UPMC *for Life*

2017 PPO Custom Basic Plan - *University of Pittsburgh*

Benefits	PPO Custom	
	In-Network	**Out-of-Network**
Total Monthly Premium	**$290**	
Annual Out-of-Pocket Limit[1]	$1,000	$3,400 combined IN/OON
Annual Deductible	$250	$500
INPATIENT CARE		
Inpatient Hospital[2]	10% coinsurance after deductible	20% coinsurance after deductible
Inpatient Mental Health Care[2]	10% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility[2] (100 day benefit limit)	10% coinsurance after deductible	20% coinsurance after deductible
Blood (3 pints)	$0 copay	20% coinsurance after deductible
Home Health Care[2]	10% coinsurance after deductible	20% coinsurance after deductible
Hospice	Medicare-covered	Medicare-covered
OUTPATIENT CARE		
Primary Care Doctor Visits	$20 copay excluded from deductible	20% coinsurance after deductible
Specialist Visits	$20 copay excluded from deductible	20% coinsurance after deductible
Chiropractic Services	10% coinsurance after deductible	20% coinsurance after deductible
Routine Chiropractic Services *(6 visits every year)*	10% coinsurance after deductible	not covered
Podiatry Services	10% coinsurance after deductible	20% coinsurance after deductible
Routine Podiatry Services *(4 visits every year)*	10% coinsurance after deductible	not covered
Outpatient Mental Health	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Psychiatric Services	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Substance Abuse	10% coinsurance after deductible	20% coinsurance after deductible
Partial Hospitalization[2]	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery and Ambulatory Surgical Center[2]	10% coinsurance after deductible	20% coinsurance after deductible
Observation Stay	10% coinsurance after deductible	20% coinsurance after deductible
Ambulance Services	10% coinsurance after deductible per one-way trip	20% coinsurance after deductible
Emergency Care *(waived if admitted within 3 days)*	$75 copay excluded from deductible	
Urgently Needed Care (Clinics) *(out-of-area; urgent care clinics)*	$20 copay excluded from deductible	
Outpatient Rehab Services *(PT, OT, ST)*	10% coinsurance after deductible	20% coinsurance after deductible
Cardiac/Pulmonary Rehab	$0 copay excluded from deductible	20% coinsurance after deductible
OUTPATIENT MEDICAL AND SUPPLIES		
Durable Medical Equipment/Oxygen[2]	10% coinsurance after deductible	50% coinsurance after deductible
Prosthetic Devices and Medical Supplies	10% coinsurance after deductible	50% coinsurance after deductible

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Diabetes Training and Diabetic Supplies	$0 copay - training excluded from deductible 10% coinsurance - supplies after deductible	20% coinsurance after deductible
Diabetic Shoes or Inserts	10% coinsurance after deductible	20% coinsurance after deductible
Kidney Disease Training and Renal Dialysis (ESRD)	$0 copay - training excluded from deductible 10% coinsurance - dialysis after deductible	20% coinsurance after deductible
Part B Drugs[2]	10% coinsurance all Part B drugs; chemotherapy / self-administered after deductible	20% coinsurance after deductible
Lab Services	$0 copay excluded from deductible	20% coinsurance after deductible
Diagnostic Procedures/Tests	$0 copay excluded from deductible	20% coinsurance after deductible
X-Ray Services	$0 copay excluded from deductible	20% coinsurance after deductible
Diagnostic Radiological Services (Advanced Imaging)[2]	$25 copay excluded from deductible	20% coinsurance after deductible
Therapeutic Radiological Services (Radiation)	$0 copay excluded from deductible	20% coinsurance after deductible
PREVENTIVE SERVICES		
Immunizations[3] *(influenza, pneumonia, Hepatitis B)*	$0 copay excluded from deductible	$0 copay excluded from deductible
Annual Wellness Exam/Routine Physical Exam[3] *(one exam per year)*	$0 copay excluded from deductible	20% coinsurance excluded from deductible
Screening Exams[3] *Includes: Bone Mass Measurement, Colorectal Screening, Mammograms, Pap & Pelvic, Prostate Exams, all Medicare-covered Preventive Services*	$0 copay excluded from deductible	20% coinsurance excluded from deductible
ADDITIONAL BENEFITS		
Dental Services		
Medicare-covered Dental Services	$20 copay excluded from deductible	20% coinsurance after deductible
Routine Dental Oral Exam & Cleaning *(once every six months)*	$20 copay excluded from deductible	50% coinsurance excluded from deductible
Routine Dental Bitewing X-rays	not covered	not covered
Restorative Services	not covered	not covered
Hearing Services		
Medicare-covered Hearing Services	$20 copay excluded from deductible	20% coinsurance after deductible
Routine Hearing Exam *(once every year)*	$20 copay excluded from deductible	50% coinsurance excluded from deductible
Routine Hearing Aid Fitting *(once every three years)*	$20 copay excluded from deductible	50% coinsurance excluded from deductible
Routine Hearing Aids *(once every three years)*	$500 combined IN/OON allowance excluded from deductible	
Vision Services		
Medicare-covered Vision Services	$20 copay excluded from deductible	20% coinsurance after deductible
Medicare-covered Glaucoma Screening and Diabetic Retinal Eye Exam	$0 copay excluded from deductible	20% coinsurance after deductible
Medicare-covered Eyewear *Cataract Glasses/Lens*	$0 copay excluded from deductible	20% coinsurance after deductible

