Benefit Plan Summaries

Options for groups with 2 to 50 employees

Effective January 1, 2014

UPMC Health Plan

The Impact of the Affordable Care Act (ACA)

Note: To remain in compliance with the Affordable Care Act (ACA), UPMC Health Plan has updated its plan offerings for groups with 2 to 50 employees. Read further to understand the impact on our standard product portfolio for the small market.

Actuarial Value

The ACA requires that all small market products meet specific Actuarial Values, which are defined as the percentage of medical expenses paid by the insurer. The ACA uses metal levels of Platinum, Gold, Silver, and Bronze to correspond with Actuarial Values of 90%, 80%, 70%, and 60% respectively. Issuers must offer plans within +/- 2% of these ranges.

Community Rating

Under community rating, premiums may only vary based upon the following four factors:

1. Rating area — On March 25, 2013, the federal government approved Pennsylvania's proposal to use nine rating regions in the state. A list of these regions by county is available from the Centers for Medicare and Medicaid Services (CMS).

2. Single vs. family coverage — Premiums for family coverage will be based on premiums for each individual in a family. Under this approach, we will add the individual rate for each family member to arrive at a family premium. However, only the three oldest covered children under age 21 will be counted.

3. Tobacco use — Premiums charged for tobacco users may be up to 1.5 times higher than premiums charged for non-tobacco users.

4. Age — Premiums based on age will work like this:

   a. Adults (ages 21-63) may have different premiums based on age. But the difference may not be more than three-to-one. That is, the premium charged to the oldest adult may not be more than three times higher than the premium charged to the youngest adult (age 21 or older).

   b. For children ages 0 to 20 years, the age-adjusted premiums must be the same for all individuals.

   c. For adults 64 years of age or older, age-adjusted premiums must be the same for all individuals.

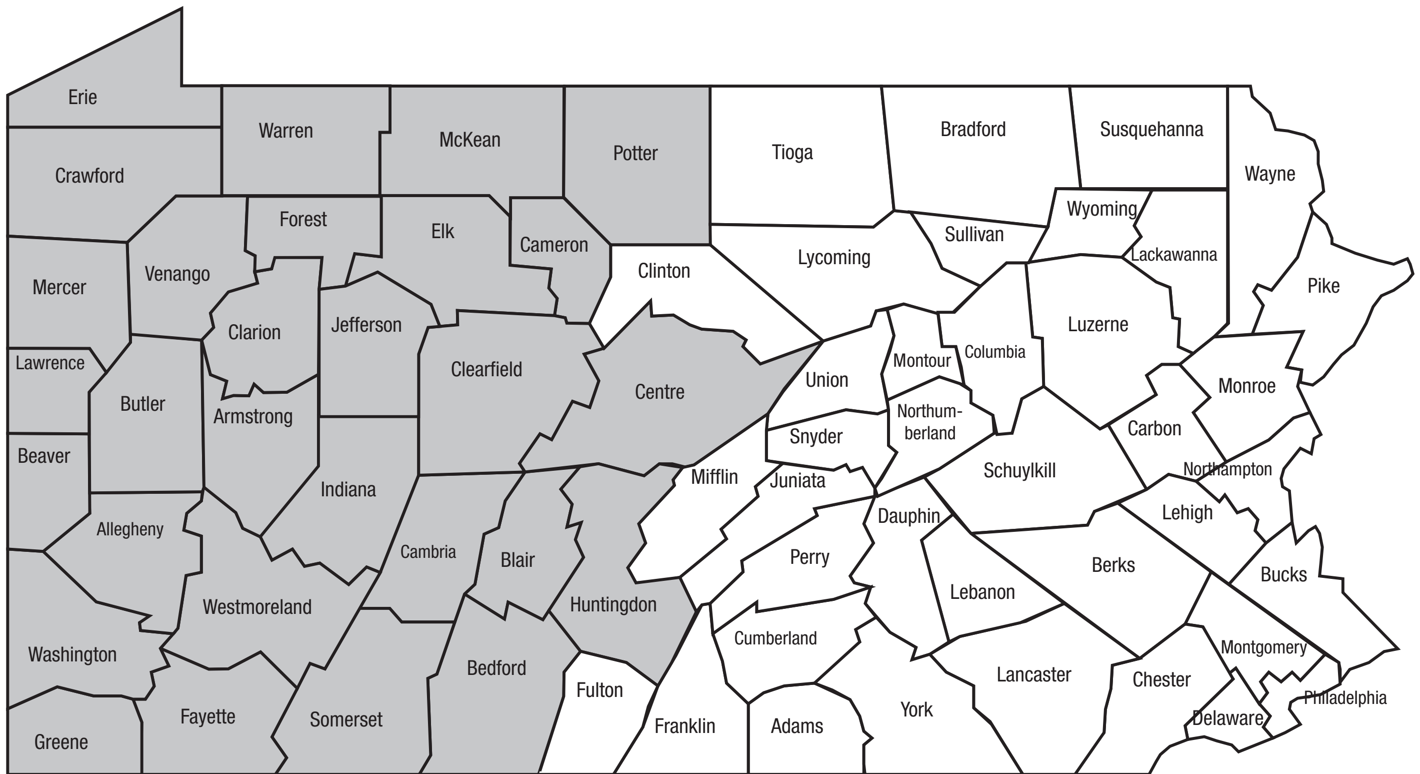
Essential Health Benefits (EHBs)

EHBs are a specific set of health benefits, items, and services that must be covered by health plans in the individual and small group markets beginning in 2014. These benefits include, among other things, pediatric dental and vision services. All Qualified Health Plans, like UPMC Health Plan, must offer and/or include pediatric dental and vision coverage for dependents in small employer groups (companies that have 2 to 50 employees).

Our pediatric dental and vision services will be administered by UPMC Dental *Advantage* and UPMC Vision *Advantage*. UPMC Health Plan has embedded these benefits into its medical plans, which makes it easy for employers to administer and comply with ACA mandates. Please refer to the Schedules of Benefits, which define the coverage for dependents.

Please note that if a dependent turns 19 years of age during a plan year, that dependent will continue to have Essential Health Benefits coverage until the next renewal period.

2014 UPMC HEALTH PLAN SERVICE AREA



2014 UPMC Health Plan Commercial Service Area

UPMC Small Business *Advantage*

UPMC Small Business *Advantage* includes plans that use our EPO, HMO, and PPO networks. All plans cover preventive care at 100 percent.

Plan Type	Unique Features
Enhanced	• Members must receive care from network physicians and facilities in order to receive coverage (except in the case of emergency services). • Members do not need referrals to see specialists. • These plans use an Exclusive Provider Organization (EPO) network.
Essential	• These plans include all the features of the Enhanced plans, but they also allow the member to visit his or her PCP three times in one plan year before the deductible applies. • These plans use an Exclusive Provider Organization (EPO) network.
Standard	• Members must select a PCP; the PCP helps members coordinate their care. • Members need referrals to see specialists. • Many services, such as prescription drugs, PCP and specialist visits, and emergency care, are not subject to the deductible. • Members must receive care from network physicians and facilities (except in the case of emergency services). • These plans use a Health Maintenance Organization (HMO) network.
Standard LoCap	• These plans include all the features of the Standard plans, plus they carry a lower out-of-pocket maximum. • These plans use a Health Maintenance Organization (HMO) network.
Premium	• Members can go out of the network for care. Care that members receive inside the network is at a lower out-of-pocket expense to them. • Members do not need referrals to see specialists. • These plans use a Preferred Provider Organization (PPO) network.
Premium LoCap	• These plans include all the features of the Premium plans, plus they carry a lower out-of-pocket maximum. • These plans use a Preferred Provider Organization (PPO) network.

