

UPMC for Life
2021 PPO Custom (Basic) - University of Pittsburgh

Plan Design	PPO Custom - Basic	
	In Network	Out-of-Network
ANNUAL MAXIMUMS		
Annual Deductible	\$250	\$500
Annual Out-of-Pocket Maximum	\$1,000	\$3,400 Combined In-Network/Out-Of-Network
INPATIENT CARE		
Inpatient Hospital <i>*prior auth required</i>	10% coinsurance after deductible	20% coinsurance after deductible
Inpatient Mental Health Care <i>*prior auth required</i>	10% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility <i>*prior auth required</i> <i>(100 day benefit per benefit period)</i>	10% coinsurance after deductible	20% coinsurance after deductible
Blood (3 pints)	\$0 copay	20% coinsurance after deductible
Home Health Care <i>*prior auth required</i>	\$0 copay excluded from deductible	\$0 copay excluded from deductible
Home Health Care (Telehealth)	\$0 copay	not covered
OUTPATIENT CARE		
Primary Care Doctor Visits	\$20 copay	20% coinsurance after deductible
Primary Care Doctor Visits (Telehealth)	\$0 copay	not covered
Specialist Visits <i>*prior auth required for acupuncture</i>	\$20 copay	20% coinsurance after deductible
Specialist Visits (Telehealth)	\$15 copay	not covered
Chiropractic Services (Medicare-covered)	10% coinsurance after deductible	20% coinsurance after deductible
Chiropractic Services (Routine) <i>(6 visits every year)</i>	10% coinsurance after deductible	not covered
Podiatry Services (Medicare-covered)	10% coinsurance after deductible	20% coinsurance after deductible
Podiatry Services (Routine) <i>(4 visits every year)</i>	10% coinsurance after deductible	not covered
Outpatient Mental Health Services	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Mental Health (Telehealth)	5% coinsurance after deductible	not covered
Outpatient Psychiatric Services	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Psychiatric Services (Telehealth)	5% coinsurance after deductible	not covered
Outpatient Substance Abuse	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Substance Abuse (Telehealth)	5% coinsurance after deductible	not covered
Outpatient Substance Abuse	10% coinsurance after deductible	20% coinsurance after deductible
Opioid Treatment Services <i>*prior auth required</i>	10% coinsurance after deductible	20% coinsurance after deductible
Partial Hospitalization	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery and Ambulatory Surgical Center (ASC) <i>*prior auth required</i>	10% coinsurance after deductible	20% coinsurance after deductible
Observation Stay <i>*prior auth required</i>	10% coinsurance after deductible	20% coinsurance after deductible

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Ambulance Services - (Ground & Air) <i>*prior auth required for non-emergency Medicare-covered services</i>	10% coinsurance after deductible per one-way trip	20% coinsurance after deductible
Emergency Care <i>(waived if admitted within 3 days)</i>	\$75 copay excluded from deductible	
Urgently Needed Care (Clinics) <i>(out-of-area; urgent care clinics)</i>	\$20 copay excluded from deductible	
Outpatient Rehab Services (PT, OT, ST) <i>*prior auth required for select PT,OT, ST services</i>	10% coinsurance after deductible	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 <i>*prior auth required for DME</i>	10% coinsurance after deductible	50% coinsurance after deductible
Prosthetic Devices and Medical Supplies <i>*prior auth required for prosthetics</i>	10% coinsurance after deductible	50% coinsurance after deductible
Diabetes Training	\$0 copay	20% coinsurance after deductible
Diabetes Training (Telehealth)	\$0 copay	not covered
Diabetic Supplies Shoes or Inserts	10% coinsurance after deductible	20% coinsurance after deductible
Part B Drugs <i>*prior auth required</i>	10% coinsurance all Part B drugs; chemotherapy / self-administered after deductible	20% coinsurance after deductible
Kidney Disease Training	\$0 copay	20% coinsurance after deductible
Renal Dialysis (ESRD) <i>*prior auth required for outpatient services</i>	10% coinsurance after deductible	20% coinsurance after deductible
Lab Services <i>(single copay per day per facility)</i>	\$0 copay	20% coinsurance after deductible
Diagnostic Procedures/Tests <i>*prior auth required for certain services (single copay per day per facility)</i>	\$0 copay	20% coinsurance after deductible
X-Ray Services (Basic Imaging) <i>(single copay per day per facility)</i>	\$0 copay	20% coinsurance after deductible
Diagnostic Radiological Services (Advanced Imaging) <i>*prior auth required (single copay per service)</i>	\$25 copay	20% coinsurance after deductible
Therapeutic Radiological Services (Radiation) <i>(single copay per service)</i>	\$0 copay	20% coinsurance after deductible
PREVENTIVE SERVICES		
Immunizations <i>(influenza, pneumonia, Hepatitis B)</i>	\$0 copay	\$0 copay excluded from deductible
Annual Wellness Visit	\$0 copay	20% coinsurance excluded from deductible
Screening Exams <i>(Includes: Bone Mass Measurement, Colorectal Screening, Mammograms, Pap & Pelvic, Prostate Exams, all Medicare-covered Preventive Services)</i>	\$0 copay	20% coinsurance excluded from deductible

