

# Summary of Benefits

## City of Pittsburgh Active Police • 001048 - P02, P12

This document is your Summary of Benefits. This summary is meant to assist in comparing the benefit plans. It is not a contract. If differences exist between this summary and a group's contract or a member's Certificate of Coverage, the contract or Certificate of Coverage prevails. All services must be Medically Necessary and, when required, Prior Authorization must be obtained.

Plan Information	Participating Provider	Non-Participating Provider
Benefit Period	2017	
<b>Annual Deductible (AGGREGATE)</b>		
Individual	\$0	\$300
Family	\$0	\$600
<b>Coinsurance</b>		
	You pay 10%.	You pay 30% after Deductible.
<b>Annual Coinsurance Limit</b>		
Individual	\$1,200	\$2,400
Family	\$2,400	\$4,800
<b>Total Annual Out-of-Pocket Limit (EMBEDDED)</b>		
Individual	\$7,150	Not Applicable
Family	\$14,300	Not Applicable
<b>Office/Virtual Visits</b>		
Primary care physician (PCP) office visit	You pay \$10 Copayment.	You pay 30% after Deductible.
Specialist office visit	You pay \$20 Copayment.	You pay 30% after Deductible.
Retail clinic visit	You pay \$20 Copayment.	You pay 30% after Deductible.
Telemedicine visit	You pay \$10 Copayment.	You pay 30% after Deductible.
Urgent care facility	You pay \$20 Copayment.	You pay 30% after Deductible.
<b>Pediatric Care and Immunizations</b>		
Preventive/Health screening exam	Covered at 100%; you pay \$0.	Not covered
Pediatric immunizations	Covered at 100%; you pay \$0.	You pay 30%; Deductible does not apply.
Well-baby visits	Covered at 100%; you pay \$0.	Not covered
<b>Adult Care and Immunizations</b>		
Preventive/Health screening examination	Covered at 100%; you pay \$0.	Not covered
Adult immunizations	Covered at 100%; you pay \$0.	You pay 30% after Deductible.
<b>Women's Care</b>		
Screening gynecological exam, including a Pap test	Covered at 100%; you pay \$0.	You pay 30%; Deductible does not apply.
Mammograms, Annual routine	Covered at 100%; you pay \$0.	You pay 30% after Deductible.
<b>Hospital Services</b>		
Hospital inpatient	You pay 10%.	You pay 30% after Deductible.
Hospital outpatient	You pay 10%.	You pay 30% after Deductible.
Observation stay	You pay 10%.	You pay 30% after Deductible.
Maternity	You pay 10%.	You pay 30% after Deductible.
<b>Emergency Services</b>		
Emergency department	You pay 10% after \$50 Copayment per visit (waived if admitted).	
Emergency transportation	You pay 10%.	
<b>Allergy Services</b>		
Treatment, injections, and serum	You pay 10%.	You pay 30% after Deductible.
<b>Diagnostic Services</b>		

Advanced imaging (PET, MRI, etc.)	You pay 10%.	You pay 30% after Deductible.
Other imaging (x-ray, sonogram, etc.)	You pay 10%.	You pay 30% after Deductible.
Lab	You pay 10%.	You pay 30% after Deductible.
Diagnostic testing	You pay 10%.	You pay 30% after Deductible.
<b>Rehabilitation Therapy Services</b>		
Physical, occupational, and speech therapy	You pay 10%.	You pay 30% after Deductible.
	Combined Limit: 30 visits per therapy per Benefit Period.	
<b>Medical Therapy Services</b>		
Chemotherapy, radiation/Dialysis therapy	You pay 10%.	You pay 30% after Deductible.
Injectable, infusion therapy, or other drugs administered in an outpatient or office setting	You pay 10%.	You pay 30% after Deductible.
Respiratory therapy	You pay 10%; Deductible does not apply. \$0 after Deductible.	
<b>Mental Health and Substance Abuse Services</b>		
Inpatient	You pay 10%.	You pay 30% after Deductible.
Inpatient (detoxification/rehabilitation)	You pay 10%.	You pay 30% after Deductible.
Outpatient	You pay 10%.	You pay 30% after Deductible.
<b>Other Medical Services</b>		
Transplant services	You pay 10%	You pay 30% after Deductible.
Autism Spectrum Disorder services	You pay 10%.	You pay 30% after Deductible.
Dental services related to accidental injury	You pay 10%.	You pay 30% after Deductible.
Durable Medical Equipment	You pay 10%.	You pay 30% after Deductible.
Assisted Fertilization Procedures	Not Covered	Not Covered
Infertility Counseling & Testing	You pay 10%.	You pay 30% after Deductible.
Home health care	You pay 10%.	You pay 30% after Deductible.
	Combined Limit: 100 visits per benefit period.	
Hospice care	You pay 10%.	You pay 30% after Deductible.
Oral surgical services	You pay 10%.	You pay 30% after Deductible.
Private duty nursing	You pay 10%.	You pay 10%; Deductible does not apply.
Skilled nursing facility	You pay 10%.	You pay 30% after Deductible.
	Combined Limit: 100 days per benefit period.	
Spinal manipulation	You pay 10%.	You pay 30% after Deductible.
	Combined Limit: 20 visits per benefit period.	
<b>Prescription Drug Coverage</b>		
Mandatory Generic  Your plan uses the Your Choice Formulary  <i>Prescription drugs filled at a non-network pharmacy are not covered.</i>	<b>Retail Prescription Drug (31-day Supply)</b> You pay \$7 Copayment for generic drugs. You pay \$15 Copayment for generic drugs. You pay \$40 Copayment for generic drugs.	
	<b>Specialty Prescription Drug (31-day Supply)</b> You pay \$40 Copayment for generic drugs.	
	<b>Mail-Order Prescription Drug (90-day Supply)</b> You pay \$14 Copayment for generic drugs. You pay \$30 Copayment for generic drugs. You pay \$80 Copayment for generic drugs.	
	<b>Specific Category of Prescription Drugs</b> <i>Antihistamine &amp; Antihistamine/Decongestant combination; Proton Pump Inhibitor</i> You pay \$40 copayment (retail) You pay \$80 copayment (mail-order)	

### Prior Authorization for out-of-network services

Certain out-of-network non-emergent care must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan and obtain Prior Authorization prior to receiving services. Your out-of-network provider may also access this list at [www.upmchealthplan.com](http://www.upmchealthplan.com) or they may call Provider Services at 1-866-918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of receiving services for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that require Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date of service.

## **Nondiscrimination statement**

UPMC Health Plan<sup>1</sup> complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

<sup>1</sup>UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., and/or UPMC Benefit Management Services Inc.

## **Translation Services**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-489-3494 (TTY: 1-800-361-2629).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-489-3494（TTY：1-800-361-2629）。

**UPMC HEALTH PLAN**

U.S. Steel Tower, 600 Grant Street  
Pittsburgh, PA 15219

[www.upmchealthplan.com](http://www.upmchealthplan.com)

