

# Your 2024 UPMC *for Life* Plan Designs

Int'l Assoc of Machinists & Aerospace Workers Local 1976

# This booklet contains your plan benefit design for 2024.

Your plan designs let you know what your retirees can expect to pay for the benefits and services included in their plan. The benefit designs have been updated to follow any changes in federal requirements or regulations for 2024. Please review this detailed plan information carefully.

If you have questions regarding your plan or plan options, please contact your group benefit administrator **Marsha Perry** at **perrym10@upmc.edu**.

## UPMC for Life 2024 HMO Standard

Plan Design	HMO Standard
Premium	\$177
<b>ANNUAL MAXIMUMS</b>	
Annual Deductible	\$0
Maximum Out-of-Pocket	\$3,400
<b>INPATIENT CARE</b>	
Inpatient Hospital/ Mental Health Care (per stay) *	\$250 copay
Skilled Nursing Facility (days 1-20) (100 day limit) *	\$0 copay
Skilled Nursing Facility (days 21-100) (100 day limit) *	\$25 copay
Blood (3 pints)	\$0 copay
Home Health Care *	\$0 copay
Home Health Care (Telehealth) *	\$0 copay
<b>OUTPATIENT CARE</b>	
Primary Care Physician (PCP) Visits	\$10 copay
Primary Care Physician (PCP) Visits (Telehealth)	\$10 copay
Specialist Visits	\$35 copay
Specialist Visits (Telehealth)	\$35 copay
Chiropractic Services (Medicare-covered) *	\$20 copay
Chiropractic Services (Routine) (6 visits every year) *	\$20 copay
Podiatry Services (Medicare-covered)	\$35 copay
Podiatry Services (Routine) (4 visits every year)	\$35 copay
Outpatient Mental Health Services/Psychiatric Services /Substance Abuse	\$35 copay
Outpatient Mental Health Services /Psychiatric Services /Substance Abuse (Telehealth)	\$35 copay
Opioid Treatment Services	\$35 copay
Partial Hospitalization	\$0 copay
Outpatient Surgery and Ambulatory Surgical Center (ASC)/Observation (\$400 annual limit) *	\$200 copay
Ambulance Services (Ground & Air) *	\$100 copay
Ambulance Services (Treat no Transport)	Not Covered
Emergency Care (waived if admitted within 3 days)	\$120 copay
Urgently Needed Care (Clinics)	\$50 copay
Outpatient Rehab Services (PT, OT, ST) *	\$35 copay
Cardiac/Pulmonary Rehab & Supervised Exercise Therapy (SET)	\$0 copay
<b>OUTPATIENT MEDICAL AND SUPPLIES</b>	
Durable Medical Equipment (DME)/Oxygen *	20% coinsurance
Prosthetic Devices and Medical Supplies *	20% coinsurance
Diabetes Training	\$0 copay
Diabetes Training (Telehealth)	\$0 copay
Diabetic Monitors and Test Strips - LifeScan Only	\$0 copay
Diabetic Supplies - All Other Brands *	20% coinsurance
Diabetic Shoes or Inserts	20% coinsurance
Part B Drugs - Insulin (max: \$35, 30-day supply)	20% coinsurance
Part B Drugs *	20% coinsurance
Kidney Disease Training	\$0 copay
Renal Dialysis (ESRD)	20% coinsurance
Lab Services (per day per facility)	\$0 copay
Diagnostic Procedures/Tests (per day per facility) *	\$0 copay
Diagnostic X-Ray Services (Basic Imaging) (per service)	\$25 copay
Diagnostic Radiological Services (Advanced Imaging)(per service) *	\$75 copay
Therapeutic Radiological Services (Radiation) (per service)	\$25 copay

