UPMC *for Life*

2016 PPO High Deductible with Rx - Western Pennsylvania (28 Counties) - Final 8/31/2015

Benefits	PPO High Deductible with Rx				Changes
Contract ID	H5533		H5533		
PBP(s)	Western Pennsylvania - 003; Lancaster - 006		Western Pennsylvania - 003; Lancaster - 006		
	2015		2016		
	In-Network (IN)	Out-of-Network (OON)	In-Network (IN)	Out-of-Network (OON)	
Premium	$39.00		Western Pennsylvania - $44; Lancaster - $43		$4-$5 increase
ANNUAL MAXIMUMS					
Annual Deductible	$1,250 combined IN/OON		$1,250 combined IN/OON		
Out-of-Pocket Maximum	$6,700 IN only	$10,000 combined IN/OON	$6,700 IN only	$10,000 combined IN/OON	
INPATIENT CARE					
Inpatient Hospital **prior auth required*	$250 copay per stay after deductible	30% coinsurance after deductible	$250 copay per stay after deductible	30% coinsurance after deductible	
Inpatient Mental Health Care **prior auth required*	$250 copay per stay after deductible	30% coinsurance after deductible	$250 copay per stay after deductible	30% coinsurance after deductible	
Skilled Nursing Facility **prior auth required 100 day limit per benefit period*	$0 copay per day - days 1-20 $125 copay per day - days 21-100 excluded from deductible	30% coinsurance after deductible	$0 copay per day - days 1-20 $160 copay per day - days 21-100 excluded from deductible	30% coinsurance after deductible	Increased copayment
Home Health Care **prior auth required*	$0 copay after deductible	30% coinsurance after deductible	$0 copay excluded from deductible	30% coinsurance after deductible	INN now excluded from deductible
OUTPATIENT CARE					
Primary Care Doctor Visits	$10 copay excluded from deductible	$40 copay after deductible	$10 copay excluded from deductible	$40 copay after deductible	
Specialist Visits	$50 copay excluded from deductible	$60 copay after deductible	$50 copay excluded from deductible	$60 copay after deductible	
Chiropractic Services	$20 copay excluded from deductible	$40 copay after deductible	$20 copay excluded from deductible	30% coinsurance after deductible	Changed to coinsurance
Routine Chiropractic Services *(8 visits every year)*	$20 copay excluded from deductible	$40 copay after deductible	$20 copay excluded from deductible	30% coinsurance excluded from deductible	Exclude OON from deductible, Changed OON to coinsurance
Podiatry Services	$50 copay excluded from deductible	$60 copay after deductible	$50 copay after deductible	30% coinsurance after deductible	Deductible applies for INN. Changed to OON coinsurance
Routine Podiatry Services *(8 visits every year)*	$50 copay excluded from deductible	$60 copay after deductible	$50 copay excluded from deductible	30% coinsurance excluded from deductible	Exclude OON from deductible, Changed OON to coinsurance
Outpatient Mental Health	$40 copay excluded from deductible	$60 copay after deductible	$40 copay after deductible	30% coinsurance after deductible	Deductible applies for INN. Changed to OON coinsurance
Outpatient Psychiatric Services	$40 copay excluded from deductible	$60 copay after deductible	$40 copay after deductible	30% coinsurance after deductible	Deductible applies for INN. Changed to OON coinsurance
Outpatient Substance Abuse	$40 copay excluded from deductible	$60 copay after deductible	$40 copay after deductible	30% coinsurance after deductible	Deductible applies for INN. Changed to OON coinsurance
Partial Hospitalization **prior auth required*	$0 copay after deductible	30% coinsurance after deductible	$0 copay after deductible	30% coinsurance after deductible	
Outpatient Surgery and Ambulatory Surgical Center **prior auth required*	$0 - $125 copay (Outpatient) $125 copay (ASC) after deductible	30% coinsurance after deductible	$125 copay after deductible	30% coinsurance after deductible	