UPMC *Consumer Advantage* for Small Business

UPMC *Consumer Advantage* is a consumer-directed health plan that offers both health savings accounts (HSAs) and health reimbursement arrangements (HRAs). HSAs and HRAs feature lower premiums than other traditional health plans and an earmarked fund for health care expenses. All plans also include these benefits:

- All in- and out-of-network coverage counts toward the deductible.
- Preventive care is covered at 100 percent and is not subject to the deductible.
- Out-of-pocket maximums are lower for in-network care.

Plan Type	Unique Features
Reserve HRA	• Members can use HRA funds to pay deductible and other out-of-pocket expenses associated with UPMC Health Plan only. • These plans do not offer an integrated HRA. The employer must select a third party vendor to administer the account. • The employer owns the funds and keeps them if the employee leaves the company.
Reserve HRA Plus	• These plans carry the same features as the Reserve HRA plans, but they also offer an integrated HRA administered by UPMC Health Plan. • The HRA funding is a standard allocation built into the plan design, and the employer funds it separately.
Savings Rx HSA	• Members can use HSA funds to pay the deductible, other out-of-pocket expenses, and a broader list of health care purchases. • The member and/or the employer can fund the HSA. • The HSA is portable, meaning that the member always owns the account and can keep the funds even if he or she leaves the company.
Savings Rx HSA Plus	• These plans carry the same features as the Savings Rx HSA plans, but they offer an integrated HSA. • UPMC Health Plan partners with BenefitWallet™ for HSA administration. • Integration with the HSA vendor allows members to access their savings account information via *My*Health OnLine. Members can see account balances and access the BenefitWallet website to pay their medical bills.

UPMC *HealthyU* for Small Business

UPMC *HealthyU* is a consumer-directed health plan that features a health incentive account (HIA), which can also be combined with an HRA or HSA. The HIA is administered by UPMC Health Plan and funded by the member's premium. Members earn reward dollars in the HIA when they complete healthy activities — they can earn up to $500 for an individual or $1,000 for a family. Members can use HIA funds to pay out-of-pocket expenses such as deductibles, coinsurance, or pharmacy copayments. All plans also cover preventive care at 100 percent.

Plan Type	Unique Features
Rewards Rx	• Pharmacy costs are subject to the deductible. • These plans include only the HIA — not an HRA or HSA.
Rewards	• Pharmacy costs are not subject to the deductible. • These plans include only the HIA — not an HRA or HSA.
Rewards Rx HRA	• Pharmacy costs are subject to the deductible. • These plans include an HRA in addition to the HIA. The HRA is administered by UPMC Health Plan. Members can use HRAs to pay deductible and other out-of-pocket expenses associated with UPMC Health Plan only.
Rewards HRA	• Pharmacy costs are not subject to the deductible. • These plans include an HRA in addition to the HIA. The HRA is administered by UPMC Health Plan. Members can use HRAs to pay deductible and other out-of-pocket expenses associated with UPMC Health Plan only.
Rewards Rx HSA	• Pharmacy costs are subject to the deductible. • The plans include a health savings account (HSA) in addition to the HIA. Members can use HSA funds to pay the deductible, other out-of-pocket expenses, and a broader list of health care purchases. • The member and/or the employer can fund the HSA. • The HSA is portable, meaning that the member always owns the account and can keep the funds even if he or she leaves the company. • UPMC Health Plan partners with BenefitWallet™ for HSA administration.

UPMC *Inside Advantage* for Small Business

UPMC *Inside Advantage* is a tiered network plan that provides members with the same type of coverage as other UPMC Health Plan offerings — but at a lower premium and with lower out-of-pocket costs when they receive care at select facilities. All plans include these benefits:

- Members receive the highest level of benefits and lowest out-of-pocket costs when they seek care at UPMC Hamot, Warren General Hospital, Kane Community Hospital, UPMC Horizon, UPMC Northwest, and all other UPMC-owned facilities.
- Preventive care is covered at 100 percent.

Available in these counties: Clarion, Crawford, Elk, Erie, Forest, McKean, Mercer, Potter, Venango, and Warren.

UPMC Small Business *Advantage*

Enhanced

													Out-of-Network		
Plan Name	Deductible $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Cost Share After Deductible	Specialist Office Visit Cost Share After Deductible	Emergency Department Cost Share After Deductible	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Deductible $ (Individual/Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Enhanced Bronze $3,500	3,500/ 7,000	EPO	6,350/ 12,700	70%	30%	30%	30%	30%	30%	30%	$8/$38/ $76/$95	N/A	N/A	N/A	N/A
Enhanced Bronze $4,500	4,500/ 9,000	EPO	6,350/ 12,700	80%	20%	20%	20%	20%	20%	20%	$8/$38/ $76/$95	N/A	N/A	N/A	N/A
Enhanced Bronze $5,500	5,500/ 11,000	EPO	6,350/ 12,700	100%	0%	0%	0%	0%	0%	0%	$8/$38/ $76/$95	N/A	N/A	N/A	N/A
Enhanced Silver $1,500	1,500/ 3,000	EPO	6,350/ 12,700	80%	20%	20%	20%	20%	20%	20%	$15/$45/ $90/50%	$8/$38/ $76/$95	N/A	N/A	N/A

Essential

													Out-of-Network		
Plan Name	Deductible $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Cost Share	Specialist Office Visit Cost Share	Emergency Department Copayment	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Deductible $ (Individual/Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Essential Gold $1,250	1,250/ 2,500	EPO	3,500/ 7,000	100%	$25 for first 3 visits, then covered at 100% after deductible	0%	$100 copayment (waived if admitted)	0%	0%	0%	$8/$38/ $76/$95	N/A	N/A	N/A	N/A

This document is meant to assist in comparing benefit plans. It is not a contract. If differences exist between this summary and a group's contract or a member's Certificate of Coverage, the contract or Certificate of Coverage prevails.

Standard

Plan Name	Deductible $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Copayment	Specialist Office Visit Copayment	Emergency Department Copayment	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Out-of-Network Deductible $ (Individual/Family)	Out-of-Network Out-of-Pocket Maximum $ (Individual/Family)	Out-of-Network Coinsurance
Standard Gold $1,000	1,000/ 2,000	HMO	3,000/ 6,000	100%	$10	$25	$175 (waived if admitted)	0%	0%	0%	$15/$45/ $90/50%	N/A	N/A	N/A	N/A
Standard Gold $1,500	1,500/ 3,000	HMO	3,250/ 6,500	100%	$15	$30	$175 (waived if admitted)	0%	0%	0%	$8/$38/ $76/$95	$15/$30/ $50/$100	N/A	N/A	N/A

Standard LoCap

Plan Name	Deductible $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Copayment	Specialist Office Visit Copayment	Emergency Department Copayment	Advanced Imaging (PET, MRI, etc.) Copayment	Other Imaging (x-ray, sonogram, etc.) Copayment	Lab and Other Services Copayment	Rx Option #1	Rx Option #2	Out-of-Network Deductible $ (Individual/Family)	Out-of-Network Out-of-Pocket Maximum $ (Individual/Family)	Out-of-Network Coinsurance
Standard Platinum LoCap $750	0	HMO	750/1,500	100%	$5	$35	$175 (waived if admitted)	$150	$35	$35	$8/$45/ $90/50%	$8/$38/ $76/$95	N/A	N/A	N/A
Standard Platinum LoCap $1,500	0	HMO	1,500/3,000	100%	$20	$40	$175 (waived if admitted)	$150	$35	$35	$15/$30/ $50/$100	$8/$38/ $76/$95	N/A	N/A	N/A

