

Summary of Benefits

City of Pittsburgh Active Police Premium • 021553 - P02, P12, P82

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 | |
| Annual Deductible (AGGREGATE) | | |
| Individual | \$100 | \$300 |
| Family | \$300 | \$900 |
| Coinsurance | | |
| | You pay 0%. | You pay 20% after Deductible. |
| Annual Coinsurance Limit | | |
| Individual | \$0 | \$2,000 |
| Family | \$0 | \$4,000 |
| Total Annual Out-of-Pocket Limit (EMBEDDED) | | |
| Individual | \$7,150 | Not Applicable |
| Family | \$14,300 | Not Applicable |
| Office/Virtual Visits | | |
| Primary care physician (PCP) office visit | You pay \$15 Copayment. | You pay 20% after Deductible. |
| Specialist office visit | You pay \$15 Copayment. | You pay 20% after Deductible. |
| Retail clinic visit | You pay \$15 Copayment. | You pay 20% after Deductible. |
| Telemedicine visit | You pay \$15 Copayment. | You pay 20% after Deductible. |
| Urgent care facility | You pay \$15 Copayment. | You pay 20% after Deductible. |
| Pediatric Care and Immunizations | | |
| Preventive/Health screening exam | Covered at 100%; you pay \$0. | You pay 20% after Deductible. |
| Pediatric immunizations | Covered at 100%; you pay \$0. | You pay 20%; Deductible does not apply. |
| Well-baby visits | Covered at 100%; you pay \$0. | You pay 20% after Deductible. |
| Adult Care and Immunizations | | |
| Preventive/Health screening examination | Covered at 100%; you pay \$0. | You pay 20% after Deductible |
| Adult immunizations | Covered at 100%; you pay \$0. | You pay 20% after Deductible. |
| Women's Care | | |
| Screening gynecological exam, including a Pap test | Covered at 100%; you pay \$0. | You pay 20%; Deductible does not apply. |
| Mammograms, Annual routine | Covered at 100%; you pay \$0. | You pay 20% after Deductible. |
| Hospital Services | | |
| Hospital inpatient | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Hospital outpatient | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Observation stay | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Maternity | Covered at 100%; you pay \$0. | You pay 20% after Deductible. |
| Emergency Services | | |
| Emergency department | You pay \$75 Copayment per visit (waived if admitted). | |
| Emergency transportation | Covered at 100%; you pay \$0. | |
| Allergy Services | | |
| Treatment, injections, and serum | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Diagnostic Services | | |
| Advanced imaging (PET, MRI, etc.) | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Other imaging (x-ray, sonogram, etc.) | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Lab | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Diagnostic testing | You pay \$0 after Deductible. | You pay 20% after Deductible. |

| Rehabilitation Therapy Services | | |
|--|---|--|
| Physical and occupational therapy | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| | Limit: 100 visits per Benefit Period for Non-Participating Provider. | |
| Speech therapy | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Medical Therapy Services | | |
| Chemotherapy, radiation/Dialysis therapy | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Injectable, infusion therapy, or other drugs administered in an outpatient or office setting | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Respiratory therapy | You pay \$0 after Deductible. | |
| Mental health and substance abuse services | | |
| Inpatient | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Inpatient (detoxification/rehabilitation) | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Outpatient | You pay \$15 Copayment. | You pay 20% after Deductible. |
| Other Medical Services | | |
| Transplant Services | You pay 0% after Deductible. | You pay 20% after Deductible. |
| Autism Spectrum Disorder services | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Dental services related to accidental injury | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Durable Medical Equipment | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Assisted Fertilization Procedures | Not Covered | Not Covered |
| Infertility Counseling & Testing | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Home health care | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Hospice care | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Oral surgical services | You pay \$0 after Deductible. | You pay 20% after Deductible. |
| Private duty nursing | You pay \$0 after Deductible. | You pay \$0 after Participating Provider Deductible. |
| Skilled nursing facility | You pay \$0 after Deductible. | You pay 30% after Deductible. |
| Spinal manipulation | You pay \$15 Copayment per visit after Deductible. | You pay 30% after Deductible. |
| | Limit: 20 visits per Benefit Period for Non-Participating Provider. | |
| Prescription Drug Coverage | | |
| Mandatory Generic Your plan uses the Your Choice Formulary <i>Prescription drugs filled at a non-network pharmacy are not covered.</i> | Retail Prescription Drug (30-day Supply) You pay 10% for generic drugs with a maximum of \$7 per prescription. You pay 15% for preferred brand drugs with a maximum of \$15 per prescription. You pay 20% for non-preferred brand drugs with a maximum of \$40 per prescription | |
| | Specialty Prescription Drug (30-day Supply) You pay 20% for non-preferred brand drugs with a maximum of \$40 per prescription. | |
| | Mail-Order Prescription Drug (90-day Supply) You pay \$14 Copayment for generic drugs. You pay \$30 Copayment for preferred brand drugs. You pay \$40 Copayment for non-preferred brand drugs. | |
| | Specific Category of Prescription Drugs <i>Antihistamine & Antihistamine/Decongestant combination; Proton Pump Inhibitor</i> You pay \$40 copayment (retail) You pay \$40 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 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 requires 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 Plan¹ complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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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）。

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