \$152 <u>copayment</u> per prescription (Mail order)	Not covered	Please see your Prescription Medication Rider for details.
	<u>Specialty drugs</u>	\$76 <u>copayment</u> per prescription	Not covered	Please see your Prescription Medication Rider for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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)	
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Not covered	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	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
If you are pregnant	Office visits	20% <u>coinsurance</u>	Not covered	Depending on the type of services, other <u>cost shares</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (<i>i.e.</i> , ultrasound). Office visit <u>cost share</u> applies to first visit only.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	Covered up to 60 days per Benefit Period.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	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.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not covered	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.

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)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	Covered up to 120 days per Benefit Period. <u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture only covered for specific diagnosis • Bariatric surgery subject to medical review 	<ul style="list-style-type: none"> • Chiropractic care covered with limitations • Private-duty nursing subject to medical review 	<ul style="list-style-type: none"> • 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, or the insurer at 1-888-876-2756. 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 1-888-876-2756. 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 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 1-888-876-2756.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-876-2756.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-876-2756.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-876-2756.

_____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 **\$3,000**
- Specialist **20%**
- Hospital (facility) **20%**
- Other coinsurance **20%**

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,970

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible **\$3,000**
- Specialist **20%**
- Hospital (facility) **20%**
- Other coinsurance **20%**

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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,700

Mia's Simple Fracture

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

- The plan's overall deductible **\$3,000**
- Specialist **20%**
- Hospital (facility) **20%**
- Other coinsurance **20%**

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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400

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 1-866-420-9589

(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 1-866-420-9589

(TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-420-9589 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-420-9589 (телетайп: 711).

Wann du Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprouch. Ruf selli Nummer uff: Call 1-866-420-9589 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-866-420-9589 (TTY: 711)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-420-9589 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-420-9589 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-420-9589 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-420-9589 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો િન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-420-9589 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-420-9589 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-420-9589 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-866-420-9589 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-420-9589 (TTY: 711).