



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 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 1-888-876-2756 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Plan Year deductible Participating Provider : \$600 Individual/ \$1,200 Family Non-Participating Provider : \$7,150 Individual/ \$14,300 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 : (Coinsurance only)\$0 Individual/ \$0 Family (All Inclusive) \$6,000 Individual/ \$12,000 Family Non-Participating Provider : (Coinsurance only) \$5,000 Individual/ \$15,000 Family (All Inclusive) Not Applicable	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 1-888-876-2756 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.

Important Questions	Answers	Why This Matters:
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.	50% coinsurance	None.
	Specialist visit	\$30 copayment per visit. Deductible does not apply.	50% coinsurance	None.
	Preventive care/screening /immunization	No cost. Deductible does not apply.	Not covered	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)	No cost	50% coinsurance	Certain Diagnostic Services may have additional cost sharing. Please see your Schedule of Benefits for details.
	Imaging (CT/PET scans, MRIs)	No cost	50% coinsurance	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myhighmark.com	Generic drugs	\$10 copayment per prescription. (Retail) \$20 copayment per prescription. (Mail Order)	Not covered	Up to 30-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
	Preferred brand drugs	\$25 copayment per prescription. (Retail) \$50 copayment per prescription. (Mail Order)	Not covered	Deductible does not apply When you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor request that the brand drug be dispensed.
	Non-preferred brand drugs	\$50 copayment per prescription. (Retail) \$100 copayment per prescription. (Mail Order)	Not covered	

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	Specialty Drug benefit matches Generic, Non-preferred Brand or Preferred Brand plan design.	Not covered	Specialty drugs are limited to a 30-day supply. Deductible does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No cost	50% coinsurance	None.
	Physician/surgeon fees	No cost	50% 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	No cost	No cost	None.
	Urgent care	\$30 copayment per visit. Deductible does not apply.	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No cost	50% coinsurance	Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
	Physician/surgeon fees	No cost	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 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	No cost	50% 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.	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 professional services	No cost	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.
	Childbirth/delivery facility services	No cost	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No cost	50% coinsurance	Covered up to 100 days per Benefit Period for Non-Participating Provider.
	Rehabilitation services	\$30 copayment per visit. Deductible does not apply.	50% coinsurance	None.
	Habilitation services	\$30 copayment per visit. Deductible does not apply.	50% coinsurance	None.
	Skilled nursing care	No cost	50% coinsurance	Preauthorization may be required. If preauthorization is not obtained, benefits could be denied.
	Durable medical equipment	No cost	50% coinsurance	None.
	Hospice services	No cost	50% 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 | • Infertility treatment | • Routine Eye Care (Adult) |
| • Dental care (Adult) | • Long-term care | • Weight loss programs |
| • Hearing aids | • Non-emergency care when traveling outside the U.S. | |

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 | • Routine foot care only covered for specific diagnoses |
| • Bariatric surgery subject to medical review | • Private-duty nursing subject to medical review | |

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 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 1-888-876-2756. 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 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 1-888-876-2756.

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.

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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	\$600
■ Specialist copayment	\$30
■ Hospital (facility)	\$0
■ Other coinsurance	0%

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:

Cost Sharing	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$670

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$600
■ Specialist copayment	\$30
■ Hospital (facility)	\$0
■ Other coinsurance	0%

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:

Cost Sharing	
Deductibles	\$100
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,600

Mia's Simple Fracture

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

■ The plan's overall deductible	\$600
■ Specialist copayment	\$30
■ Hospital (facility)	\$0
■ Other coinsurance	0%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$5
The total Mia would pay is	\$905

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, and sex stereotypes. **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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Translation Services

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-869-7228 (TTY: 711) or speak to your provider.

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

सावधान: यदी तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-869-7228 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Russian

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-869-7228 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-869-7228 (711) أو تحدث إلى مقدم الخدمة.

Vietnamese

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-869-7228 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Ukrainian

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Portuguese

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French

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Korean

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Pennsylvania Dutch

ACHTUNG: Wann du Pennsylvanisch Deutsch schwetzscht, sin Hilfsdienst fer die Sprooch fer dich gratis verfügbar. Passende Hilfsmittel un Dienscht, fer Informatione in zugängliche Formate ze gebbe, sin aa gratis verfügbar. Ruf 1-855-869-7228 (TTY: 711) oder schwetz mit dein Anbieter.

German

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Igbo

NLEBARA ANYA : Ọ bụrụ na ị na-asụ asụsụ Igbo, enwere ọrụ enyemaka asụsụ n'efu maka gị. A na-enyekwa ihe enyemaka na ọrụ ndị kwesiri ekwesị jiri nye ihe ọmụma n'ụdị ndị dị mfe inweta n'efu. Kpọọ 1-855-869-7228 (TTY: 711) ma ọ bụ gwa ndị na-ahụ maka ahụike gị okwu.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-869-7228 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian

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