UPMC HEALTH PLAN

Benefits at a glance

RMU Student Health Plan

Plan Information	**Participating Provider**	**Non-Participating Provider**
Benefit Period	Plan Year	
Member Cost Sharing	**Participating Provider**	**Non-Participating Provider**
Annual Deductible		
Individual	$500	$1,000
Coinsurance		
	You pay 20% after Deductible.	You pay 40% after Deductible.
	Copayments may apply to certain Participating Provider services.	
Total Annual Out-of-Pocket Limit		
Individual	$6,000	$10,000
Preventive Services	**Participating Provider**	**Non-Participating Provider**
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 Care and Immunizations		
Preventive/Health screening examination	Covered at 100%; you pay $0.	Not covered
Pediatric immunizations	Covered at 100%; you pay $0.	You pay 40%. Deductible does not apply.
Pediatric dental and vision services	Pediatric Dental and Vision Services are covered in compliance with requirements under the Affordable Care Act (ACA). Find eligibility and benefit details in your Summary of Benefits and Coverage (SBC) and Dental and Vision Essential Health Benefits Rider at *My*Health OnLine or call Member Services.	
Adult Care and Immunizations		
Preventive/Health screening examination	Covered at 100%; you pay $0.	Not covered
Adult immunizations required by the ACA to be covered at no cost sharing	Covered at 100%; you pay $0.	You pay 40% after Deductible.
Women's Care		
Routine gynecological exam, including a Pap test	Covered at 100%; you pay $0.	You pay 40% after Deductible.
Mammograms, annual routine and medically necessary	Covered at 100%; you pay $0.	You pay 40% after Deductible.
Covered Services	**Participating Provider**	**Non-Participating Provider**
Hospital Services		
Inpatient	You pay 20% after Deductible.	You pay 40% after Deductible.
Outpatient/Ambulatory surgery	You pay 20% after Deductible.	You pay 40% after Deductible.
Maternity	You pay 20% after Deductible.	You pay 40% after Deductible.
Emergency department	You pay $125 Copayment per visit.	
	Copayment waived if you are admitted to hospital.	
Emergency transportation	You pay 20% after Deductible	
Urgent care facility	You pay $40 Copayment per visit.	You pay 40% after Deductible.
Provider Medical Services		
Primary care provider office visit	You pay $20 Copayment per visit.	You pay 40% after Deductible.
Specialist office visit	You pay $40 Copayment per visit.	You pay 40% after Deductible.
Convenience care visit	You pay $20 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Level 1 (e.g., non-specialist)	You pay $10 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Level 2 (e.g., specialist)	You pay $40 Copayment per visit.	You pay 40% after Deductible.
Allergy Services		
Treatment, injections, and serum	You pay 20% after Deductible.	You pay 40% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Diagnostic Services		
Advanced imaging (e.g., PET, MRI, etc.)	You pay 20% after Deductible.	You pay 40% after Deductible.
Other imaging (e.g., x-ray, sonogram, etc.)	You pay 20% after Deductible.	You pay 40% after Deductible.
Lab	You pay 20% after Deductible.	You pay 40% after Deductible.
Diagnostic testing	You pay 20% after Deductible.	You pay 40% after Deductible.
Rehabilitation and Habilitation Therapy Services		
Physical and occupational therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 60 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 30 visits per Benefit Period.	
Cardiac rehabilitation	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Pulmonary rehabilitation	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Mental Health and Substance Abuse Services | Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083		
Inpatient (e.g., detoxification, etc.)	You pay 20% after Deductible.	You pay 40% after Deductible.
Inpatient non-hospital residential services	You pay 20% after Deductible.	You pay 40% after Deductible.
Outpatient (e.g., rehabilitation, therapy, etc.)	You pay $35 Copayment per visit.	You pay 40% after Deductible.
Other Medical Services		
Dental services related to accidental injury	You pay 20% after Deductible.	You pay 40% after Deductible.
Durable medical equipment	You pay 20% after Deductible.	You pay 40% after Deductible.
Home health care	You pay 20% after Deductible.	You pay 40% after Deductible.
	Refer to the Policy for specific Benefit Limitations.	
Hospice care	You pay 20% after Deductible.	You pay 40% after Deductible.
Oral surgical services	You pay 20% after Deductible.	You pay 40% after Deductible.
	Refer to the Policy for specific Benefit Limitations.	
Private duty nursing	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 30 visits per Benefit Period. Refer to the Policy for specific Benefit Limitations.	
Skilled nursing facility	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 100 days per Benefit Period for Non-Participating Provider. Refer to the Policy for specific Benefit Limitations.	
Therapeutic manipulation	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 25 visits per Benefit Period. Refer to the Policy for specific Benefit Limitations.	

Prescription Drug Coverage
For additional information on your pharmacy benefits, please reference your Prescription Drug Schedule of Benefits.
The Advantage Choice pharmacy program will apply (mandatory generic). Not subject to Plan Deductible

Retail prescription drug • Prescriptions must be dispensed by a participating pharmacy • 31-day supply	You pay $15 Copayment for generic drugs. You pay $50 Copayment for preferred brand drugs. You pay $75 Copayment for non-preferred brand drugs. 90-day maximum retail supply available for three copayments.
Specialty prescription drug • Specialty medications are limited to a 31-day supply • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request)	You pay $75 Copayment for specialty drugs. 31-day maximum supply.
Mail-order prescription drug • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy	You pay $30 Copayment for generic drugs. You pay $100 Copayment for preferred brand drugs. You pay $150 Copayment for non-preferred brand drugs. 90-day maximum mail-order supply.
If the brand-name drug is dispensed instead of the generic equivalent, you must pay the copayment associated with the brand-name drug as well as the price difference between the brand-name drug and the generic drug.	

This is not your complete Schedule of Benefits. It is intended as an at-a-glance reference of the RMU Student Health Plan. A full schedule of benefits can be obtained by calling Member Services at 1-844-833-0520.

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