Premium

													Out-of-Network		
Plan Name	Deductible $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Copayment	Specialist Office Visit Copayment	Emergency Department Copayment	Advanced Imaging (PET, MRI, etc.) Cost Share	Other Imaging (x-ray, sonogram, etc.) Copayment	Lab and Other Services Copayment	Rx Option #1	Rx Option #2	Deductible $ (Individual/Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Premium Silver $3,000	3,000/ 6,000	PPO	6,350/ 12,700	80%	$20	$40	$150 (waived if admitted)	20% after deductible	$40	$40	$15/$30/ $50/$95	$8/$38/ $76/$95	4,000/ 8,000	10,000/ 20,000	40%
Premium Silver $3,250	3,250/ 6,500	PPO	6,350/ 12,700	80%	$25	$50	$150 (waived if admitted)	20% after deductible	$30	$30	$15/$30/ $50/$95	$8/$38/ $76/$95	6,500/ 13,000	10,000/ 20,000	40%
Premium Silver $3,500	3,500/ 7,000	PPO	6,350/ 12,700	70%	$10	$40	$150 (waived if admitted)	30% after deductible	$40	$40	$15/$30/ $50/$95	$8/$38/ $76/$95	4,000/ 8,000	10,000/ 20,000	40%
Premium Gold $1,000	1,000/ 2,000	PPO	4,000/ 8,000	100%	$20	$40	$150 (waived if admitted)	$0	$20	$20	$15/$30/ $50/$95	$8/$38/ $76/$95	2,000/ 4,000	10,000/ 20,000	40%
Premium Gold $1,250	1,250/ 2,500	PPO	5,000/ 10,000	100%	$10	$40	$150 (waived if admitted)	$0	$0	$0	$8/$38/ $76/$95	$15/$30/ $50/$95	2,500/ 5,000	10,000/ 20,000	40%
Premium Gold $1,500/$10	1,500/ 3,000	PPO	4,500/ 9,000	100%	$10	$40	$150 (waived if admitted)	$0	$10	$10	$8/$38/ $76/$95	$15/$30/ $50/$95	3,000/ 6,000	10,000/ 20,000	40%
Premium Gold $1,500/$20	1,500/ 3,000	PPO	4,000/ 8,000	100%	$20	$40	$150 (waived if admitted)	$0	$0	$0	$8/$38/ $76/$95	$15/$30/ $50/$95	3,000/ 6,000	10,000/ 20,000	40%
Premium Gold $2,000/$10	2,000/ 4,000	PPO	4,000/ 8,000	100%	$10	$40	$150 (waived if admitted)	$0	$10	$10	$8/$38/ $76/$95	$15/$30/ $50/$95	4,000/ 8,000	10,000/ 20,000	40%
Premium Gold $2,000/$20	2,000/ 4,000	PPO	3,750/ 7,500	100%	$20	$40	$100 (waived if admitted)	$0	$40	$40	$8/$38/ $76/$95	$15/$30/ $50/$95	4,000/ 8,000	10,000/ 20,000	40%
Premium Platinum $25	0	PPO	1,000/ 2,000	100%	$10	$25	$100 (waived if admitted)	$150	$10	$10	$8/$38/ $76/$95	N/A	1,000/ 2,000	10,000/ 20,000	40%
Premium Platinum $250 $10/$25	250/ 500	PPO	1,250/ 2,500	100%	$10	$25	$100 (waived if admitted)	$150	$10	$10	$8/$38/ $76/$95	$15/$30/ $50/$95	1,000/ 2,000	10,000/ 20,000	40%
Premium Platinum $250 $20/$40	250/ 500	PPO	1,000/ 2,000	100%	$20	$40	$100 (waived if admitted)	$150	$15	$15	$8/$38/ $76/$95	$15/$30/ $50/$95	1,000/ 2,000	10,000/ 20,000	40%
Premium Platinum $750 $10/$25	750/ 1,500	PPO	1,250/ 2,500	100%	$10	$25	$100 (waived if admitted)	$150	$10	$10	$15/$30/ $50/$95	$8/$38/ $76/$95	1,500/ 3,000	10,000/ 20,000	40%
Premium Platinum $750 $15/$30	750/ 1,500	PPO	1,000/ 2,000	100%	$15	$30	$100 (waived if admitted)	$150	$15	$15	$8/$38/ $76/$95	$15/$30/ $50/$95	1,500/ 3,000	10,000/ 20,000	40%
Premium Platinum $750 $10/$40	750/ 1,500	PPO	1,250/ 2,500	100%	$10	$40	$100 (waived if admitted)	$150	$10	$10	$15/$30/ $50/$95	$8/$38/ $76/$95	1,500/ 3,000	10,000/ 20,000	40%

Premium LoCap

													Out-of-Network		
Plan Name	Deductible $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Copayment	Specialist Office Visit Copayment	Emergency Department Copayment	Advanced Imaging (PET, MRI, etc.) Copayment	Other Imaging (x-ray, sonogram, etc.) Copayment	Lab and Other Services Copayment	Rx Option #1	Rx Option #2	Deductible $ (Individual/Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Premium Platinum LoCap $10/$25	0	PPO	1,250/ 5,000	100%	$10	$25	$100 (waived if admitted)	$150	$10	$10	$15/$30/ $50/$95	$8/$38/ $76/$95	1,000/ 2,000	10,000/ 20,000	40%
Premium Platinum LoCap $15/$30	0	PPO	1,250/ 5,000	100%	$15	$30	$100 (waived if admitted)	$150	$15	$15	$8/$38/ $76/$95	$15/$30/ $50/$95	1,000/ 2,000	10,000/ 20,000	40%

UPMC *HealthyU* for Small Business

Rewards Rx HRA

Plan Name	Deductible $ (Individual/Family)	Employer HRA Contribution $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Cost Share After Deductible	Specialist Office Visit Cost Share After Deductible	Emergency Department Cost Share After Deductible	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Out-of-Network Deductible $ (Individual/Family)	Out-of-Network Out-of-Pocket Maximum $ (Individual/Family)	Out-of-Network Coinsurance
Rewards Rx HRA Silver $2,250	2,250/ 4,500	125/ 250	PPO	6,350/ 12,700	85%	15%	15%	15%	15%	15%	15%	$8/$38/ $76/$95 after deductible	N/A	4,500/ 9,000	10,000/ 20,000	40%
Rewards Rx HRA Gold $1,500	1,500/ 3,000	125/ 250	PPO	2,500/ 5,000	90%	10%	10%	10%	10%	10%	10%	$8/$38/ $76/$95 after deductible	N/A	3,000/ 6,000	10,000/ 20,000	40%
Rewards Rx HRA Platinum $750	750/ 1,500	125/ 250	PPO	1,200/ 2,400	90%	10%	10%	10%	10%	10%	10%	$8/$38/ $76/$95 after deductible	N/A	1,500/ 3,000	10,000/ 20,000	40%

Rewards HRA

Plan Name	Deductible $ (Individual/Family)	Employer HRA Contribution $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Cost Share After Deductible	Specialist Office Visit Cost Share After Deductible	Emergency Department Cost Share After Deductible	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Out-of-Network Deductible $ (Individual/Family)	Out-of-Network Out-of-Pocket Maximum $ (Individual/Family)	Out-of-Network Coinsurance
Rewards HRA Gold $1,500	1,500/ 3,000	125/ 250	PPO	3,000/ 6,000	90%	10%	10%	10%	10%	10%	10%	$15/$35/ $50/$50	N/A	3,000/ 6,000	10,000/ 20,000	40%
Rewards HRA Platinum $750	750/ 1,500	125/ 250	PPO	1,200/ 2,400	90%	10%	10%	10%	10%	10%	10%	$15/$35/ $50/$50	N/A	1,500/ 3,000	10,000/ 20,000	40%

