UPMC *for Life* 2025 PPO Custom Basic - University of Pittsburgh

	2025							
	In-network (IN)		Out-of-network (OON)		IN/OON		IN ONLY	
	Cost-share	Metric	Cost-share	Metric	Other Info	Deductible Applies	Telehealth	Prior Auth*
ANNUAL MAXIMUMS								
Annual Deductible	$250		$500					
Maximum Out-of-Pocket	$1,000		$3,400	IN/OON				
INPATIENT CARE								
Inpatient Hospital/ Mental Health Care	10%	coinsurance	$0	coinsurance	per stay	Y-IN/OON		Y
Skilled Nursing Facility (days 1-100)	10%	coinsurance	$0	coinsurance	100 day limit	Y-IN/OON		Y
Blood	$0	copay	$0	coinsurance	3 pints	Y-OON		N
Home Health Care	$0	copay	$0	copay		N	$0	Y
OUTPATIENT CARE								
Primary Care Physician (PCP) Visits	$20	copay	20%	coinsurance		Y-OON	$20	N
Specialist Visits	$20	copay	20%	coinsurance		Y-OON	$20	N
Chiropractic Services (Medicare-covered)	10%	coinsurance	20%	coinsurance		Y-IN/OON		Y
Chiropractic Services (Routine)	10%	coinsurance	Not Covered		6 visits every year	Y-IN		Y
Podiatry Services (Medicare-covered)	10%	coinsurance	20%	coinsurance		Y-IN/OON		N
Podiatry Services (Routine)	10%	coinsurance	Not Covered		4 visits every year	Y-IN		N
Outpatient Mental Health Services /Psychiatric Services/Substance Abuse	10%	coinsurance	20%	coinsurance		Y-IN/OON	10%	N
Opioid Treatment Services	10%	coinsurance	20%	coinsurance		Y-IN/OON		N
Partial Hospitalization	10%	coinsurance	20%	coinsurance		Y-IN/OON		N
Outpatient Surgery and Ambulatory Surgical Center (ASC)	10%	coinsurance	20%	coinsurance		Y-IN/OON		Y
Observation	10%	coinsurance	20%	coinsurance		Y-IN/OON		Y
Ambulance Services (Ground & Air)	10%	coinsurance	20%	coinsurance		Y-IN/OON		Y
Ambulance Services (Treat no Transport)	Not Covered		Not Covered					
Emergency Care	$75	IN/OON	$75	IN/OON	waived if admitted within 3 days	N		N
Urgently Needed Care (Clinics)	$20	IN/OON	$20	IN/OON		N		N
Outpatient Rehab Services (PT, OT, ST)	10%	coinsurance	20%	coinsurance		Y-IN/OON		Y
Cardiac/Pulmonary Rehab & Supervised Exercise Therapy (SET)	$0	copay	20%	coinsurance		Y-OON		N
OUTPATIENT MEDICAL AND SUPPLIES								
Durable Medical Equipment (DME) / Oxygen	10%	coinsurance	50%	coinsurance		Y-IN/OON		Y
Prosthetic Devices and Medical Supplies	10%	coinsurance	50%	coinsurance		Y-IN/OON		Y
Diabetes Training	$0	copay	20%	coinsurance		Y-OON		N
Diabetic Monitors and Test Strips - LifeScan Only	$0	copay	20%	coinsurance		N		N
Diabetic Supplies - All Other Brands	10%	coinsurance	20%	coinsurance		Y-IN/OON		Y
Diabetic Shoes or Inserts	10%	coinsurance	20%	coinsurance		Y-IN/OON		N
Part B Drugs - Insulin	0-10%	coinsurance	20%	coinsurance	up to $35 copay/ 30 day supply	N		N
Part B Drugs	0-10%	coinsurance	20%	coinsurance		Y-IN/OON		Y
Kidney Disease Training	0%	copay	20%	coinsurance		Y-OON		N
Renal Dialysis (ESRD)	10%	coinsurance	20%	coinsurance		Y-IN/OON		N
Lab Services	$0	copay	20%	coinsurance	per day per facility	Y-OON		Y
Diagnostic Procedures/Tests	$0	copay	20%	coinsurance	per day per facility	Y-OON		Y
Diagnostic X-Ray Services (Basic Imaging)	$0	copay	20%	coinsurance	per service	Y-OON		Y
Diagnostic Radiological Services (Advanced Imaging)	$25	copay	20%	coinsurance	per service	Y-OON		Y
Therapeutic Radiological Services (Radiation)	$0	copay	20%	coinsurance	per service	Y-OON		Y
PREVENTIVE SERVICES								
Immunizations	$0	copay	$0	copay		N		N
Annual Wellness Visit	$0	copay	20%	coinsurance		N		N
Screening Exams	$0	copay	20%	coinsurance		N		N

