

UPMC for Life 2024 PPO Custom Standard - University of Pittsburgh		
Plan Design	PPO Custom Standard	
Premium	\$297	
	In-network (IN)	Out-of-network (OON)
ANNUAL MAXIMUMS		
Annual Deductible	\$0	500
Maximum Out-of-Pocket	\$3,400	\$5,100 IN and OON
INPATIENT CARE		
Inpatient Hospital/ Mental Health Care (per stay) *	\$250 copay	20% coinsurance after deductible
Skilled Nursing Facility (days 1-20) (100 day limit) *	\$0 copay	20% coinsurance after deductible
Skilled Nursing Facility (days 21-100) (100 day limit) *	\$25 copay	20% coinsurance after deductible
Blood (3 pints)	\$0 copay	20% coinsurance after deductible
Home Health Care *	\$0 copay	\$0 copay
Home Health Care (Telehealth) *	\$0 copay	Not Covered
OUTPATIENT CARE		
Primary Care Physician (PCP) Visits	\$20 copay	20% coinsurance after deductible
Primary Care Physician (PCP) Visits (Telehealth)	\$20 copay	Not Covered
Specialist Visits	\$20 copay	20% coinsurance after deductible
Specialist Visits (Telehealth)	\$20 copay	Not Covered
Chiropractic Services (Medicare-covered) *	\$20 copay	20% coinsurance after deductible
Chiropractic Services (Routine) (6 visits every year) *	\$20 copay	Not Covered
Podiatry Services (Medicare-covered)	\$20 copay	20% coinsurance after deductible
Podiatry Services (Routine) (4 visits every year)	\$20 copay	Not Covered
Outpatient Mental Health Services /Psychiatric Services /Substance Abuse	\$20 copay	20% coinsurance after deductible
Outpatient Mental Health Services /Psychiatric Services /Substance Abuse (Telehealth)	\$20 copay	Not Covered
Opioid Treatment Services	\$20 copay	20% coinsurance after deductible
Partial Hospitalization	\$0 copay	20% coinsurance after deductible
Outpatient Surgery and Ambulatory Surgical Center (ASC)/Observation	\$100 copay	20% coinsurance after deductible
Ambulance Services (Ground & Air) *	\$25 copay	20% coinsurance after deductible
Ambulance Services (Treat no Transport)	Not Covered	Not Covered
Emergency Care (waived if admitted within 3 days) (IN/OON)	\$75 copay	\$75 copay
Urgently Needed Care (Clinics) (IN/OON)	\$20 copay	\$20 copay
Outpatient Rehab Services (PT, OT, ST) *	\$20 copay	20% coinsurance after deductible
Cardiac/Pulmonary Rehab & Supervised Exercise Therapy (SET)	\$0 copay	20% coinsurance after deductible
OUTPATIENT MEDICAL AND SUPPLIES		
Durable Medical Equipment (DME)/ Oxygen *	\$0 copay	50% coinsurance after deductible
Prosthetic Devices and Medical Supplies *	\$0 copay	50% coinsurance after deductible
Diabetes Training	\$0 copay	20% coinsurance after deductible
Diabetes Training (Telehealth)	\$0 copay	Not Covered
Diabetic Monitors and Test Strips - LifeScan Only	\$0 copay	20% coinsurance
Diabetic Supplies - All Other Brands *	\$0 copay	20% coinsurance after deductible
Diabetic Shoes or Inserts	\$0 copay	20% coinsurance after deductible
Part B Drugs - Insulin (up to \$35 copay/ 30 day supply)	\$0 copay	20% coinsurance
Part B Drugs (visit) *	\$0 copay	20% coinsurance after deductible
Part B Drugs (30-day supply) *	\$20 copay	20% coinsurance after deductible
Kidney Disease Training	\$0 copay	20% coinsurance after deductible
Renal Dialysis (ESRD)	\$0 copay	20% coinsurance after deductible
Lab Services (per day per facility)	\$0 copay	20% coinsurance after deductible
Diagnostic Procedures/Tests (per day per facility) *	\$0 copay	20% coinsurance after deductible
Diagnostic X-Ray Services (Basic Imaging) (per service)	\$0 copay	20% coinsurance after deductible
Diagnostic Radiological Services (Advanced Imaging)(per service) *	\$25 copay	20% coinsurance after deductible
Therapeutic Radiological Services (Radiation) (per service)	\$0 copay	20% coinsurance after deductible