Ambulance Services	$0 copay after deductible	30% coinsurance after deductible	$0 copay after deductible	30% coinsurance after deductible	
Emergency Care *(waived if admitted within 3 days)*	$65 copay excluded from deductible		$75 copay excluded from deductible		Increased copayment
Urgently Needed Care (Clinics) *(out-of-area; urgent care clinics)*	$50 copay excluded from deductible		$50 copay excluded from deductible		
Outpatient Rehab Services *(PT, OT, ST)*	$40 copay excluded from deductible	30% coinsurance after deductible	$40 copay after deductible	30% coinsurance after deductible	Deductible applies for INN
Cardiac/Pulmonary Rehab	$0 copay after deductible	30% coinsurance after deductible	$0 copay after deductible	30% coinsurance after deductible	
OUTPATIENT MEDICAL AND SUPPLIES					
Durable Medical Equipment/Oxygen **prior auth required*	15% coinsurance excluded from deductible	50% coinsurance after deductible	20% coinsurance excluded from deductible	50% coinsurance after deductible	Increased coinsurance
Prosthetic Devices and Medical Supplies	15% coinsurance excluded from deductible	50% coinsurance after deductible	20% coinsurance excluded from deductible	50% coinsurance after deductible	Increased coinsurance
Diabetes Training and Diabetic Supplies	$0 copay - training excluded from deductible 10% coinsurance - supplies after deductible	50% coinsurance after deductible	$0 copay - training excluded from deductible 20% coinsurance - supplies after deductible	30% coinsurance -training 50% coinsurance - supplies after deductible	Increased INN/lowered OON training coinsurance
Diabetic Shoes or Inserts	10% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible	Increased coinsurance
Part B Drugs **prior auth required*	20% coinsurance all Part B drugs; chemotherapy / self-administered excluded from deductible	50% coinsurance after deductible	20% coinsurance all Part B drugs; chemotherapy / self-administered excluded from deductible	50% coinsurance after deductible	
Kidney Disease Training and Renal Dialysis (ESRD)	$0 copay - training excluded from deductible 20% coinsurance - dialysis after deductible	30% coinsurance after deductible	$0 copay - training excluded from deductible 20% coinsurance - dialysis after deductible	30% coinsurance after deductible	
Lab Services	$0-$5 copay per day excluded from deductible	30% coinsurance after deductible	$0-$10 copay per day excluded from deductible	30% coinsurance after deductible	Increased copayment
Diagnostic Procedures/Tests	$0-$5 copay per day excluded from deductible	30% coinsurance after deductible	$0-$10 copay per day excluded from deductible	30% coinsurance after deductible	Increased copayment
X-Ray Services	$10 copay after deductible	30% coinsurance after deductible	$10 copay after deductible	30% coinsurance after deductible	
Diagnostic Radiological Services (Advanced Imaging) **prior auth required*	$50 copay after deductible	30% coinsurance after deductible	$100 copay after deductible	30% coinsurance after deductible	Increased copayment
Therapeutic Radiological Services (Radiation)	$0 copay after deductible	30% coinsurance after deductible	$0 copay after deductible	30% coinsurance after deductible	
PREVENTIVE SERVICES					
Immunizations *(influenza, pneumonia, Hepatitis B)*	$0 copay excluded from deductible	30% coinsurance excluded from deductible	$0 copay excluded from deductible	30% coinsurance excluded from deductible	
Annual Wellness Visit	$0 copay excluded from deductible	30% coinsurance excluded from deductible	$0 copay excluded from deductible	30% coinsurance excluded from deductible	
Screening Exams *Includes Bone Mass Measurement, Colorectal Screening, Mammograms, Pap & Pelvic, Prostate Exams, all Medicare-covered Preventive Services*	$0 copay excluded from deductible	30% coinsurance excluded from deductible	$0 copay excluded from deductible	30% coinsurance excluded from deductible	

