This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.upmchealthplan.com or by calling 1-844-780-7044.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Policy period deductible Non-Participating Provider: **$300 Person/$600 Family** Deductible does not apply to Preventive Services	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Participating Provider (Coinsurance only): **$1,200 Person/$2,400 Family**, (All-inclusive): **$7,150 Person/$14,300 Family** Out-of-network (Coinsurance only): **$2,400 Person/$4,800 Family**, (All-inclusive): **Not applicable**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.upmchealthplan.com or call 1-844-780-7044 for a list of **in-network providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Questions: Call 1-844-780-7044 or visit us at www.upmchealthplan.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-844-780-7044 to request a copy.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	30% coinsurance	——————none——————
	Specialist visit	$20 copay/visit	30% coinsurance	——————none——————
	Other practitioner office visit	$10 copay/visit	30% coinsurance	You pay $20 copay/visit for Convenience care and you pay 10% coinsurance for Chiropractor
	Preventive care/screening/immunization	No Cost	Not Covered	Limited Coverage for immunizations and women's care out of network
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	$7 copay/prescription (Retail), $14 copay/prescription (Mail order)	Not Covered	31 day maximum retail supply. 90 day maximum mail order supply
	Preferred brand drugs	$15 copay/prescription (Retail), $30 copay/prescription (Mail order)	Not Covered	31 day maximum retail supply. 90 day maximum mail order supply

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
www.upmchealthplan.com.	Non-preferred brand drugs	$40 copay/prescription (Retail), $80 copay/prescription (Mail order)	Not Covered	31 day maximum retail supply. 90 day maximum mail order supply
	Specialty drugs	$40 copay/prescription	Not Covered	31 day maximum supply
	Specific categories of prescription drugs: Antihistamine/Decongestant combination and Proton Pump Inhibitors	$40 copay/prescription (Retail), $80 copay/prescription (Mail order)	Not Covered	31 day maximum retail supply 90 day maximum mail order supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Prior Authorization may be required
	Physician/surgeon fees	10% coinsurance	30% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	10% coinsurance + $50 copay/visit	10% coinsurance + $50 copay/visit	Copayment waived if admitted. Out-of-network: not subject to Deductible
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network: subject to Deductible
	Urgent care	$20 copay	30% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Prior Authorization may be required
	Physician/surgeon fee	10% coinsurance	30% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	Prior Authorization may be required
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	——————none——————
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Prior Authorization may be required
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Prior Authorization may be required
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Limit of 100 days per Benefit Period
	Rehabilitation services	10% coinsurance	30% coinsurance	Limit of 30 visits per Benefit Period for Physical therapy, 30 visits per Benefit Period for Occupational therapy, and 30 visits per Benefit Period for Speech therapy.
	Habilitation services	10% coinsurance	30% coinsurance	Limit of 30 visits per Benefit Period for Physical therapy, 30 visits per Benefit Period for Occupational therapy, and 30 visits per Benefit Period for Speech therapy.
	Skilled nursing care	10% coinsurance	30% coinsurance	Limit of 100 days per Benefit Period. Prior Authorization may be required
	Durable medical equipment	10% coinsurance	30% coinsurance	——————none——————
	Hospice service	10% coinsurance	30% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Abortion Services • 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 diagnosis

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-844-780-7044**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at **1-844-780-7044**. You can contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform** For questions about your rights, this notice, or assistance, you can contact your state insurance department at **1-877-881-6388**. Additionally, a consumer assistance program can help you file your appeal. Contact **1-877-881-6388**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage**.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-844-780-7044**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-844-780-7044**.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1-844-780-7044**.

Questions: Call **1-844-780-7044** or visit us at **www.upmchealthplan.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **1-844-780-7044** to request a copy.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-844-780-7044**.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These Coverage Examples illustrate coverage for an individual (a patient).

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,630
- **Patient pays** $910

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$10
Coinsurance	$700
Limits or exclusions	$200
Total	**$910**

Note: For Family Policies (more than one Insured on Policy), the entire family Deductible must be met by one or a combination of the covered family members before the plan pays for covered benefits for anyone on the Policy.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,720
- **Patient pays** $680

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$500
Coinsurance	$100
Limits or exclusions	$80
Total	**$680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Nondiscrimination Notice

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

UPMC Health Plan[1]:

- Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact the Civil Rights Administrator.

If you believe that UPMC Health Plan[1] 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 grievance with:

Civil Rights Administrator
UPMC Health Plan
600 Grant Street - 55th Floor
Pittsburgh, PA 15219

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

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Administrator 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/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

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

[1]UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-869-7228 (TTY: 1-800-361-2629).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-869-7228（TTY：1-800-361-2629）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-869-7228 (TTY: 1-800-361-2629).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-869-7228 (телетайп: 1-800-361-2629).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-869-7228 (TTY: 1-800-361-2629).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-869-7228 (TTY: 1-800-361-2629)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-869-7228 (TTY: 1-800-361-2629).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-869-7228 (رقم هاتف الصم والبكم: 1-800-361-2629).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-869-7228 (ATS : 1-800-361-2629).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-869-7228 (TTY: 1-800-361-2629).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-869-7228 (TTY: 1-800-361-2629).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-869-7228 (TTY: 1-800-361-2629).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-869-7228 (TTY: 1-800-361-2629).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-869-7228 (TTY: 1-800-361-2629)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-869-7228 (TTY: 1-800-361-2629).