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PREVENTIVE SERVICES		
Immunizations	\$0 copay	\$0 copay
Annual Wellness Visit	\$0 copay	20% coinsurance
Screening Exams	\$0 copay	20% coinsurance
SUPPLEMENTAL BENEFITS		
Dental Services		
Dental Services (Medicare-covered)	\$20 copay	20% coinsurance after deductible
Preventive Dental Benefit:		
Cleaning (2 every year)	\$0 copay	50% coinsurance
Routine Oral Exam (2 every year)	\$20 copay	50% coinsurance
Limited Oral Exam (1 every 12 months)	\$20 copay	50% coinsurance
Comprehensive Oral Exam (1 every 36 months)	\$20 copay	50% coinsurance
Bitewing X-rays (1 every 12 months)	\$20 copay	50% coinsurance
Panoramic X-rays (1 every 36 months)	\$20 copay	50% coinsurance
Restorative Dental Benefit	Not Covered	Not Covered
Hearing Services		
Hearing Services (Medicare-covered)	\$20 copay	20% coinsurance after deductible
Hearing Exam (Routine) (1 every year)	\$20 copay	50% coinsurance
Hearing Aid Fitting (Routine) (1 every year)	\$20 copay	50% coinsurance
Hearing Aids (Routine) - Amplifon Only (1 every year)	\$690 - \$1,890 copay	\$690 - \$1,890 copay
Hearing Aids (Routine) - Combined Allowance (1 every 3 year)	\$500 allowance	\$500 allowance
Vision Services		
Vision Services (Medicare-covered)	\$20 copay	20% coinsurance after deductible
Glaucoma Screening and Diabetic Retinal Eye Exam (Medicare-covered)	\$0 copay	20% coinsurance after deductible
Eyewear (Medicare-covered)	\$0 copay	20% coinsurance after deductible
Vision Exam (Routine)	\$0 copay	20% coinsurance
Vision Eyewear (Routine)	\$250 allowance	\$250 allowance
Other Services		
Counseling Services (Resources for Life) (6 sessions per issue)	\$0 copay	Not Covered
Fitness Benefit (SilverSneakers and personal training session) (1 every year)	\$0 copay	Not Covered
Health and Wellness Benefit (Rx Well) (1 every year)	\$0 copay	Not Covered
Home Safety Items (3 items every year)	\$0 copay	Not Covered
In-Home Safety Assessment (1 every year)	\$0 copay	Not Covered
Nurse Advice Line	\$0 copay	Not Covered
Palliative Care (including eligible meals) (56 meals for 28 days)	\$0 copay	Not Covered
Remote Technologies - (AnywhereCare eVisits)	\$20 copay	Not Covered
Routine Physical Exam	Not Covered	Not Covered
Smoking and Tobacco Use Cessation (4 addtl sessions)	\$0 copay	Not Covered
Support for Caregivers (Resources for Life) (6 sessions)	\$0 copay	Not Covered
Support for Caregivers (Powerful Tools for Caregivers)	\$0 copay	Not Covered
Worldwide Emergency Coverage	\$0 copay	\$0 copay
ADDITIONAL BENEFIT PROGRAMS		
Visitor/Travel Benefit	Not Covered	Not Covered

* Requires Prior Authorization

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Part D Prescription Drugs										
DEDUCTIBLE STAGE	There is no deductible for Part D prescription drugs.									
Rx Deductible	\$0									
INITIAL COVERAGE STAGE	Member pays cost-sharing amounts below until total yearly costs reach the Initial Coverage Limit.									
Initial Coverage Limit (ICL)	\$5,030									
	Retail pharmacy						Mail-order		LTC	OON
	30 day supply		60 day supply		100 day supply		100 day supply		30 day	31 day
	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Tier 1: Preferred Generic Drugs	\$0	\$15	\$0	\$30	\$0	\$30	\$0	\$30	\$0	\$15
Tier 2: Generic Drugs	\$10	\$20	\$20	\$40	\$20	\$40	\$20	\$40	\$10	\$20
Tier 3: Preferred Brand Drugs	\$47	\$47	\$94	\$94	\$129.50	\$141	\$117.50	\$141	\$47	\$47
Tier 4: Non-Preferred Drugs	\$100	\$100	\$200	\$200	\$300	\$300	\$300	\$300	\$100	\$100
Tier 5: Specialty Drugs	33%	33%	n/a	n/a	n/a	n/a	33% (30 day)	33% (30 day)	33%	33%
IRA - Insulin	\$35	\$35	\$70	\$70	\$96.25	\$105	\$87.50	\$105	\$35	\$35
COVERAGE GAP STAGE	When total costs from the Coverage Gap Stage, combined with the out-of-pocket costs from the Initial Coverage Stage, reach the True Out-of-Pocket (TrOOP) limit, the member moves to the Catastrophic Coverage Stage.									
Out-of-Pocket Limit (TrOOP)	\$8,000									
Coverage in the Coverage Gap	Full Wrap-around Gap Coverage: Member pays the same cost-sharing in the coverage gap as the initial coverage stage for Tier 1-5 drugs.									
CATASTROPHIC COVERAGE STAGE	Once a member has hit the catastrophic coverage phase, there is no cost sharing responsibility.									