

UPMC for Life 2022 PPO Custom Basic - University of Pittsburgh		
Plan Design	PPO Custom - Basic	
	In-network (IN)	Out-of-network (OON)
ANNUAL MAXIMUMS		
Annual Deductible	\$250	\$500 OON
Maximum Out-of-Pocket	\$1,000	\$3,400 IN and OON
INPATIENT CARE		
Inpatient Hospital/ Mental Health Care	10% coinsurance per stay after deductible	20% coinsurance per stay after deductible
Skilled Nursing Facility (days 1-100) (100 day limit)	10% coinsurance after deductible	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)	\$0 copay	not covered
Specialist Visits	\$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) (6 visits every year)	10% coinsurance after deductible	not covered
Podiatry Services (Medicare-covered)	10% coinsurance after deductible	20% coinsurance after deductible
Podiatry Services (Routine) (4 visits every year)	10% coinsurance after deductible	not covered
Outpatient Mental Health Services /Psychiatric Services/Substance Abuse	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Mental Health Services /Psychiatric Services/Substance Abuse (Telehealth)	5% coinsurance after deductible	not covered
Opioid Treatment Services	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)/Observation	10% coinsurance after deductible	20% coinsurance after deductible
Ambulance Services (Ground & Air)	10% coinsurance after deductible	20% coinsurance after deductible
Emergency Care (waived if admitted within 3 days)	\$75 IN/OUT	\$75 IN/OUT
Urgently Needed Care (Clinics)	\$20 IN/OUT	\$20 IN/OUT
Outpatient Rehab Services (PT, OT, ST)	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	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	\$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	10% coinsurance after deductible	20% coinsurance after deductible
Kidney Disease Training	\$0 copay	20% coinsurance after deductible
Renal Dialysis (ESRD)	10% coinsurance after deductible	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
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
Comprehensive Oral Exam (1 every 36 months)	\$20 copay	50% coinsurance
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 3 years)	\$20 copay	50% coinsurance
Hearing Aids (Routine) (1 every 3 years)	\$500 allowance IN/OUT	\$500 allowance IN/OUT
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) (1 every 2 years)	\$0 copay	20% coinsurance
Vision Eyewear (Routine) (1 every 2 years)	\$250 allowance IN/OUT	\$250 allowance IN/OUT
Other Services		

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Bathroom Safety Items (3 items every year)	\$0 copay	50% coinsurance
Counseling Services (<i>Resources for Life</i>) (6 sessions per issue)	\$0 copay	50% coinsurance
Fitness Benefit (SilverSneakers and personal training session) (1 every year)	\$0 copay	50% coinsurance
In-Home Safety Assessment (1 every year)	\$0 copay	50% coinsurance
Nurse Advice Line	\$0 copay	50% coinsurance
Palliative Care (including eligible meals) (14 meals for 7 days)	\$0 copay	50% coinsurance
Remote Technologies - (AnywhereCare eVisits)	\$20 copay	50% coinsurance
Smoking and Tobacco Use Cessation (4 additional sessions)	\$0 copay	50% coinsurance
Support for Caregivers (<i>Resources for Life</i>) (6 sessions)	\$0 copay	50% coinsurance
Support for Caregivers (Powerful Tools for Caregivers)	\$0 copay	50% coinsurance
Worldwide Emergency Coverage (Assist America)	\$0 copay	\$0 copay

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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)	\$4,430									
	Retail pharmacy						Mail-order		LTC	OON
	30 day supply		60 day supply		90 day supply		90 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%
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)	\$7,050									
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	Member pays the greater of 5% or \$3.95 for a generic drug or a drug treated like a generic and \$9.85 for all other drugs.									