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Benefits	PPO High Deductible with Rx				Changes
Contract ID	H5533		H5533		
PBP(s)	Western Pennsylvania - 003; Lancaster - 006		Western Pennsylvania - 003; Lancaster - 006		
	2015		2016		
	In-Network (IN)	Out-of-Network (OON)	In-Network (IN)	Out-of-Network (OON)	
ADDITIONAL SERVICES					
Dental Services					
Medicare-covered Dental Services	$50 copay excluded from deductible	$60 copay after deductible	$50 copay excluded from deductible	30% coinsurance after deductible	Changed OON to coinsurance
Routine Dental Oral Exam & Cleaning *(once every 6 months)*	$15 copay excluded from deductible	50% coinsurance excluded from deductible	$15 copay excluded from deductible	50% coinsurance excluded from deductible	
Routine Dental Bitewing X-rays *(once every year)*	$15 copay excluded from deductible	50% coinsurance excluded from deductible	$15 copay excluded from deductible	50% coinsurance excluded from deductible	X-rays were every 3 years
Hearing Services					
Medicare-covered Hearing Services	$50 copay excluded from deductible	$60 copay after deductible	$50 copay excluded from deductible	30% coinsurance after deductible	Changed OON to coinsurance
Routine Hearing Exam	not covered		not covered		
Routine Hearing Aid Fitting	not covered		not covered		
Routine Hearing Aids	VAIS discount		VAIS discount		
Vision Services					
Medicare-covered Vision Services	$50 copay excluded from deductible	$60 copay after deductible	$50 copay excluded from deductible	30% coinsurance after deductible	Changed OON to coinsurance
Medicare-covered Glaucoma Screening and Diabetic Retinal Eye Exam	$0 copay excluded from deductible	$60 copay after deductible	$0 copay excluded from deductible	30% coinsurance after deductible	Changed OON to coinsurance
Medicare-covered Eyewear *Cataract Glasses/Lens*	$0 copay excluded from deductible	30% coinsurance after deductible	$0 copay excluded from deductible	30% coinsurance after deductible	
Routine Vision Exam & Eyewear *(once every two years)* Allowance must be used for both routine eye exam and eyewear.	$100 combined IN/OON allowance excluded from deductible		$100 combined IN/OON allowance excluded from deductible		
Other Services					
Health & Wellness *Fitness Center Benefit*	Silver & Fit excluded from deductible	50% coinsurance excluded from deductible	Silver & Fit excluded from deductible	50% coinsurance excluded from deductible	
Remote Technologies	N/A	N/A	$10 for eVisits / $38 for eDerm excluded from deductible	50% coinsurance excluded from deductible	New Supplemental Benefit
Worldwide Emergency Coverage	Assist America Travel Benefit excluded from deductible		Assist America Travel Benefit excluded from deductible		
Part D Prescription Drugs					
Tier 1: Generic Drugs	$10 copay - 30 day supply (retail) $30 copay - 90 day supply (retail) $20 copay - 90 day supply (mail-order)		$14 copay - 30 day supply (retail) $42 copay - 90 day supply (retail) $28 copay - 90 day supply (mail-order)		Increased copayment
Tier 2: Preferred Brand Drugs	$45 copay - 30 day supply (retail) $135 copay - 90 day supply (retail) $112.50 copay - 90 day supply (mail-order)		$47 copay - 30 day supply (retail) $141 copay - 90 day supply (retail) $117.50 copay - 90 day supply (mail-order)		Increased copayment
Tier 3: Non-Preferred Brand Drugs	$95 copay - 30 day supply (retail) $285 copay - 90 day supply (retail) $285 copay - 90 day supply (mail-order)		$100 copay - 30 day supply (retail) $300 copay - 90 day supply (retail) $300 copay - 90 day supply (mail-order)		Increased copayment