Rewards Rx HSA

														Out-of-Network		
Plan Name	Deductible $ (Individual/Family)	Employer HSA Contribution $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Cost Share After Deductible	Specialist Office Visit Cost Share After Deductible	Emergency Department Cost Share After Deductible	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Deductible $ (Individual/Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Rewards Rx HSA Silver $2,250	2,250/ 4,500	125/ 250	PPO	6,350/ 12,700	85%	15%	15%	15%	15%	15%	15%	$8/$38/ $76/$76 after deductible	$15/$35/ $50/$50 after deductible	4,500/ 9,000	10,000/ 20,000	40%
Rewards Rx HSA Gold $1,500	1,500/ 3,000	125/ 250	PPO	2,500/ 5,000	90%	10%	10%	10%	10%	10%	10%	$8/$38/ $76/$76 after deductible	$15/$35/ $50/$50 after deductible	3,000/ 6,000	10,000/ 20,000	40%
Rewards Rx HSA Platinum $1,250	1,250/ 2,500	500/ 1,000	PPO	2,000/ 4,000	90%	10%	10%	10%	10%	10%	10%	$8/$38/ $76/$76 after deductible	$15/$35/ $50/$50 after deductible	2,500/ 5,000	10,000/ 20,000	40%

Rewards Rx

													Out-of-Network		
Plan Name	Deductible $ (Individual/ Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Cost Share After Deductible	Specialist Office Visit Cost Share After Deductible	Emergency Department Cost Share After Deductible	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Deductible $ (Individual/ Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Rewards Rx Gold $1,250	1,250/ 2,500	PPO	2,250/ 4,500	90%	10%	10%	10%	10%	10%	10%	$8/$38/ $76/$95 after deductible	N/A	2,500/ 5,000	10,000/ 20,000	40%
Rewards Rx Platinum $750	750/ 1,500	PPO	1,200/ 2,400	90%	10%	10%	10%	10%	10%	10%	$8/$38/ $76/$95 after deductible	N/A	1,500/ 3,000	10,000/ 20,000	40%

Rewards

													Out-of-Network		
Plan Name	Deductible $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Cost Share After Deductible	Specialist Office Visit Cost Share After Deductible	Emergency Department Cost Share After Deductible	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Deductible $ (Individual/Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Rewards Silver $2,000	2,000/ 4,000	PPO	6,350/ 12,700	75%	25%	25%	25%	25%	25%	25%	$15/$35/ $50/$50	N/A	4,000/ 8,000	10,000/ 20,000	40%
Rewards Platinum $750	750/ 1,500	PPO	1,200/ 2,400	90%	10%	10%	10%	10%	10%	10%	$15/$35/ $50/$50	N/A	1,500/ 3,000	10,000/ 20,000	40%

UPMC *Consumer Advantage* for Small Business

Reserve HRA

													Out-of-Network		
Plan Name	Deductible $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Copayment	Specialist Office Visit Copayment	Emergency Department Copayment	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Copayment	Lab and Other Services Copayment	Rx Option #1	Rx Option #2	Deductible $ (Individual/Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Reserve HRA Gold $1,250	1,250/ 2,500	PPO	3,500/ 7,000	100%	$20	$40	$150 (waived if admitted)	0%	$40	$40	$5/$20/ $50/$50	$8/$38/ $76/$95	2,500/ 5,000	10,000/ 20,000	40%
Reserve HRA Gold $2,000	2,000/ 4,000	PPO	3,000/ 6,000	100%	$20	$40	$150 (waived if admitted)	0%	$40	$40	$5/$20/ $50/$50	$8/$38/ $76/$95	4,000/ 8,000	10,000/ 20,000	40%

Reserve HRA Plus

														Out-of-Network		
Plan Name	Deductible $ (Individual/Family)	Employer HRA Contribution $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Copayment	Specialist Office Visit Copayment	Emergency Department Copayment	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Copayment	Lab and Other Services Copayment	Rx Option #1	Rx Option #2	Deductible $ (Individual/Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Reserve HRA Plus Platinum $1,250	1,250/ 2,500	700/ 1,400	PPO	3,500/ 7,000	100%	$20	$40	$150 (waived if admitted)	0%	$40	$40	$5/$20/ $50/$50	$8/$38/ $76/$95	2,250/ 4,500	10,000/ 20,000	40%
Reserve HRA Plus Platinum $2,000	2,000/ 4,000	1,000/ 2,000	PPO	3,000/ 6,000	100%	$20	$40	$150 (waived if admitted)	0%	$40	$40	$8/$38/ $76/$95	$5/$20/ $50/$50	4,000/ 8,000	10,000/ 20,000	40%

Savings Rx HSA

													Out-of-Network		
Plan Name	Deductible $ (Individual/ Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Cost Share After Deductible	Specialist Office Visit Cost Share After Deductible	Emergency Department Cost Share After Deductible	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Deductible $ (Individual/ Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Savings Rx HSA Silver $2,000	2,000/ 4,000	PPO	6,000/ 12,000	100%	0%	0%	0%	0%	0%	0%	$8/$38/ $76/$95 (subject to deductible)	$15/$30/ $50/$50 (subject to deductible)	2,250/ 4,500	10,000/ 20,000	40%
Savings Rx HSA Gold $1,250	1,250/ 2,500	PPO	2,500/ 5,000	100%	0%	0%	0%	0%	0%	0%	$8/$38/ $76/$95 (subject to deductible)	$15/$30/ $50/$50 (subject to deductible)	2,250/ 4,500	10,000/ 20,000	40%

Savings Rx HSA Plus

														Out-of-Network		
Plan Name	Deductible $ (Individual/Family)	Employer HSA Contribution $ (Individual/Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Cost Share After Deductible	Specialist Office Visit Cost Share After Deductible	Emergency Department Cost Share After Deductible	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Cost Share After Deductible	Lab and Other Services Cost Share After Deductible	Rx Option #1	Rx Option #2	Deductible $ (Individual/Family)	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance
Savings Rx HSA Plus Gold $2,000	2,000/ 4,000	625/ 1,250	PPO	6,000/ 12,000	100%	0%	0%	0%	0%	0%	0%	$8/$38/ $76/$95 (subject to deductible)	$15/$30/ $50/$50 (subject to deductible)	2,250/ 4,500	10,000/ 20,000	40%
Savings Rx HSA Plus Platinum $1,250	1,250/ 2,500	500/ 1,000	PPO	2,500/ 5,000	100%	0%	0%	0%	0%	0%	0%	$8/$38/ $76/$95 (subject to deductible)	$15/$30/ $50/$50 (subject to deductible)	2,250/ 4,500	10,000/ 20,000	40%

UPMC *Inside Advantage* for Small Business

Plan Name	Deductible $ (Individual/ Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Copayment	Specialist Office Visit Copayment	Emergency Department Copayment	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Copayment	Lab and Other Services Copayment	Rx Option #1	Rx Option #2
Premium Silver $5,000 UPMC Network Level 1	5,000/ 10,000	PPO	6,350/ 12,700	100%	$20	$40	$100 (waived if admitted)	0%	$30	$30	$8/$38/ $76/$95	$15/$30/ $50/$95
Premium Silver $5,000 UPMC Network Level 2	6,350/ 12,700	PPO	6,350/ 12,700	20%	$20	$40	$100 (waived if admitted)	20%	20%	20%	$8/$38/ $76/$95	$15/$30/ $50/$95
Premium Silver $5,000 Non-Participating Provider Level 3	6,350/ 12,700	PPO	10,000/ 20,000	40%	40%	40%	$100 (waived if admitted)	40%	40%	40%	N/A	N/A
Premium Gold $1,500 UPMC Network Level 1	1,500/ 3,000	PPO	3,000/ 6,000	100%	$20	$40	$100 (waived if admitted)	0%	$30	$30	$15/$30/ $50/$95	$8/$38/ $76/$95
Premium Gold $1,500 UPMC Network Level 2	3,000/ 6,000	PPO	6,000/ 12,000	20%	$20	$40	$100 (waived if admitted)	20%	20%	20%	$15/$30/ $50/$95	$8/$38/ $76/$95
Premium Gold $1,500 Non-Participating Provider Level 3	6,000/ 12,000	PPO	10,000/ 20,000	40%	40%	40%	$100 (waived if admitted)	40%	40%	40%	N/A	N/A
Premium Gold $2,000 UPMC Network Level 1	2,000/ 4,000	PPO	3,000/ 6,000	100%	$20	$40	$100 (waived if admitted)	0%	$30	$30	$8/$38/ $76/$95	$15/$30/ $50/$95
Premium Gold $2,000 UPMC Network Level 2	$4,000/ $8,000	PPO	$5,000/ $10,000	20%	$20	$40	$100 (waived if admitted)	20%	20%	20%	$8/$38/ $76/$95	$15/$30/ $50/$95
Premium Gold $2,000 Non-Participating Provider Level 3	6,000/ 12,000	PPO	10,000/ 20,000	40%	40%	40%	$100 (waived if admitted)	40%	40%	40%	N/A	N/A
Premium Platinum $250 UPMC Network Level 1	250/ 500	PPO	1,000/ 2,000	100%	$20	$40	$100 (waived if admitted)	0%	$30	$30	$15/$30/ $50/$95	$8/$38/ $76/$95
Premium Platinum $250 UPMC Network Level 2	1,000/ 2,000	PPO	2,000/ 4,000	20%	$20	$40	$100 (waived if admitted)	20%	20%	20%	$15/$30/ $50/$95	$8/$38/ $76/$95
Premium Platinum $250 Non-Participating Provider Level 3	6,000/ 12,000	PPO	10,000/ 20,000	40%	40%	40%	$100 (waived if admitted)	40%	40%	40%	N/A	N/A