<b>UPMC for Life 2024 HMO Standard</b>	
<b>Plan Design</b>	<b>HMO Standard</b>
<b>Premium</b>	<b>\$177</b>
<b>PREVENTIVE SERVICES</b>	
<b>Immunizations</b>	\$0 copay
<b>Annual Wellness Visit</b>	\$0 copay
<b>Screening Exams</b>	\$0 copay
<b>SUPPLEMENTAL BENEFITS</b>	
<b>Dental Services</b>	
<b>Dental Services (Medicare-covered)</b>	\$35 copay
<b>Preventive Dental Benefit:</b>	
<b>Cleaning</b>	Not Covered
<b>Routine Oral Exam</b>	Not Covered
<b>Limited Oral Exam</b>	Not Covered
<b>Comprehensive Oral Exam</b>	Not Covered
<b>Bitewing X-rays</b>	Not Covered
<b>Panoramic X-rays</b>	Not Covered
<b>Restorative Dental Benefit</b>	Not Covered
<b>Hearing Services</b>	
<b>Hearing Services (Medicare-covered)</b>	\$35 copay
<b>Hearing Exam (Routine) (1 every year)</b>	\$35 copay
<b>Hearing Aid Fitting (Routine) (1 every year)</b>	\$35 copay
<b>Hearing Aids (Routine) (1 every year)</b>	\$690-\$1,890 copay
<b>Vision Services</b>	
<b>Vision Services (Medicare-covered)</b>	\$35 copay
<b>Glaucoma Screening and Diabetic Retinal Eye Exam (Medicare-covered)</b>	\$0 copay
<b>Eyewear (Medicare-covered)</b>	\$0 copay
<b>Vision Exam (Routine) (1 every year)</b>	\$0 copay
<b>Vision Eyewear (Routine) (1 every year)</b>	\$200 allowance
<b>Other Services</b>	
<b>Counseling Services (Resources for Life ) (6 sessions per issue)</b>	\$0 copay
<b>Fitness Benefit (SilverSneakers and personal training session) (1 every year)</b>	\$0 copay
<b>Health and Wellness Benefit (Rx Well)</b>	\$0 copay
<b>Home Safety Items (3 items every year)</b>	\$0 copay
<b>In-Home Safety Assessment (1 every year)</b>	\$0 copay
<b>Nurse Advice Line</b>	\$0 copay
<b>Over-the-counter (OTC) Items</b>	Not Covered
<b>Palliative Care (including eligible meals) (56 meals for 28 days)</b>	\$0 copay
<b>Remote Technologies (AnywhereCare eVisits)</b>	\$10 copay
<b>Routine Physical Exam</b>	Not Covered
<b>Smoking and Tobacco Use Cessation (4 addtl sessions)</b>	\$0 copay
<b>Support for Caregivers (Resources for Life ) (6 sessions )</b>	\$0 copay
<b>Support for Caregivers (Powerful Tools for Caregivers)</b>	\$0 copay
<b>Worldwide Emergency Travel Assistance Coverage</b>	\$0 copay
<b>ADDITIONAL BENEFIT PROGRAMS</b>	
<b>Visitor/Travel Benefit</b>	Covered in Arizona, Florida, Georgia, North Carolina, South Carolina and Tennessee

\* Requires Prior Authorization

## UPMC for Life 2024 HMO Standard

<b>Part D Prescription Drugs</b>											
<b>DEDUCTIBLE STAGE</b>	There is no deductible for Part D prescription drugs.										
<b>Rx Deductible</b>	<b>\$0</b>										
<b>INITIAL COVERAGE STAGE</b>											
Member pays cost-sharing amounts below until total yearly costs reach the Initial Coverage Limit.											
<b>Initial Coverage Limit (ICL)</b>	<b>\$5,030</b>										
	<b>Retail pharmacy</b>						<b>Mail-order</b>		<b>LTC</b>	<b>OON</b>	
	<b>30 day supply</b>		<b>60 day supply</b>		<b>100 day supply</b>		<b>100 day supply</b>		<b>30 day</b>	<b>31 day</b>	
	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>	
<b>Tier 1:</b>											
<b>Preferred Generic Drugs</b>	\$0	\$15	\$0	\$30	\$0	\$30	\$0	\$30	\$0	\$15	
<b>Tier 2:</b>											
<b>Generic Drugs</b>	\$10	\$20	\$20	\$40	\$20	\$40	\$20	\$40	\$10	\$20	
<b>Tier 3:</b>											
<b>Preferred Brand Drugs</b>	\$47	\$47	\$94	\$94	\$129.50	\$141	\$117.50	\$141	\$47	\$47	
<b>Tier 4:</b>											
<b>Non-Preferred Drugs</b>	\$100	\$100	\$200	\$200	\$300	\$300	\$300	\$300	\$100	\$100	
<b>Tier 5:</b>											
<b>Specialty Drugs</b>	33%	33%	n/a	n/a	n/a	n/a	33% (30 day)	33% (30 day)	33%	33%	
<b>IRA - Insulin</b>	<b>\$35</b>	<b>\$35</b>	<b>\$70</b>	<b>\$70</b>	<b>\$96.25</b>	<b>\$105</b>	<b>\$87.50</b>	<b>\$105</b>	<b>\$35</b>	<b>\$35</b>	
<b>COVERAGE GAP STAGE</b>											
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.											
<b>Out-of-Pocket Limit (TrOOP)</b>	<b>\$8,000</b>										
<b>Coverage in the Coverage Gap</b>	Discount program: Member pays up to 25% of the plan's cost for brand-name and generic drugs plus a portion of the dispensing fee.										
<b>CATASTROPHIC COVERAGE STAGE</b>											
<b>Once a member has hit the catastrophic coverage phase, there is no cost-sharing responsibility.</b>											