Tier 4: Specialty Drugs	33% coinsurance - 30 day supply only		33% coinsurance - 30 day supply only		
Tier 5: Select Care Drugs	$0 copay - 30 day supply (retail) $0 copay - 90 day supply (retail) $0 copay - 90 day supply (mail-order)		$0 copay - 30 day supply (retail) $0 copay - 90 day supply (retail) $0 copay - 90 day supply (mail-order)		
Initial Coverage Limit	$2,960		$3,310		CMS Limit Change
Out-of-Pocket Limit (TrOOP)	$4,700		$4,850		CMS Limit Change
Gap Coverage	Member pays 65% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap		Member pays 58% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap		CMS Annual Change
Catastrophic Copays	Greater of: $2.65 generic/brand treated as generic $6.60 or 5% all others		Greater of: $2.95 generic/brand treated as generic $7.40 or 5% all others		CMS Limit Change

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2016 PPO Rx Enhanced Plan - Western Pennsylvania (28 Counties) - Final 8/5/2015

Benefits	PPO Rx Enhanced				Changes
Contract ID	H5533		H5533		
PBP(s)	005		005		
	2015		2016		
	In-Network (IN)	Out-of-Network (OON)	In-Network (IN)	Out-of-Network (OON)	
Premium	$139.00		$152.00		$13 increase
ANNUAL MAXIMUMS					
Annual Deductible	N/A	$500 OON only	N/A	$500 OON only	
Out-of-Pocket Maximum	$6,700 IN only	$10,000 combined IN/OON	$6,700 IN only	$10,000 combined IN/OON	
INPATIENT CARE					
Inpatient Hospital *prior auth required	$250 copay per stay $1,000 annual limit (4x max)	30% coinsurance after deductible	$250 copay per stay	30% coinsurance after deductible	Removed annual benefit maximum
Inpatient Mental Health Care *prior auth required	$250 copay per stay $1,000 annual limit (4x max)	30% coinsurance after deductible	$250 copay per stay	30% coinsurance after deductible	Removed annual benefit maximum
Skilled Nursing Facility *prior auth required 100 day limit per benefit period	$0 copay per day - days 1-20 $125 copay per day - days 21-100	30% coinsurance after deductible	$0 copay per day - days 1-20 $160 copay per day - days 21-100	30% coinsurance after deductible	Increased copayment
Home Health Care *prior auth required	$0 copay	30% coinsurance after deductible	$0 copay	30% coinsurance after deductible	
OUTPATIENT CARE					
Primary Care Doctor Visits	$5 copay	$30 copay after deductible	$5 copay	$30 copay after deductible	
Specialist Visits	$40 copay	$50 copay after deductible	$40 copay	$50 copay after deductible	
Chiropractic Services	$20 copay	$30 copay after deductible	$20 copay	30% coinsurance after deductible	Changed OON to coinsurance
Routine Chiropractic Services (8 visits every year)	$20 copay	$30 copay after deductible	$20 copay	30% coinsurance exclude from deductible	Changed OON to coinsurance; Exclude from deductible
Podiatry Services	$40 copay	$50 copay after deductible	$40 copay	30% coinsurance after deductible	Changed OON to coinsurance
Routine Podiatry Services (8 visits every year)	$40 copay	$50 copay after deductible	$40 copay	30% coinsurance exclude from deductible	Changed OON to coinsurance; Exclude from deductible
Outpatient Mental Health Services	$40 copay	$50 copay after deductible	$40 copay	30% coinsurance after deductible	Changed OON to coinsurance
Outpatient Psychiatric Services	$40 copay	$50 copay after deductible	$40 copay	30% coinsurance after deductible	Changed OON to coinsurance
Outpatient Substance Abuse	$40 copay	$50 copay after deductible	$40 copay	30% coinsurance after deductible	Changed OON to coinsurance
Partial Hospitalization *prior auth required	$0 copay	30% coinsurance after deductible	$0 copay	30% coinsurance after deductible	
Outpatient Surgery and Ambulatory Surgical Center *prior auth required	$0 - $150 copay (Outpatient) $150 copay (ASC)	30% coinsurance after deductible	$150 copay	30% coinsurance after deductible	