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	2025							
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	Cost-share	Metric	Cost-share	Metric	Other Info	Deductible Applies	Telehealth	Prior Auth*
SUPPLEMENTAL BENEFITS								
Dental Services								
Dental Services (Medicare-covered)	$20	copay	20%	coinsurance		Y-OON		N
Preventive Dental Benefit:								
Cleaning	$0	copay	50%	coinsurance	2 every year	N		N
Routine Oral Exam	$20	copay	50%	coinsurance	2 every year	N		N
Limited Oral Exam	$20	copay	50%	coinsurance	1 every 12 months	N		N
Comprehensive Oral Exam	$20	copay	50%	coinsurance	1 every 36 mos	N		N
Bitewing X-rays	$20	copay	50%	coinsurance	1 every 12 months	N		N
Panoramic X-rays	$20	copay	50%	coinsurance	1 every 36 mos	N		N
Restorative Dental Benefit	Not Covered		Not Covered					
Hearing Services								
Hearing Services (Medicare-covered)	$20	copay	20%	coinsurance		Y-OON		N
Hearing Exam (Routine)	$20	copay	50%	coinsurance	1 every year	N		N
Hearing Aid Fitting (Routine)	$20	copay	50%	coinsurance	1 every year	N		N
Hearing Aids (Routine) - Amplifon Only	$690-$1,890	copay	$690-$1,890	copay	1 every year	N		N
Hearing Aids (Routine) - Combined Allowance	$500	allowance IN/OON	$500	allowance IN/OON	1 every 3 years	N		N
Vision Services								
Vision Services (Medicare-covered)	$20	copay	20%	coinsurance		Y-OON		N
Glaucoma Screening and Diabetic Retinal Eye Exam (Medicare-covered)	$0	copay	20%	coinsurance		Y-OON		N
Eyewear (Medicare-covered)	$0	copay	20%	coinsurance		Y-OON		N
Vision Exam (Routine)	$0	copay	20%	coinsurance	1 every year	N		N
Vision Eyewear (Routine)	$250	allowance IN/OON	$250	allowance IN/OON	1 every year	N		N
Other Services								
Counseling Services (Resources *for Life*)	$0	copay	Not Covered		6 sessions per issue	N		N
Fitness Benefit (SilverSneakers and personal training session)	$0	copay	Not Covered		1 every year	N		N
Health and Wellness Benefit (Rx Well)	$0	copay	Not Covered			N		N
Home Safety Items	$0	copay	Not Covered		3 items every year	N		N
In-Home Safety Assessment	$0	copay	Not Covered		1 every year	N		N
Nurse Advice Line	$0	copay	Not Covered			N		N
Palliative Care (including eligible meals)	Not Covered		Not Covered					
Remote Technologies - (AnywhereCare eVisits)	$20	copay	Not Covered			N		N
Routine Physical Exam	Not Covered		Not Covered					
Smoking and Tobacco Use Cessation	$0	copay	Not Covered		4 addtl sessions	N		N
Support for Caregivers (Resources *for Life*)	Not Covered		Not Covered					
Support for Caregivers (Powerful Tools for Caregivers)	$0	copay	Not Covered			N		N
Worldwide Emergency Coverage	$0	copay	$0	copay	IN/OON	N		N
ADDITIONAL BENEFIT PROGRAMS								
Visitor/Travel Benefit	Not Covered		Not Covered					

***Please see separate prior auth details chart for more detail**

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Part D Prescription Drugs

	2025													
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 Out-of-pocket Limit.													
Initial Coverage Limit (ICL)	N/A													
	Retail pharmacy						**Mail-order**						**LTC**	**OON**
	30 day supply		**60 day supply**		**100 day supply**		**30 day supply**		**60 day supply**		**100 day supply**		**31 day**	**30 day**
	Preferred	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1: Preferred Generic Drugs	$0	$15	$0	$30	$0	$30	$0	$15	$0	$30	$0	$30	$0	$15
Tier 2: Generic Drugs	$10	$20	$20	$40	$20	$40	$10	$20	$20	$40	$20	$40	$10	$20
Tier 3: Preferred Brand Drugs	$47	$47	$94	$94	$129.50	$141	$47	$47	$94	$94	$117.50	$141	$47	$47
Tier 4: Non-Preferred Drugs	$100	$100	$200	$200	$300	$300	$100	$100	$200	$200	$300	$300	$100	$100
Tier 5: Specialty Drugs	33%	33%	n/a	n/a	n/a	n/a	33%	33%	n/a	n/a	n/a	n/a	33%	33%
COVERAGE GAP STAGE	Starting in 2025, the Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit. Member moves from the Initial Coverage Stage to the Catastrophic Coverage Stage once the Out-of-Pocket Limit has been met.													
Out-of-Pocket Limit (TrOOP)	**$2,000**													
Coverage in the Coverage Gap	Starting in 2025, the Coverage Gap Discount Program will be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.													
	Retail pharmacy						**Mail-order**						**LTC**	**OON**
	30 day supply		**60 day supply**		**100 day supply**		**30 day supply**		**60 day supply**		**100 day supply**		**31 day**	**30 day**
	Preferred	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1: Preferred Generic Drugs	$0	$15	$0	$30	$0	$30	$0	$15	$0	$30	$0	$30	$0	$15
Tier 2: Generic Drugs	$10	$20	$20	$40	$20	$40	$10	$20	$20	$40	$20	$40	$10	$20
Tier 3: Preferred Brand Drugs	$35	$35	$70	$70	$96.25	$105	$35	$35	$70	$70	$87.50	$105	$35	$35
Tier 4: Non-Preferred Drugs	$35	$35	$70	$70	$96.25	$105	$35	$35	$70	$70	$87.50	$105	$35	$35
CATASTROPHIC COVERAGE STAGE	Member Pays $0													