(Continued on next page)

UPMC *Inside Advantage* for Small Business (Continued)

Plan Name	Deductible $ (Individual/ Family)	Plan Type	Out-of-Pocket Maximum $ (Individual/Family)	Coinsurance	Provider Office Visit Copayment	Specialist Office Visit Copayment	Emergency Department Copayment	Advanced Imaging (PET, MRI, etc.) Cost Share After Deductible	Other Imaging (x-ray, sonogram, etc.) Copayment	Lab and Other Services Copayment	Rx Option #1	Rx Option #2
Premium Platinum $500 UPMC Network Level 1	500/ 1,000	PPO	1,000/ 2,000	100%	$20	$40	$100 (waived if admitted)	0%	$30	$30	$8/$38/ $76/$95	$15/$30/ $50/$95
Premium Platinum $500 UPMC Network Level 2	1,000/ 2,000	PPO	2,000/ 4,000	20%	$20	$40	$100 (waived if admitted)	20%	20%	20%	$8/$38/ $76/$95	$15/$30/ $50/$95
Premium Platinum $500 Non-Participating Provider Level 3	6,000/ 12,000	PPO	10,000/ 20,000	40%	40%	40%	$100 (waived if admitted)	40%	40%	40%	N/A	N/A
Premium Platinum $1,250 UPMC Network Level 1	1,250/ 2,500	PPO	1,250/ 2,500	100%	$20	$40	$100 (waived if admitted)	0%	$30	$30	$8/$38/ $76/$95	$15/$30/ $50/$95
Premium Platinum $1,250 UPMC Network Level 2	2,500/ 5,000	PPO	5,000/ 10,000	20%	$20	$40	$100 (waived if admitted)	20%	20%	20%	$8/$38/ $76/$95	$15/$30/ $50/$95
Premium Platinum $1,250 Non-Participating Provider Level 3	6,000/ 12,000	PPO	10,000/ 20,000	40%	40%	40%	$100 (waived if admitted)	40%	40%	40%	N/A	N/A

UPMC Vision *Advantage*

UPMC Vision *Advantage* offers three plan models — Basic, Standard, and Premium — and a network of credentialed vision providers, within the regions where UPMC Vision *Advantage* is offered. There are many reasons to choose UPMC Vision *Advantage*, including:

- By calling one number, members receive outstanding customer service from the UPMC Health Plan Health Care Concierge team. The team is able to answer questions about vision benefits, as well as medical, dental through UPMC Dental *Advantage*, and *MyFlex Advantage* benefits, if applicable.
- Members can chat online with a Health Care Concierge regarding vision benefits, eligibility, and claim status.
- Members have access to vision benefits and information through *My*Health OnLine. If members are enrolled in our other products, UPMC Dental *Advantage* or *MyFlex Advantage*, for example, or any of our medical plans, they will be able to access information on those products as well.
- Members' eligibility for vision services will be auto-substantiated when they use their *MyFlex Advantage* card, if applicable.
- Members receive a 20% discount on exams, frames, and lenses for glasses purchased through a participating UPMC Vision *Advantage* provider prior to their next eligibility period. **Discount does not apply to contact lenses.**
- UPMC Vision *Advantage* members are also eligible for discounts on LASIK procedures at the following locations: UPMC Eye Center, QualSight, and TLC Vision.

In addition, UPMC Health Plan offers a discount vision network through Small Business *Advantage*'s arrangement with OptiCare Managed Vision at no extra charge. Discounts are available on exams, eyeglass frames and/or lenses, contact lenses, and sunglasses. For more information, visit OptiCare's website at www.myvisionplan.com/upmc/discountvision/.

OptiCare discount program may not be used in conjunction with UPMC Vision *Advantage* benefits. The OptiCare discount may only be utilized once vision benefits have been exhausted.

For additional information, visit www.upmchealthplan.com.

Basic

Benefit	In-Network	Out-of-Network	Frequency	
			Employee/Spouse/ Adult Dependents	Children Through Age 18
Copayment (applies to vision exam)	$15	N/A		
Examination (less copayment)	100%	$30	24 months	24 months
Lenses (for glasses)				
Single Vision	20% Discount	Not Covered	Not Covered	Not Covered
Bifocal	20% Discount	Not Covered	Not Covered	Not Covered
Trifocal	20% Discount	Not Covered	Not Covered	Not Covered
Polycarbonate Lens Material	20% Discount	Not Covered	Not Covered	Not Covered
Frames				
	20% Discount	Not Covered	Not Covered	Not Covered
Contact Lenses (in lieu of glasses)				
Contact Lens Fitting and Follow-Up	Not Covered	Not Covered	Not Covered	Not Covered
Contact Lens Material	Not Covered	Not Covered	Not Covered	Not Covered

Standard

Benefit	In-Network	Out-of-Network	Frequency: Employee/Spouse/ Adult Dependents	Frequency: Children Through Age 18
Copayment (applies to vision exam)	$15	N/A		
Examination (less copayment)	100%	$40	24 months	12 months
Lenses (for glasses) Lens reimbursement percentage is based on the base cost of the lens and does not include overages or lens add-ons. Out-of-network amount reflects the total amount reimbursed for services.				
Single Vision	100%	$40	24 months	12 months
Bifocal	100%	$50	24 months	12 months
Trifocal	100%	$75	24 months	12 months
Polycarbonate Lens Material **Available in-network at no cost for children under age 19**	100%	Not Covered	Not Covered	Not Covered
UPMC Vision Advantage does cover progressive lenses at 100% of the base cost of the lens when treated by a participating provider. Any additional charges above the base cost are not covered and are to be billed to the member. Payment may vary based on the type of lens billed to the plan. Progressive lenses received from a non-participating provider are reimbursed at $75.				
Frames Frame reimbursement is based on retail value. The plan will reimburse the participating provider 70% of the member's maximum for frames. The remaining 30% is a contractual discount to the plan and cannot be billed to the member. Any remainder above the member's frame allowance is to be charged to the member, minus a 20% discount, and can be collected at the time of service when a participating provider is used.				
Frames	$60	$35	24 months	24 months
Contact Lenses (in lieu of glasses) Contact lens fitting and follow-up reimbursement is separate from contact lens material. For specialty contact lens evaluation, the provider may bill the patient the difference between the provider's billed charges and the plan/member allowance. Provider cannot balance bill for standard lens evaluation when received in-network. Contact lens material is reimbursed at 100% of billed charges up to the member's plan maximum when a participating provider is used.				
Contact Lens Fitting and Follow-Up	$50	$40	24 months	12 months
Contact Lens Material	$75	$60	24 months	12 months