Ambulance Services	$100 copay per one way trip	30% coinsurance after deductible	$100 copay per one way trip	30% coinsurance after deductible	
Emergency Care (waived if admitted within 3 days)	$65 copay excluded from deductible		$75 copay excluded from deductible		Increased copayment
Urgently Needed Care (Clinics) (out-of-area, urgent care clinics)	$40 copay excluded from deductible		$50 copay excluded from deductible		Increased copayment
Outpatient Rehab Services (PT, OT, ST)	$40 copay	$50 copay after deductible	$40 copay	30% coinsurance after deductible	Changed OON to coinsurance
Cardiac/Pulmonary Rehab	$0 copay	30% coinsurance after deductible	$0 copay	30% coinsurance after deductible	
OUTPATIENT MEDICAL AND SUPPLIES					
Durable Medical Equipment/Oxygen *prior auth required	15% coinsurance	50% coinsurance after deductible	20% coinsurance	50% coinsurance after deductible	Increased coinsurance
Prosthetic Devices and Medical Supplies	15% coinsurance	50% coinsurance after deductible	20% coinsurance	50% coinsurance after deductible	Increased coinsurance
Diabetes Training and Diabetic Supplies	$0 copay - training 20% coinsurance - supplies	30% coinsurance - training after deductible 50% coinsurance - supplies after deductible	$0 copay - training 20% coinsurance - supplies	30% coinsurance - training after deductible 50% coinsurance - supplies after deductible	
Diabetic Shoes or Inserts	20% coinsurance	50% coinsurance after deductible	20% coinsurance	50% coinsurance after deductible	
Part B Drugs *prior auth required	20% coinsurance all Part B drugs; chemotherapy / self-administered $5,000 annual limit	30% coinsurance after deductible no max	20% coinsurance all Part B drugs; chemotherapy / self-administered	30% coinsurance after deductible no max	Removed annual benefit maximum
Kidney Disease Training and Renal Dialysis (ESRD)	$0 copay - training 20% coinsurance - dialysis	30% coinsurance after deductible	$0 copay - training 20% coinsurance - dialysis	30% coinsurance after deductible	
Lab Services	$0-$5 copay per day	30% coinsurance after deductible	$0-$5 copay per day	30% coinsurance after deductible	
Diagnostic Procedures/Tests	$0-$5 copay per day	30% coinsurance after deductible	$0-$5 copay per day	30% coinsurance after deductible	
X-Ray Services	$20 copay	30% coinsurance after deductible	$20 copay	30% coinsurance after deductible	
Diagnostic Radiological Services (Advanced Imaging) *prior auth required	$100 copay	30% coinsurance after deductible	$100 copay	30% coinsurance after deductible	
Therapeutic Radiological Services (Radiation)	$25 copay	30% coinsurance after deductible	$25 copay	30% coinsurance after deductible	
PREVENTIVE SERVICES					
Immunizations (influenza, pneumonia, Hepatitis B)	$0 copay	30% coinsurance excluded from deductible	$0 copay	30% coinsurance excluded from deductible	
Annual Wellness Visit	$0 copay	30% coinsurance excluded from deductible	$0 copay	30% coinsurance excluded from deductible	
Screening Exams Includes Bone Mass Measurement, Colorectal Screening, Mammograms, Pap & Pelvic, Prostate Exams, all Medicare-covered Preventive Services	$0 copay	30% coinsurance excluded from deductible	$0 copay	30% coinsurance excluded from deductible	

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2016 PPO Rx Enhanced Plan - Western Pennsylvania (28 Counties) - Final 8/5/2015

Benefits	PPO Rx Enhanced				Changes
Contract ID	H5533		H5533		
PBP(s)	005		005		
	2015		2016		
	In-Network (IN)	Out-of-Network (OON)	In-Network (IN)	Out-of-Network (OON)	
ADDITIONAL SERVICES					
Dental Services					
Medicare-covered Dental Services	$40 copay	$50 copay after deductible	$40 copay	30% coinsurance after deductible	Changed OON to coinsurance
Routine Dental Oral Exam & Cleaning *(once every 6 months)*	$15 copay	50% coinsurance excluded from deductible	$15 copay	50% coinsurance excluded from deductible	