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ADDITIONAL BENEFITS		
Dental Services (Preventive Dental Services are offered through Avesis)		
Dental Services (Medicare-covered)	\$20 copay	20% coinsurance after deductible
Dental Cleaning (Routine) (two every year)	\$0 copay	50% coinsurance excluded from deductible
Dental Oral Exam (Routine) (two every year)	\$20 copay	50% coinsurance excluded from deductible
Dental Oral Exam - Comprehensive (one every 36 months)	\$20 copay	50% coinsurance excluded from deductible
Dental X-rays - Bitewing (once every year)	not covered	not covered
Comprehensive Dental Allowance	not covered	not covered
Hearing Services		
Hearing Services (Medicare-covered)	\$20 copay	20% coinsurance after deductible
Hearing Exam (Routine) (once every year)	\$20 copay	50% coinsurance excluded from deductible
Hearing Aid Fitting (Routine) (once every three years)	\$20 copay	50% coinsurance excluded from deductible
Hearing Aids (Routine) (once every three years)	\$500 combined IN/OON allowance excluded from deductible	
Vision Services (Routine Vision Services offered through Envolve)		
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) (Cataract Glasses/Lens)	\$0 copay	20% coinsurance after deductible
Vision Exam (Routine) (once every two years)	\$0 copay	20% coinsurance excluded from deductible
Vision Eyewear (Routine) (once every two years)	\$250 combined IN/OON allowance excluded from deductible	
Other Services		
Fitness Benefit (SilverSneakers) (includes 1 personal training session/year)	\$0 copay	50% coinsurance excluded from deductible
Nurse Advice Line (UPMC MyHealth 24/7 Nurse Line)	\$0 copay	50% coinsurance excluded from deductible
Remote Technologies - eVisits (UPMC AnywhereCare)	\$20 copay - eVisits	50% coinsurance excluded from deductible
Counseling Services (6 sessions per year)	\$0 copay	50% coinsurance excluded from deductible
Support for Caregivers 6 Sessions through Resources for Life and Powerful Tools for Caregivers	\$0 copay	50% coinsurance excluded from deductible
Palliative Care *prior auth required	\$0 copay	50% coinsurance excluded from deductible
Smoking and Tobacco Use Cessation (4 additional sessions)	\$0 copay	50% coinsurance excluded from deductible
Bathroom Safety Devices (BSD) (3 products per year)	\$0 copay	50% coinsurance excluded from deductible
In-Home Safety Assessment (1 per year)	\$0 copay	50% coinsurance excluded from deductible
Worldwide Emergency Coverage	Assist America Travel Benefit	

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PART D PRESCRIPTION DRUGS		
Tier 1: Preferred Generic Drugs	Preferred: \$0 copay - 30 day supply (retail) \$0 copay - 90 day supply (retail)	
	Standard: \$15 copay - 30 day supply (retail) \$30 copay - 90 day supply (retail) \$0 copay - 90 day supply (mail-order)	
Tier 2: Generic Drugs	Preferred: \$10 copay - 30 day supply (retail) \$20 copay - 90 day supply (retail)	
	Standard: \$20 copay - 30 day supply (retail) \$40 copay - 90 day supply (retail) \$20 copay - 90 day supply (mail-order)	
Tier 3: Preferred Brand Drugs	Preferred: \$47 copay - 30 day supply (retail) \$117.50 copay - 90 day supply (retail)	
	Standard: \$47 copay - 30 day supply (retail) \$141 copay - 90 day supply (retail) \$117.50 copay - 90 day supply (mail-order)	
Tier 4: Non-Preferred Drugs	Preferred: \$100 copay - 30 day supply (retail) \$300 copay - 90 day supply (retail)	
	Standard: \$100 copay - 30 day supply (retail) \$300 copay - 90 day supply (retail) \$300 copay - 90 day supply (mail-order)	
Tier 5: Specialty Drugs	Preferred & Standard: 33% coinsurance - 30 day supply only	
Initial Coverage Limit	\$4,130	
Out-of-Pocket Limit (TrOOP)	\$6,550	
Coverage Gap	Full coverage with Wrap-around:	
	During the Coverage Gap Stage, the member will continue to pay the same copays as in the Initial Coverage stage.	
Catastrophic Coverage Copays	Greater of: \$3.70 generic/brand treated as generic \$9.20 or 5% all others	