Standard - No Copay

Benefit	In-Network	Out-of-Network	Frequency: Employee/Spouse/ Adult Dependents	Frequency: Children Through Age 18
Copayment	None	N/A		
Examination	100%	$40	24 months	12 months
Lenses (for glasses) Lens reimbursement percentage is based on the base cost of the lens and does not include overages or lens add-ons. Out-of-network amount reflects the total amount reimbursed for services.				
Single Vision	100%	$40	24 months	12 months
Bifocal	100%	$50	24 months	12 months
Trifocal	100%	$75	24 months	12 months
Polycarbonate Lens Material **Available in-network at no cost for children under age 19**	100%	Not Covered	Not Covered	Not Covered
UPMC Vision Advantage does cover progressive lenses at 100% of the base cost of the lens when treated by a participating provider. Any additional charges above the base cost are not covered and are to be billed to the member. Payment may vary based on the type of lens billed to the plan. Progressive lenses received from a non-participating provider are reimbursed at $75.				
Frames Frame reimbursement is based on retail value. The plan will reimburse the participating provider 70% of the member's maximum for frames. The remaining 30% is a contractual discount to the plan and cannot be billed to the member. Any remainder above the member's frame allowance is to be charged to the member, minus a 20% discount, and can be collected at the time of service when a participating provider is used.				
Frames	$60	$35	24 months	24 months
Contact Lenses (in lieu of glasses) Contact lens fitting and follow-up reimbursement is separate from contact lens material. For specialty contact lens evaluation, the provider may bill the patient the difference between the provider's billed charges and the plan/member allowance. Provider cannot balance bill for standard lens evaluation when received in-network. Contact lens material is reimbursed at 100% of billed charges up to the member's plan maximum when a participating provider is used.				
Contact Lens Fitting and Follow-Up	$50	$40	24 months	12 months
Contact Lens Material	$75	$60	24 months	12 months

Premium

Benefit	In-Network	Out-of-Network	Frequency: Employee/Spouse/ Adult Dependents	Frequency: Children Through Age 18
Copayment (applies to vision exam)	$15	N/A		
Examination (less copayment)	100%	$40	12 months	12 months
Lenses (for glasses) Lens reimbursement percentage is based on the base cost of the lens and does not include overages or lens add-ons. Out-of-network amount reflects the total amount reimbursed for services.				
Single Vision	100%	$40	12 months	12 months
Bifocal	100%	$50	12 months	12 months
Trifocal	100%	$75	12 months	12 months
Polycarbonate Lens Material **Available in-network at no cost for children under age 19**	100%	Not Covered	Not Covered	12 months
UPMC Vision Advantage does cover progressive lenses at 100% of the base cost of the lens when treated by a participating provider. Any additional charges above the base cost are not covered and are to be billed to the member. Payment may vary based on the type of lens billed to the plan. Progressive lenses received from a non-participating provider are reimbursed at $75.				
Frames Frame reimbursement is based on retail value. The plan will reimburse the participating provider 70% of the member's maximum for frames. The remaining 30% is a contractual discount to the plan and cannot be billed to the member. Any remainder above the member's frame allowance is to be charged to the member, minus a 20% discount, and can be collected at the time of service when a participating provider is used.				
Frames	$60	$35	24 months	24 months
Contact Lenses (in lieu of glasses) Contact lens fitting and follow-up reimbursement is separate from contact lens material. For specialty contact lens evaluation, the provider may bill the patient the difference between the provider's billed charges and the plan/member allowance. Provider cannot balance bill for standard lens evaluation when received in-network. Contact lens material is reimbursed at 100% of billed charges up to the member's plan maximum when a participating provider is used.				
Contact Lens Fitting and Follow-Up	$50	$40	12 months	12 months
Contact Lens Material	$100	$80	12 months	12 months

Premium - No Copay

Benefit	In-Network	Out-of-Network	Frequency: Employee/Spouse/ Adult Dependents	Frequency: Children Through Age 18
Copayment	None	N/A		
Examination	100%	$40	12 months	12 months
Lenses (for glasses) Lens reimbursement percentage is based on the base cost of the lens and does not include overages or lens add-ons. Out-of-network amount reflects the total amount reimbursed for services.				
Single Vision	100%	$40	12 months	12 months
Bifocal	100%	$50	12 months	12 months
Trifocal	100%	$75	12 months	12 months
Polycarbonate Lens Material **Available in-network at no cost for children under age 19**	100%	Not Covered	Not Covered	12 months
UPMC Vision Advantage does cover progressive lenses at 100% of the base cost of the lens when treated by a participating provider. Any additional charges above the base cost are not covered and are to be billed to the member. Payment may vary based on the type of lens billed to the plan. Progressive lenses received from a non-participating provider are reimbursed at $75.				
Frames Frame reimbursement is based on retail value. The plan will reimburse the participating provider 70% of the member's maximum for frames. The remaining 30% is a contractual discount to the plan and cannot be billed to the member. Any remainder above the member's frame allowance is to be charged to the member, minus a 20% discount, and can be collected at the time of service when a participating provider is used.				
Frames	$100	$55	12 months	12 months
Contact Lenses (in lieu of glasses) Contact lens fitting and follow-up reimbursement is separate from contact lens material. For specialty contact lens evaluation, the provider may bill the patient the difference between the provider's billed charges and the plan/member allowance. Provider cannot balance bill for standard lens evaluation when received in-network. Contact lens material is reimbursed at 100% of billed charges up to the member's plan maximum when a participating provider is used.				
Contact Lens Fitting and Follow-Up	$50	$40	12 months	12 months
Contact Lens Material	$100	$80	12 months	12 months

Out-of-network reimbursement is based on Usual, Customary, and Reasonable as determined by UPMC Vision *Advantage*.

Members are eligible for a 20% discount on additional examinations, frames, and lenses for glasses received from a participating provider prior to the next eligibility period.

20% discount does not apply to contact lenses.

Lens reimbursement is based on the base cost of the lens and does not include coverage for lens add-ons and/or treatments (such as coatings, tinting, polarization, photochromatics). These services are not covered by or to be billed to UPMC Vision *Advantage*. Participating providers are to discount these services by 20%. Note: This does not apply to the Basic Plan.

UPMC Vision *Advantage* participants are eligible for discounts on LASIK surgery when received by one of the following preferred providers: **UPMC Eye Center, TLC Vision, and QualSight.**

Essential Health Benefits Rider for Members Under Age 19

Benefit	In-Network[1]	Out-of-Network[2]	Frequency
Examination	100%	$35	12 months
Lenses (for glasses)			
Single Vision	100%	$25	12 months
Bifocal	100%	$35	12 months
Trifocal	100%	$50	12 months
Progressive	100%	$50	12 months
Lenticular	100%	$45	12 months
Polycarbonate Lens Material	100%	$20	12 months
Frames			
Frames	100%	$45	12 months
Contact Lenses (in lieu of glasses) if deemed medically necessary Contact lens fitting and follow-up reimbursement is separate from contact lens material.			
Contact Lens Fitting and Follow-up	100%	$35	12 months
Contact Lens Material	100%	$75	12 months

[1]In-network reimbursement is based on the percentage of provider reimbursement. The provider is not permitted to bill the member for the difference for any services unless otherwise stated. The provider may charge the member a copayment for optional lenses and treatments as described below.

[2]Out-of-network reimbursement is based on Usual, Customary, and Reasonable rates as determined by UPMC Vision *Advantage*.

Members are eligible for a 20% discount on additional examinations, frames, and lenses for glasses received from a participating provider prior to their next eligibility period. **The 20% discount does not apply to contact lenses.**

UPMC Vision Advantage members are eligible for discounts on LASIK surgery when it is received by one of the following preferred providers: UPMC Eye Center, TLC Vision, and QualSight.