Routine Dental Bitewing X-rays *(once every year)*	$15 copay	50% coinsurance excluded from deductible	$15 copay	50% coinsurance excluded from deductible	X-rays were every 3 years
Hearing Services					
Medicare-covered Hearing Services	$40 copay	$50 copay after deductible	$40 copay	30% coinsurance after deductible	Changed OON to coinsurance
Routine Hearing Exam *(once every year)*	$40 copay	$50 copay excluded from deductible	$40 copay	30% coinsurance excluded from deductible	Changed OON to coinsurance
Routine Hearing Aid Fitting *(once every 3 years)*	$40 copay	$50 copay excluded from deductible	$40 copay	30% coinsurance excluded from deductible	Changed OON to coinsurance
Routine Hearing Aids *(once every 3 years)*	N/A $1,500 combined IN/OON allowance	50% coinsurance excluded from deductible	$1,500 combined IN/OON allowance		Eliminated 50% OON coinsurance
Vision Services					
Medicare-covered Vision Services	$40 copay	$50 copay after deductible	$40 copay	30% coinsurance after deductible	Changed OON to coinsurance
Medicare-covered Glaucoma Screening and Diabetic Retinal Eye Exam	$0 copay	$50 copay after deductible	$0 copay	30% coinsurance after deductible	Changed OON to coinsurance
Medicare-covered Eyewear *Cataract Glasses/Lens*	$0 copay	30% coinsurance after deductible	$0 copay	30% coinsurance after deductible	
Routine Vision Exam & Eyewear *(once every year)* Allowance must be used for both routine eye exam and eyewear.	$200 combined IN/OON allowance excluded from deductible (OON)		$200 combined IN/OON allowance excluded from deductible (OON)		
Other Services					
Health & Wellness *Fitness Center Benefit*	Silver & Fit	50% coinsurance excluded from deductible	Silver & Fit	50% coinsurance excluded from deductible	
Remote Technologies	N/A	N/A	$5 for eVisits / $38 for eDerm	50% coinsurance excluded from deductible	New Supplemental Benefit
Worldwide Emergency Coverage	Assist America Travel Benefit excluded from deductible (OON)		Assist America Travel Benefit excluded from deductible (OON)		
Part D Prescription Drugs					
Tier 1: Generic Drugs	$10 copay - 30 day supply (retail) $30 copay - 90 day supply (retail) $20 copay - 90 day supply (mail-order)		$12 copay - 30 day supply (retail) $36 copay - 90 day supply (retail) $24 copay - 90 day supply (mail-order)		Increased copayment
Tier 2: Preferred Brand Drugs	$45 copay - 30 day supply (retail) $135 copay - 90 day supply (retail) $112.50 copay - 90 day supply (mail-order)		$47 copay - 30 day supply (retail) $141 copay - 90 day supply (retail) $117.50 copay - 90 day supply (mail-order)		Increased copayment
Tier 3: Non-Preferred Brand Drugs	$95 copay - 30 day supply (retail) $285 copay - 90 day supply (retail) $285 copay - 90 day supply (mail-order)		$100 copay - 30 day supply (retail) $300 copay - 90 day supply (retail) $300 copay - 90 day supply (mail-order)		Increased copayment
Tier 4: Specialty Drugs	33% coinsurance - 30 day supply only		33% coinsurance - 30 day supply only		
Tier 5: Select Care Drugs	$0 copay - 30 day supply (retail) $0 copay - 90 day supply (retail) $0 copay - 90 day supply (mail-order)		$0 copay - 30 day supply (retail) $0 copay - 90 day supply (retail) $0 copay - 90 day supply (mail-order)		
Initial Coverage Limit	$2,960		$3,310		CMS Limit Change
Out-of-Pocket Limit (TrOOP)	$4,700		$4,850		CMS Limit Change
Gap Coverage	Member pays 65% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap		Member pays 58% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap		CMS Annual Change
Catastrophic Copays	Greater of: $2.65 generic/brand treated as generic $6.60 or 5% all others		Greater of: $2.95 generic/brand treated as generic $7.40 or 5% all others		CMS Limit Change