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 1-844-881-4146 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 1-844-881-4146 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Plan Year deductible Participating Provider: $375 Individual/ $750 Family Non-Participating Provider: $750 Individual/ $1,500 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, Emergency Department.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Participating Provider: $2,100 Individual/ $4,200 Family Non-Participating Provider: $4,200 Individual/ $8,400 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 1-844-881-4146 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.	$30 copayment per visit. Deductible does not apply.	40% coinsurance	None.
	Specialist visit	$50 copayment per visit. Deductible does not apply.	40% coinsurance	None.
	Preventive care/screening/immunization	No cost. Deductible does not apply.	40% 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)	20% coinsurance	40% coinsurance	Certain Diagnostic Services may have additional cost sharing. Please see your Schedule of Benefits for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.caremark.com/	Generic drugs	Not Applicable	Not Applicable	Prescription drug coverage is administered by CVS Caremark. Refer to CVS Caremark materials for coverage details, limitations, and exclusions.
	Preferred brand drugs	Not Applicable	Not Applicable	Prescription drug coverage is administered by CVS Caremark. Refer to CVS Caremark materials for coverage details, limitations, and exclusions.
	Non-preferred brand drugs	Not Applicable	Not Applicable	Prescription drug coverage is administered by CVS Caremark. Refer to CVS Caremark materials for coverage details, limitations, and exclusions.
	Specialty drugs	Not Applicable	Not Applicable	Prescription drug coverage is administered by CVS Caremark. Refer to

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)	
				CVS Caremark materials for coverage details, limitations, and exclusions.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	$150 copayment per visit. Deductible does not apply.	$150 copayment per visit. Deductible does not apply.	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	$50 copayment per visit. Deductible does not apply.	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment per visit. Deductible does not apply.	40% 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	20% coinsurance	40% coinsurance	Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
If you are pregnant	Office visits	$30 copayment per visit. Deductible does not apply.	40% coinsurance	
	Childbirth/delivery professional services	20% coinsurance	40% 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	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	None.
	Rehabilitation services	$50 copayment per visit. Deductible does not apply.	40% coinsurance	Physical, Speech and Occupational Therapy - Combined: Covered up to 60 visits per Benefit Period for all three therapies combined. Visit limits do not apply for mental or behavioral health services.
	Habilitation services	$50 copayment per visit. Deductible does not apply.	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Covered up to 100 days per Benefit Period. Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
	Durable medical equipment	20% coinsurance	40% coinsurance	None.
	Hospice services	20% coinsurance	40% coinsurance	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 plan document.)

- Acupuncture only covered for specific diagnosis
- Bariatric surgery subject to medical review
- Chiropractic care covered with limitations
- Private-duty nursing subject to medical review
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the insurer at 1-844-881-4146. 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 1-844-881-4146 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

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? 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 1-844-881-4146.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-881-4146.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-844-881-4146.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-881-4146.

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

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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	**$375**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$375
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,145**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$375**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$375**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$375
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$400
The total Mia would pay is	**$1,275**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Discrimination is Against the Law

UPMC Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, sex stereotypes, pre-existing conditions, health status, and marital status. **UPMC Health Plan** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

UPMC Health Plan:

- Provides people with disabilities reasonable modifications and free and timely appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified interpreters
  - Written information in other formats (large print, Braille, other formats).
- Provides free and timely language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.
- If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact **UPMC Health Plan Member Services at** 1-844-220-4785. Help is available Monday to Friday 8 a.m. to 6 p.m.

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

Complaints/Grievances/Appeals
Attn: Chief Risk, Compliance & Ethics Officer
PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-844-220-4785
TTY: 711
Fax: 412-454-7920
Email: HealthPlanCompliance@upmc.edu

You can file a complaint/grievance in person or by mail, fax, or email. If you need help filing a complaint/ grievance, **UPMC Health Plan Member Services** is available to help you.

You can also 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/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

This notice is available at **UPMC Health Plan's** website: **https://www.upmchealthplan.com/members/**

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Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-869-7228 (TTY: 711) o hable con su proveedor.

Chinese; Mandarin
注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-869-7228（文本电话：711）或咨询您的服务提供商。

Nepali
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