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	In-Network	**Out-of-Network**
Routine Vision Exam & Eyewear *(once every two years)* Allowance must be used for both routine eye exam and eyewear.	$250 combined IN/OON allowance excluded from deductible	
Other Services		
Health & Wellness *Fitness Center Benefit*	Silver & Fit	50% coinsurance excluded from deductible
Remote Technologies	$20 copay - eVisits $20 copay - eDerm	50% coinsurance excluded from deductible
Worldwide Emergency Coverage	Assist America Travel Benefit	Assist America Travel Benefit
PART D PRESCRIPTION DRUGS		
Tier 1: Preferred Generic Drugs	$10 copay - 30 day supply (retail) $20 copay - 90 day supply (retail & mail-order)	
Tier 2: Preferred Brand Drugs	$35 copay - 30 day supply (retail) $70 copay - 90 day supply (retail & mail-order)	
Tier 3: Non-Preferred Drugs	$70 copay - 30 day supply (retail) $140 copay - 90 day supply (retail & mail-order)	
Tier 4: Specialty Drugs	25% coinsurance - 30 day supply only	
Tier 5: Select Care Drugs	$0 copay - 30 day supply (retail) $0 copay - 90 day supply (retail & mail-order)	
Initial Coverage Limit	**$3,700**	
Coverage Gap Cost-Sharing *During the Coverage Gap Stage, the member will continue to pay the same copays as in the Initial Coverage stage.*	**<u>30-day Supply</u>** Once the Initial Coverage Limit **$3,700** is met, the following cost-sharing applies until the member reaches **$4,950** (TrOOP): $10 copay for Generic Drugs $35 copay for Preferred Brand Drugs $70 copay for Non-Preferred Brand Drugs 25% coinsurance for Specialty Drugs $0 copay for Select Care Drugs	
	<u>90-day Supply</u> Once the Initial Coverage Limit **$3,700** is met, the following cost-sharing applies until the member reaches **$4,950** (TrOOP): $20 copay for Generic Drugs $70 copay for Preferred Brand Drugs $140 copay for Non-Preferred Brand Drugs $0 copay for Select Care Drugs	
Out-of-Pocket Limit (TrOOP)	**$4,950**	
Catastrophic Coverage Copays	Greater of: **$3.30** generic/brand treated as generic **$8.25** or **5%** all others	

[1] Member's cost-sharing for Medicare-covered benefits accumulates toward the OOP limit (excludes Part D drugs, routine dental, routine hearing, routine vision and fitness benefit). Once the annual out-of-pocket maximum is met, additional covered services are paid at 100% by the plan.

[2] These services require prior authorization.

[3] A separate copay may apply if additional medical services are performed during the same visit as a preventive service.

NOTE: UPMC Health Plan has determined that the prescription drug coverage offered by this employer group plan for 2017 is creditable coverage.

This grid is not intended to provide a full description of benefits. Please refer to the Evidence of Coverage for complete benefit information.