PROGRAM REQUIRING A LOCAL RESIDENCY

UPMC *for Life* PPO
And
Prescription Drug Plan (PDP)

UPMC *for Life*

UPMC Health Plan Medicare Program

UPMC *for Life*
2007 University of Pittsburgh PPO Plan Design

In order to receive the highest level of benefits, you must receive care from in-network providers or facilities. If you choose to go to a provider or facility outside of the UPMC *for Life* network, you will pay a higher amount for covered services.

Covered Services	In-network	Out-of-Network
Lifetime Maximum	Unlimited	$1,000,000
Annual Deductible	$0	$500
Annual Out-of-Pocket Maximum	N/A	$20,000
INPATIENT CARE		
Inpatient Hospital	$250 copay per admission	You pay 20% after deductible (limit of 70 inpatient days annually)
Inpatient Mental Health/Substance Abuse[2]	$250 copay per admission	You pay 20% after deductible (limit of 70 inpatient days annually)
Skilled Nursing Facility	$0 each day for days 1-20 $25 each day for days 21-100 (limit of 100 days per benefit period)	You pay 20% after deductible (limit of 100 days per benefit period)
Home Health Care	100% covered	You pay 20% after deductible
Hospice	Medicare-covered benefit	Medicare-covered benefit
OUTPATIENT CARE		
PCP Visit	$20 copay per visit	You pay 20% after deductible
Routine Physical Exam	100% covered, one exam per year	You pay 20% after deductible
Specialist Visit	$20 copay per visit	You pay 20% after deductible
Chiropractic Services	$15 copay per visit	You pay 20% after deductible
Routine Chiropractic Visits	$15 copay per visit, limit of 6 visits per year	Not covered out-of-network
Podiatry Services	$20 copay per visit	You pay 20% after deductible
Routine Podiatry Visits	$20 copay per visit, limit of 4 visits per year	Not covered out-of-network
Outpatient Mental Health/Substance Abuse	• $20 copay for each individual visit • $15 copay for each group visit	You pay 20% after deductible
Outpatient Surgery/ASC	$100 copay per visit	You pay 20% after deductible
Ambulance Services	$25 copay	You pay 20% after deductible
Emergency Care	$50 copay per visit (waived if admitted within 3 days)	
Urgent Care	$50 copay per visit (waived if admitted within 3 days)	
Outpatient Therapy: includes physical, occupational and speech therapy	$25 copay per visit	You pay 20% after deductible

[2] 190 day lifetime maximum – combined total in-network and out-of-network days.

Covered Services	In-network	Out-of-Network
OUTPATIENT MEDICAL AND SUPPLIES		
Durable Medical Equipment	100% covered for durable medical equipment and oxygen	You pay 20% after deductible
Prosthetic Devices	100% covered for prosthetics	You pay 20% after deductible
OUTPATIENT MEDICAL AND SUPPLIES continued…		
Diabetes Training & Supplies	• Diabetic training covered in full at 100%. • $20 copay for a 31-day supply of diabetic supplies • $40 copay for a 90-day supply of diabetic supplies	• You pay 20% after deductible for diabetic training • You pay 20% after deductible for diabetic supplies
Diagnostic Tests, X-Rays, & Labs	• $0 copay per visit for clinical/diagnostic lab services • $0 copay per visit for general x-rays • $25 copay per visit for CTscans, MRIs, MRAs, PET scans, Nuclear Medicine	You pay 20% after deductible
PREVENTIVE SERVICES		
Bone Mass Measurement	100% covered	You pay 20% after deductible
Immunizations (flu vaccine, pneumonia and Hepatitis B vaccines)	100% covered for Medicare-covered immunizations	
Screening Exams – colorectal screenings, mammograms, Pap smears, pelvic exams, prostate exams	100% covered + 1 additional screening exam per year	• You pay 20% after deductible • No out-of-network additional screening exam
ADDITIONAL BENEFITS		
Dental Services	• $20 copay oral exam and cleaning, one exam every year	• You pay 50% after deductible for out-of-network dental services. • $100 annual maximum
Hearing Services	• $20 copay Medicare-covered exams • $20 copay routine exam, one exam per year • $20 copay for hearing aid fitting and evaluation, once every three years • $500 allowance toward hearing aid(s), every three years (not to exceed the cost of aid)	• You pay 20% after deductible for Medicare-covered services. • You pay 50% after deductible for Non-Medicare-covered services. • $100 annual maximum

Covered Services	In-network	Out-of-Network
Vision Services	• $20 copay Medicare-covered eye exams • $20 copay routine exam, one exam every two years • Standard lenses (single, bifocal, trifocal) are covered in full, one pair every two years • $100 allowance toward eyewear, one pair of frames or contacts every two years.	• You pay 20% after deductible for Medicare-covered services. • You pay 50% after deductible for Non-Medicare-covered services. • $100 annual maximum
Health & Wellness (Fitness Center Benefit)	100% covered	• You pay 50% after deductible • $100 annual maximum
ADDITIONAL BENEFITS continued….		
Emergency Travel Assistance Benefit	100% covered	100% covered
Part B Prescription Drugs	• $20 copay for a 31-day supply of Part B drugs • $40 copay for a 90-day supply of Part B drugs	You pay 20% after deductible
Prescription Drugs	• **Unlimited** annual prescription drug coverage • No deductible • 31-day Retail Copays: * $10/$20/$40/25%/25%[3] • 90-day Retail Copays: * $20/$40/$80/25%/25%[2] • 90-day Mail Order Copays: * $20/$40/$80/25%/25%[2] • **After your yearly out-of-pocket drug costs reach $3,850, you pay the greater of:** * $2.15 for generic or preferred brand drugs, and * $5.35 for all other drugs, or * 5% coinsurance • **Out-of-network prescription drugs covered only in emergency**[3]	

NOTE: UPMC Health Plan, Inc. has determined that the prescription drug coverage offered by this employer group plan for 2007 is creditable coverage.

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[3] You have a 5-tier prescription drug formulary. The copay structure listed above is: Generic, Preferred Brand, Non-Preferred Brand, Low Cost Injectable and Specialty-Drugs. Out-of-network prescription drugs covered only in an emergency.

[3] If you use an Out-of-Network pharmacy, you must pay the full cost of the prescription, at the point of sale. You will **not** be reimbursed for the difference between UPMC *for Life* allowed amount and the total billed amount for the prescription drug.