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

Plan Design	PPO Custom - Standard	
	In Network	**Out-of-Network**
ANNUAL MAXIMUMS		
Annual Deductible	$0	$500
Annual Out-of-Pocket Limit	$3,400	$5,100 Combined In-Network/Out-Of-Network
INPATIENT CARE		
Inpatient Hospital **prior auth required*	$250 copay	20% coinsurance after deductible
Inpatient Mental Health Care **prior auth required*	$250 copay	20% coinsurance after deductible
Skilled Nursing Facility **prior auth required* *(100 day benefit per benefit period)*	$0 copay per day for days 1-20 $25 copay per day for days 21-100	20% coinsurance after deductible
Blood *(3 pints)*	$0 copay	20% coinsurance after deductible
Home Health Care **prior auth required*	$0 copay	$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 **prior auth required for acupuncture*	$20 copay	20% coinsurance after deductible
Specialist Visits (Telehealth)	$15 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	$20 copay	20% coinsurance after deductible
Outpatient Mental Health (Telehealth)	$15 copay	not covered
Outpatient Psychiatric Services	$20 copay	20% coinsurance after deductible
Outpatient Psychiatric Services (Telehealth)	$15 copay	not covered
Outpatient Substance Abuse	$20 copay	20% coinsurance after deductible
Outpatient Substance Abuse (Telehealth)	$15 copay	not covered
Opioid Treatment Services **prior auth required*	$20 copay	20% coinsurance after deductible
Partial Hospitalization	$0 copay	20% coinsurance after deductible
Outpatient Surgery and **Ambulatory Surgical Center (ASC)** **prior auth required*	$100 copay	20% coinsurance after deductible
Observation Stay **prior auth required*	$100 copay	20% coinsurance after deductible
Ambulance Services - (Ground & Air) **prior auth required for non-emergency Medicare-covered services*	$25 copay 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	

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Outpatient Rehab Services (PT, OT, ST) **prior auth required for select PT,OT, ST services*	$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 **prior auth required for DME*	$0 copay	50% coinsurance after deductible
Prosthetic Devices and Medical Supplies **prior auth required for prosthetics*	$0 copay	50% coinsurance after deductible
Diabetes Training	$0 copay	20% coinsurance after deductible
Diabetes Training (Telehealth)	$0 copay	not covered
Diabetic Supplies Shoes or Inserts	$0 copay	20% coinsurance after deductible
Part B Drugs **Pior auth required*	$0 copay Part B drugs (non-self admin) in office/outpatient $20 copay - 30 day supply	20% coinsurance after deductible
Kidney Disease Training	$0 copay	20% coinsurance after deductible
Renal Dialysis (ESRD) *prior auth required for outpatient services	$0 copay	20% coinsurance after deductible
Lab Services *(single copay per day per facility)*	$0 copay	20% coinsurance after deductible
Diagnostic Procedures/Tests **prior auth required for certain services* *(single copay per day per facility)*	$0 copay	20% coinsurance after deductible
X-Ray Services **(Basic Imaging)** *(single copay per day per facility)*	$0 copay	20% coinsurance after deductible
Diagnostic Radiological Services (Advanced Imaging) **prior auth required* *(single copay per service)*	$25 copay	20% coinsurance after deductible
Therapeutic Radiological Services (Radiation) *(single copay per day per facility)*	$0 copay	20% coinsurance after deductible
PREVENTIVE SERVICES		
Immunizations *(influenza, pneumonia, Hepatitis B)*	$0 copay	$0 copay excluded from deductible
Annual Wellness Visit	$0 copay	20% coinsurance excluded from deductible
Screening Exams *(Includes: Bone Mass Measurement, Colorectal Screening, Mammograms, Pap & Pelvic, Prostate Exams, all Medicare-covered Preventive Services)*	$0 copay	20% coinsurance excluded from deductible
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

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Dental X-rays - Bitewing *(one 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 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 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	