UPMC *for Life* 2026 PPO Custom Basic - University of Pittsburgh

Plan Design	PPO Custom Basic		
Premium	**$271**		
	In-network (IN)	**Out-of-network**	**IN/OON**
	Cost-share	**Cost-share**	**Other Info**
ANNUAL MAXIMUMS			
Annual Deductible	$250	$500	
Maximum Out-of-Pocket	$1,000	$3,400	
INPATIENT CARE			
Inpatient Hospital/ Mental Health Care	10%	$0	per stay
Skilled Nursing Facility (days 1-100)	10%	$0	100 day limit
Blood	$0	$0	3 pints
Home Health Care	$0	$0	
OUTPATIENT CARE			
Primary Care Physician (PCP) Visits	$20	20%	
Specialist Visits	$20	20%	
Chiropractic Services (Medicare-covered)	10%	20%	
Chiropractic Services (Routine)	Not Covered	Not Covered	
Podiatry Services (Medicare-covered)	10%	20%	
Podiatry Services (Routine)	10%	Not Covered	4 visits every year
Outpatient Mental Health Services /Psychiatric Services/Substance Abuse	10%	20%	
Opioid Treatment Services	10%	20%	
Partial Hospitalization	10%	20%	
Outpatient Surgery and Ambulatory Surgical Center (ASC)	10%	20%	
Observation	10%	20%	
Ambulance Services (Ground & Air)	10%	20%	
Ambulance Services (Treat no Transport)	Not Covered	Not Covered	
Emergency Care	$75	$75	waived if admitted within 3 days
Urgently Needed Care (Clinics)	$20	$20	
Outpatient Rehab Services (PT, OT, ST)	10%	20%	
Cardiac/Pulmonary Rehab & Supervised Exercise Therapy (SET)	$0	20%	
OUTPATIENT MEDICAL AND SUPPLIES			
Durable Medical Equipment (DME) / Oxygen	10%	50%	
Prosthetic Devices and Medical Supplies	10%	50%	
Diabetes Training	$0	20%	
Diabetic Monitors and Test Strips - Preferred Brand	$0	20%	
Diabetic Supplies - All Other Brands	10%	20%	
Diabetic Shoes or Inserts	10%	20%	
Part B Drugs - Insulin	0-10%	20%	up to $35 copay/ 30 day supply
Part B Drugs	0-10%	20%	
Kidney Disease Training	0%	20%	
Renal Dialysis (ESRD)	10%	20%	
Lab Services	$0	20%	per day per facility
Diagnostic Procedures/Tests	$0	20%	per day per facility
Diagnostic X-Ray Services (Basic Imaging)	$0	20%	per service
Diagnostic Radiological Services (Advanced Imaging)	$25	20%	per service
Therapeutic Radiological Services (Radiation)	$0	20%	per service
PREVENTIVE SERVICES			
Immunizations	$0	$0	
Annual Wellness Visit	$0	20%	
Screening Exams	$0	20%	

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SUPPLEMENTAL BENEFITS			
Dental Services			
Dental Services (Medicare-covered)	$20	20%	
Preventive Dental Benefit:			
Cleaning	$0	50%	2 every year
Routine Oral Exam	$20	50%	2 every year
Limited Oral Exam	$20	50%	1 every 12 months
Comprehensive Oral Exam	$20	50%	1 every 36 mos
Bitewing X-rays	$20	50%	1 every 12 months
Panoramic X-rays	$20	50%	1 every 36 mos
Restorative Dental Benefit	Not Covered	Not Covered	
Hearing Services			
Hearing Services (Medicare-covered)	$20	20%	
Hearing Exam (Routine)	$20	50%	1 every year
Hearing Aid Fitting (Routine)	$20	50%	1 every year
Hearing Aids (Routine) - Amplifon Only	$690-$1,890	$690-$1,890	1 every year
Hearing Aids (Routine) - Combined Allowance	$500	$500	1 every 3 years
Vision Services			
Vision Services (Medicare-covered)	$20	20%	
Glaucoma Screening and Diabetic Retinal Eye Exam (Medicare-covered)	$0	20%	
Eyewear (Medicare-covered)	$0	20%	
Vision Exam (Routine)	$0	20%	1 every year
Vision Eyewear (Routine)	$250	$250	1 every year
Other Services			
Counseling Services (Resources *for Life*)	$0	Not Covered	6 sessions per issue
Fitness Benefit (SilverSneakers and personal training session)	$0	Not Covered	1 every year
Health and Wellness Benefit	$0	Not Covered	
Home Safety Items	$0	Not Covered	3 items every year
In-Home Safety Assessment	$0	Not Covered	1 every year
Nurse Advice Line	$0	Not Covered	
Palliative Care (including eligible meals)	Not Covered	Not Covered	
Remote Technologies - (AnywhereCare eVisits)	$20	Not Covered	
Routine Physical Exam	Not Covered	Not Covered	
Smoking and Tobacco Use Cessation	$0	Not Covered	4 addtl sessions
Support for Caregivers (Resources *for Life*)	Not Covered	Not Covered	
Support for Caregivers (Powerful Tools for Caregivers)	$0	Not Covered	
Worldwide Emergency Coverage	$0	$0	IN/OON
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														
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**	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%
Tier 4: **Non-Preferred Drugs**	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
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)	**$2,100**													
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**
Insulins under the Inflation Reduction Act (IRA)	**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													