**UPMC for Life 2024 HMO Prime**

Plan Design	HMO PRIME
Premium	\$395
<b>ANNUAL MAXIMUMS</b>	
Annual Deductible	\$0
Maximum Out-of-Pocket	\$3,400
<b>INPATIENT CARE</b>	
Inpatient Hospital/ Mental Health Care (per stay) *	\$150 copay
Skilled Nursing Facility (days 1-20) (100 day limit) *	\$0 copay
Skilled Nursing Facility (days 21-100) (100 day limit) *	\$25 copay
Blood (3 pints)	\$0 copay
Home Health Care *	\$0 copay
Home Health Care (Telehealth) *	\$0 copay
<b>OUTPATIENT CARE</b>	
Primary Care Physician (PCP) Visits	\$5 copay
Primary Care Physician (PCP) Visits (Telehealth)	\$5 copay
Specialist Visits	\$30 copay
Specialist Visits (Telehealth)	\$30 copay
Chiropractic Services (Medicare-covered) *	\$20 copay
Chiropractic Services (Routine) (6 visits every year) *	\$20 copay
Podiatry Services (Medicare-covered)	\$30 copay
Podiatry Services (Routine) (4 visits every year)	\$30 copay
Outpatient Mental Health Services/Psychiatric Services /Substance Abuse	\$30 copay
Outpatient Mental Health Services /Psychiatric Services /Substance Abuse (Telehealth)	\$30 copay
Opioid Treatment Services	\$30 copay
Partial Hospitalization	\$0 copay
Outpatient Surgery and Ambulatory Surgical Center (ASC)/Observation (\$200 annual limit) *	\$100 copay
Ambulance Services (Ground & Air) *	\$100 copay
Ambulance Services (Treat no Transport)	Not Covered
Emergency Care (waived if admitted within 3 days)	\$120 copay
Urgently Needed Care (Clinics)	\$30 copay
Outpatient Rehab Services (PT, OT, ST) *	\$30 copay
Cardiac/Pulmonary Rehab & Supervised Exercise Therapy (SET)	\$0 copay
<b>OUTPATIENT MEDICAL AND SUPPLIES</b>	
Durable Medical Equipment (DME)/Oxygen *	15% coinsurance
Prosthetic Devices and Medical Supplies *	15% coinsurance
Diabetes Training	\$0 copay
Diabetes Training (Telehealth)	\$0 copay
Diabetic Monitors and Test Strips - LifeScan Only	\$0 copay
Diabetic Supplies - All Other Brands *	15% coinsurance
Diabetic Shoes or Inserts	15% coinsurance
Part B Drugs - Insulin (max: \$35, 30-day supply)	15% coinsurance
Part B Drugs *	15% coinsurance
Kidney Disease Training	\$0 copay
Renal Dialysis (ESRD)	15% coinsurance
Lab Services (per day per facility)	\$0 copay
Diagnostic Procedures/Tests (per day per facility) *	\$0 copay
Diagnostic X-Ray Services (Basic Imaging) (per service)	\$20 copay
Diagnostic Radiological Services (Advanced Imaging)(per service) *	\$60 copay
Therapeutic Radiological Services (Radiation) (per service)	\$0 copay