The optional lenses and treatments are available for an additional copayment and may be billed by the provider. Please refer to the chart below for additional services.

Optional Lenses and Treatments	Copayment
Anti-Reflective Coating	$20
Blended Segment Lenses	$15
Hi-Index Lenses	$25
Intermediate Vision Lenses	$15
Photochromatic Glass Lenses	$25
Plastic Photosensitive Lenses (Transitions©)	$23
Polarized Lenses	$38
Premium Progressives (Varilux©, etc)	$90
Ultraviolet Protective Coating	$15

UPMC Dental *Advantage*

UPMC Health Plan has developed UPMC Dental *Advantage* to offer a single source for all your health insurance needs. UPMC Dental *Advantage* offers members three plan models — Basic, Standard, and Premium — with a network of credentialed dentists. The plan is designed to encourage regular preventive care and foster open communication between patients and dentists regarding recommended treatment plans.

- By calling one number, members receive outstanding customer service from the UPMC Health Plan Health Care Concierge team. The team is able to answer questions about dental benefits, as well as medical, vision through UPMC Vision *Advantage*, and MyFlex *Advantage* benefits, if applicable.
- UPMC Dental *Advantage* does not require prior authorization for major services.
- Enhanced benefits include: One additional cleaning for members who are pregnant, during the course of pregnancy; increased coverage for non-surgical periodontal treatment, including topical application of fluoride, for adults with a history of surgical periodontal treatment; and coverage for microbial test and brush biopsies.

For more information, visit www.upmchealthplan.com.

	Service Class			Deductible			Out-of-Network Coverage	Annual Maximum			Ortho Coverage	
	Class I	Class II	Class III	$0	$50	$75		$1,000	$1,500	$2,000	Yes	No
Basic												
Basic 100/0/0/$0	✓			✓			80/0/0					✓
Basic 100/0/0/$50	✓				✓		80/0/0					✓
Basic 100/0/0/$75	✓					✓	80/0/0					✓
Standard												
Standard 100/50/50/$0/ $1,500/No Ortho	✓	✓	✓	✓			80/40/20		✓			✓
Standard 100/50/50/$75/ $2,000/No Ortho	✓	✓	✓			✓	80/40/20			✓		✓
Premium												
Premium 100/80/50/$0/ $1,500/No Ortho	✓	✓	✓	✓			80/60/40		✓			✓
Premium 100/70/50/$0/ $1,000/No Ortho	✓	✓	✓	✓			80/40/20	✓				✓
Premium 100/70/50/$50/ $1,000/No Ortho	✓	✓	✓		✓		80/40/20	✓				✓
Premium 100/70/50/$0/ $1,500/No Ortho	✓	✓	✓	✓			80/40/20		✓			✓
Premium 100/70/50/$50/ $1,500/No Ortho	✓	✓	✓		✓		80/40/20		✓			✓

Essential Health Benefits Rider for Members Under Age 19

UPMC Dental *Advantage* will cover the services set forth below, which are related to the dental benefits provided in accordance with UPMC Dental *Advantage* policies and procedures. In the event that the terms and conditions set forth in other dental benefit materials you have been provided conflict with those set forth in this plan document, the terms and conditions of this plan document control.

	In-Network	Out-of-Network
Plan Year Deductible	**$50 Individual/ $150 Eligible Dependents (waived for Class I)***	**$75 Individual/ $200 Eligible Dependents**
Class I: Diagnostic/Preventive	**100%**	**90%**
Exams and Prophylaxis	Payable for two services in a benefit year	
Bitewings	Payable for two services in a benefit year up to age 14; one service in a benefit year for 14+ years	
Complete Series and Panoramic Films	Payable for one service in a 36-month period and is not covered for members under the age of 5	
Topical Fluoride	Payable to age 19 for two services in a benefit year	
Periodontal Scaling/Root Planing	Payable for one service every 24 months	
Sealants	Payable to age 14 for one service per tooth (molar) every 36 months	
Space Maintainers	Payable to age 19	
Class II: Basic Services	**70%**	**60%**
Amalgam and Composite Filings	Payable	
Pulpal Therapy/Anterior and Posterior	Payable	
Endodontic Therapy (Including treatment plan, clinical procedures, and follow-up care)	Payable	
Extractions and Oral Surgery	Payable	
Class III: Major Services	**50%**	**40%**
Crowns	Payable for one service per tooth in a 60-month period	
Inlay/Onlay — metallic/porcelain/resin, up to 4+ services	Payable for one service per tooth in a 60-month period	
Implants	Payable for one service per tooth, per lifetime	
Prosthodontics	Payable	
Dentures Complete and Partial	Payable for one service in a 60-month period	
Prefabricated Stainless Steel Crown/Primary Tooth	Payable for one service per tooth in a 60-month period	
Orthodontia: Child Under Age 19	**50%**	**50%**

The services above are not all-inclusive — they include only the most common dental procedures in a class or service grouping. UPMC Dental *Advantage* encourages, but does not require, members to seek predetermination for major services, such as crowns and bridges, to obtain the most accurate payment estimate. Additional plan information can be found in the Certificate of Insurance.

*Orthodontia coverage is subject to the Medical Deductible, which can be found in the Medical Schedule of Benefits. Orthodontic services are only payable when deemed medically necessary by the plan.

Compliance Requirements & Business Rules Small Group 2 to 50 Eligible Employees

1. Eligible employer groups must employ 2 to 50 eligible employees.

2. An employer/employee relationship must be present for all employees.

3. The employer group must be in business for a minimum of three months prior to the effective date.

4. The minimum employer contribution toward medical cost must be no less than 50% of the employee-only premium of the lowest Actuarial Value plan selected by the group.

   The employer contribution toward medical cost cannot exceed the actual cost of the monthly premium for any individual.

5. Union employees may be carved out. All other carve-outs are not permitted.

6. For groups that have been terminated for non-payment, prepayment of all premiums prior to ability to reapply will be required, and the group can only enroll during the special enrollment period from November 15 to December 15 each year.

7. Out-of-area (OOA) percent will be limited to the following:

Out-of-Area (OOA) Coverage	
# Eligible Employees	Maximum Out-of-Area Percent of Total Employees
2 to 6	No Coverage Available
7 to 20	15%
21 to 50	25%

8. If, for any reason, an existing group's OOA exceeds the 15% or 25%, as noted above, the group will not be eligible to renew. Calculations for OOA percent will round down.

9. Groups with 2 to 20 eligible employees may elect one (1) OOA plan. Groups with 21 to 50 eligible employees may elect two (2) OOA plans. Note: Rule is based on final plan options selected.

10. The only plans offered for OOA coverage are PPOs. The OOA plan must have a deductible and coinsurance equivalent to or of lesser value than the deductible and coinsurance of the in-area plan.

11. An employee must work $\geq$30 hours per week to be eligible for coverage (self-enforced by the group).

12. Part time (<30 hours per week), absentee owners, seasonal workers, IRS 1099 contractors who are not employees, directors and trustees of the company, and Medicare-eligible retirees are not eligible for coverage (self-enforced by the group).

13. An owner must receive full-time compensation to be eligible for coverage.

14. All groups must submit a copy of the most recent PA UC-2A, which must contain the names, salaries, and weeks worked for all employees.

15. Employees who have been terminated or work part time must be noted on the UC-2A.

16. New hires not on the UC-2A must have a W-4 or paystub submitted with the UC-2A.

17. There may be circumstances in which an employee is not on the UC-2A or when the company is not required to file a UC-2A. Refer to the following table for alternate types of acceptable documentation.