<b>UPMC for Life 2024 HMO Prime</b>	
<b>Plan Design</b>	<b>HMO PRIME</b>
<b>Premium</b>	<b>\$395</b>
<b>PREVENTIVE SERVICES</b>	
Immunizations	\$0 copay
Annual Wellness Visit	\$0 copay
Screening Exams	\$0 copay
<b>SUPPLEMENTAL BENEFITS</b>	
<b>Dental Services</b>	
Dental Services (Medicare-covered)	\$30 copay
<b>Preventive Dental Benefit:</b>	
Cleaning (2 every year)	\$0 copay
Routine Oral Exam (2 every year)	\$30 copay
Limited Oral Exam (1 every 12 months)	\$30 copay
Comprehensive Oral Exam (1 every 36 months)	\$30 copay
Bitewing X-rays (1 every 12 months)	\$30 copay
Panoramic X-rays (1 every 36 months)	\$30 copay
Restorative Dental Benefit	Not Covered
<b>Hearing Services</b>	
Hearing Services (Medicare-covered)	\$30 copay
Hearing Exam (Routine) (1 every year)	\$30 copay
Hearing Aid Fitting (Routine) (1 every year)	\$30 copay
Hearing Aids (Routine) (1 every year)	\$690-\$1,890 copay
<b>Vision Services</b>	
Vision Services (Medicare-covered)	\$30 copay
Glaucoma Screening and Diabetic Retinal Eye Exam (Medicare-covered)	\$0 copay
Eyewear (Medicare-covered)	\$0 copay
Vision Exam (Routine) (1 every year)	\$0 copay
Vision Eyewear (Routine) (1 every year)	\$250 allowance
<b>Other Services</b>	
Counseling Services (Resources for Life ) (6 sessions per issue)	\$0 copay
Fitness Benefit (SilverSneakers and personal training session) (1 every year)	\$0 copay
Health and Wellness Benefit (Rx Well)	\$0 copay
Home Safety Items (3 items every year)	\$0 copay
In-Home Safety Assessment (1 every year)	\$0 copay
Nurse Advice Line	\$0 copay
Over-the-counter (OTC) Items	Not covered
Palliative Care (including eligible meals) (56 meals for 28 days)	\$0 copay
Remote Technologies (AnywhereCare eVisits)	\$5 copay
Routine Physical Exam	Not covered
Smoking and Tobacco Use Cessation (4 addtl sessions)	\$0 copay
Support for Caregivers (Resources for Life ) (6 sessions )	\$0 copay
Support for Caregivers (Powerful Tools for Caregivers)	\$0 copay
Worldwide Emergency Travel Assistance Coverage	\$0 copay
<b>ADDITIONAL BENEFIT PROGRAMS</b>	
Visitor/Travel Benefit	Covered in Arizona, Florida, Georgia, North Carolina, South Carolina and Tennessee

\* Requires Prior Authorization

## UPMC for Life 2024 HMO Prime

<b>Part D Prescription Drugs</b>											
<b>DEDUCTIBLE STAGE</b>	There is no deductible for Part D prescription drugs.										
<b>Rx Deductible</b>	<b>\$0</b>										
<b>INITIAL COVERAGE STAGE</b>	Member pays cost-sharing amounts below until total yearly costs reach the Initial Coverage Limit.										
<b>Initial Coverage Limit (ICL)</b>	<b>\$5,030</b>										
	<b>Retail pharmacy</b>						<b>Mail-order</b>		<b>LTC</b>	<b>OON</b>	
	<b>30 day supply</b>		<b>60 day supply</b>		<b>100 day supply</b>		<b>100 day supply</b>		<b>30 day</b>	<b>31 day</b>	
	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>	<b>Preferred</b>	<b>Standard</b>	
<b>Tier 1: Preferred Generic Drugs</b>	\$0	\$15	\$0	\$30	\$0	\$30	\$0	\$30	\$0	\$15	
<b>Tier 2: Generic Drugs</b>	\$10	\$20	\$20	\$40	\$20	\$40	\$20	\$40	\$10	\$20	
<b>Tier 3: Preferred Brand Drugs</b>	\$47	\$47	\$94	\$94	\$129.50	\$141	\$117.50	\$141	\$47	\$47	
<b>Tier 4: Non-Preferred Drugs</b>	\$100	\$100	\$200	\$200	\$300	\$300	\$300	\$300	\$100	\$100	
<b>Tier 5: Specialty Drugs</b>	33%	33%	n/a	n/a	n/a	n/a	33% (30 day)	33% (30 day)	33%	33%	
<b>IRA - Insulin</b>	<b>\$35</b>	<b>\$35</b>	<b>\$70</b>	<b>\$70</b>	<b>\$96.25</b>	<b>\$105</b>	<b>\$87.50</b>	<b>\$105</b>	<b>\$35</b>	<b>\$35</b>	
<b>COVERAGE GAP STAGE</b>	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.										
<b>Out-of-Pocket Limit (TrOOP)</b>	<b>\$8,000</b>										
<b>Coverage in the Coverage Gap</b>	<p><b>Tier 1 and Tier 2 coverage:</b> Member pays the same cost-sharing in the coverage gap as the initial coverage stage for Tier 1 Preferred Generic and Tier 2 Generic drugs.</p> <p><b>For all other drugs - Tiers 3-5:</b> Member pays 25% for generic drugs and 25% plus a dispensing fee for brand-name drugs through the coverage gap.</p>										
<b>CATASTROPHIC COVERAGE STAGE</b>	<b>Once a member has hit the catastrophic coverage phase, there is no cost sharing responsibility.</b>										