If a UC-2A is not available, submit one from Category A and one from Category B	
Category A	**Category B**
IRS 1040 - Schedule C or F	K-1s or Articles of Incorporation
IRS 1065 - Partnership Income	K1s or Partnership Agreements
IRS 1120 - Corporate Income	Current Business License
IRS 941 - Not-for-Profit Use Only**	Leases and Other Contracts
IRS 990 - Return of Organization Exempt from Tax**	
**Must submit copy of payroll journal; no Category B information required.	

18. Employees will be permitted to enroll during the special enrollment period (November 15 to December 15) or at open enrollment. Employees experiencing a qualifying event will be permitted to enroll outside the special enrollment period (November 15 to December 15) or open enrollment. Enrollment is limited to a 30-day period after the qualifying event. A qualifying event is defined as:
    a. Change in marital status
    b. Birth or adoption of a child
    c. Loss of affordable coverage
    d. Change in employment status
    e. A change in place of residence
    f. Judgments, decrees, or orders
    g. A change in coverage of a spouse or dependent under another employer's plan

19. A minimum of two eligible employees must be enrolled with UPMC Health Plan.

20. Minimum participation rules are below:
    a. A minimum of 75% of eligible employees must have coverage in a health benefit plan either through a plan offered by an employer group, a spouse's employer group, the Marketplace, a government program (Medicare, Medicaid, military), a union, or other comparable coverage.

    AND

    b. A minimum of 50% of all eligible employees must be enrolled in a group plan offered by UPMC Health Plan.

21. Groups with 2 to 20 eligible employees may elect up to five plan options. Groups with 21 to 50 eligible employees may elect any number of plans.

22. Consolidated Omnibus Budget Reconciliation Act (COBRA) will be offered to eligible individuals who formerly received coverage through employer groups that have active enrollment in UPMC Health Plan and/or to those whom UPMC Health Plan is required to offer coverage under state or federal law. Total COBRA coverage cannot exceed 10% of total enrolled subscribers.

23. All employer groups must submit their first month's premium no later than the effective date of coverage.

24. Submitted applications/censuses must include those waiving coverage as well as COBRA participants, and must include:
    a. Date of birth (including dependents)
    b. ZIP code (including dependents)
    c. Dependents
    d. Tobacco usage (not required for applicants <18 years of age)

25. All applications must be signed/dated by the employee and spouse (if applicable). Adult dependents are not required to sign the application.

26. Quoted rates are subject to change based on validation of group demographics and compliance with all small market requirements.

27. Groups that meet all small market requirements may enroll during any month of the year.

28. Groups that do not meet all the small market requirements may only enroll during the open enrollment period, which is November 15 to December 15 each year.

29. Benefit plan changes are permitted only at renewal, and can only be increased one metal level per calendar year.

30. Medicare-eligible retirees >65 years old may not enroll in employer-based group coverage. UPMC Health Plan offers Medicare plans through UPMC *for Life.* For more information, prospective members can call 1-877-389-8313 (TTY: 1-800-361-2629).

Underwriting Guidelines – UPMC Dental and Vision *Advantage* 2 to 50 Eligible Employees

1. Eligible employer groups must employ 2 to 50 eligible employees.

2. An employer/employee relationship between each individual seeking coverage and the small business entity, regardless of the marital or ownership status of any individual seeking coverage, must be present in order for an individual to be eligible for coverage.

3. Employer groups must be in business for a minimum of three months prior to the effective date.

4. Union employees may be carved out. Non-union carve-outs will be considered on a case-by-case basis. Executive management level carve-outs will not be permitted.

5. Employer groups that have been terminated by UPMC Health Plan for non-payment of premium will not be eligible to reapply for coverage until 12 months have lapsed after the termination date.

   In the event that UPMC Health Plan grants the reapplication, UPMC Health Plan will require a payment of two months of premium in advance of issuance of the policy.

6. Out-of-area coverage is limited to 10% of the enrolled population. If, for any reason, an existing group's out-of-area enrollment becomes greater than 10%, the entire group may be non-renewed for failure to meet UPMC Health Plan participation guidelines.

7. An employee must work ≥30 hours per week to be eligible for coverage.

8. Part time (<30 hours per week), absentee owners, seasonal workers, IRS 1099 contractors who are not employees, directors and trustees of the company, and Medicare-eligible retirees are not eligible for coverage.

9. An owner must receive full-time compensation from the company to be considered for coverage.

10. Waiting periods are determined by the employer group and must be applied consistently to all employees.

11. Only new employees and employees experiencing a documented qualifying event will be permitted to enroll outside the open enrollment period during the benefit year. Enrollment is limited to a 30-day period after the qualifying event. A qualifying event is defined as:

    a. Change in marital status

    b. Birth or adoption of a child

    c. Change in employment status

    d. Change in place of residence

    e. Judgments, decrees, or orders

    f. Change in coverage of a spouse or dependent under another employer's plan

12. Employees initially waiving group coverage for any reason other than the employer's waiting period must wait until the next open enrollment period to enroll, unless there is a documented qualifying event.

13. After the initial effective date, UPMC Dental *Advantage* and/or UPMC Vision *Advantage* quoted in combination with UPMC Health Plan medical coverage must renew on the same renewal effective date. Plan deductibles and annual maximums will need to be re-satisfied based on the new effective date of the UPMC Dental *Advantage* and/or UPMC Vision *Advantage* coverage.

14. Rates quoted in combination with UPMC Health Plan medical coverage will receive a discounted rate.

15. For groups with 2 to 9 eligible employees, UPMC Dental *Advantage* and/or UPMC Vision *Advantage* will require 100% participation. Coverage may be terminated if required participation levels and minimum enrolled contracts are not met and maintained throughout the policy period. If the overall average number of members per contract is 5 or more, UPMC Health Plan reserves the right to re-evaluate our quoted rates.

16. For groups with 10+ eligible employees, rates quoted require that a minimum of 70% of all eligible employees must enroll in UPMC Dental *Advantage* and/or UPMC Vision *Advantage* coverage, including employees waiving for spousal coverage. Coverage may be terminated if required participation levels and minimum enrolled contracts are not met and maintained throughout the policy period. If the overall average number of members per contract is 5 or more, UPMC Health Plan reserves the right to re-evaluate our quoted rates.

17. UPMC Health Plan must be offered as total replacement coverage for groups of 2 to 50 eligible employees. Dual option plans will not be permitted for groups with 2 to 50 eligible employees.

18. Groups with no prior dental and/or vision coverage will only be permitted to enroll in Basic Dental and/or Basic Vision plans for the first 12 months of coverage. This requirement can be waived under special circumstances.

19. Rates quoted for Voluntary Dental/Vision for groups with 2 to 9 eligible employees require that a minimum of 50% of all eligible employees must enroll for coverage.

20. Rates quoted for Voluntary Dental/Vision for groups with 10+ eligible employees require that a minimum of 20% of all eligible employees must enroll for coverage.

21. Consolidated Omnibus Budget Reconciliation Act (COBRA) will be offered to eligible individuals who formerly received coverage through employer groups that have active enrollment in UPMC Health Plan and/or to those whom UPMC Health Plan is required to offer coverage under state or federal law. The percentage of COBRA subscribers cannot exceed 10% of the total number of enrolled subscribers.

22. All employer groups must submit their first month's premium no later than the effective date of coverage.

23. Should final enrollment change by +/- 10% during new group implementation or at annual open enrollment either in total or by tier, UPMC Health Plan reserves the right to re-evaluate rates.

24. Dental and vision benefit plan changes/additions/deletions are permitted at time of renewal only.

25. Non-standard dental and vision benefit plans will not be permitted.

26. Stand-alone dental and vision will follow the same guidelines as outlined above but will not receive the discount for bundled coverage.

Any deviation from the underwriting guidelines must be approved by UPMC Health Plan's Underwriting Department.

This document is meant to be informative and is not intended to be an all-inclusive statement of UPMC Health Plan's underwriting guidelines. Other policies and guidelines may apply.

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