Housing Authority of the City of Pittsburgh

Contracting Officer
100 Ross Street
2nd Floor Suite 200
Pittsburgh, PA 15219
(412) 456-5248
Fax: (412) 456-5007
www.hacp.org

August 1, 2017

Medical and RX Insurance for Authority Employees Rebid
RFP #650-15-17REBID

ADDENDUM NO. 1

This addendum issued August 1, 2017 becomes in its entirety a part of the Request for Proposals RFP #650-15-17REBID as is fully set forth herein:

Item 1: Q: Is the Housing Authority of the City of Pittsburgh's current funding arrangement with UPMC fully insured or Administrative Services Only?

A: Fully Insured.

Item 2: Q: Is Highmark to provide a fully Insured proposal? ASO Proposal? Or both?

A: Fully Insured.

Item 3: Q: Can you please send a copy of the EPO plan grid? The POS grid was attached twice in the RFP.

A: The previous Attachment M-2 in the RFP shall be deleted and replaced with the revised Attachment M-2 attached to this Addendum.

Item 4: Q: Highmark requires employee zip codes on the census. Are you able to send over a revised census that includes the employees zip codes?

A: Please see *Attachment B - HACP Active Employee Zip Codes* available for viewing and download on our website: www.HACP.org.

Item 5: Q: Are we able to request a copy of the current carrier rates and renewal rates?

A: There are no renewal rates, that is why HACP is issuing this RFP. For previous rates you must file a Right to Know Request. The Right to Know Request contact and form can be found on our website (www.HACP.org) on the contact tab under Open Records Officer.

Item 6: Q: Can you please provide a large claims report (claims over $50,000)?

A: Please see Attachment 1 to this Addendum.

Item 7: Q: Have you made any plan changes 1/16 or 1/17? If so, can we please get prior grids?

A: No.

Item 8: The proposal due date, time and location remain unchanged at August 11, 2017 at 9:00 AM, at the HACP Procurement Dept., 100 Ross St. 2nd Floor, Suite 200, Pittsburgh, PA 15219.

END OF ADDENDUM NO. 1

Kim Detrick

Mr. Kim Detrick
Procurement Director/Chief Contracting Officer

8-1-17

Date

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ATTACHMENT M-2

Medical/RX Insurance for HACP Employees Rebid
RFP# 650-15-17REBID
EPO Schedule of Benefits

UPMC HEALTH PLAN

Schedule of Benefits

UPMC Business Advantage
EPO - Premium Network

Deductible: $0 / $0
Coinsurance: 0%
Total Annual Out-of-Pocket: $6,350 / $12,700

Primary Care Provider: $15 Copayment per visit
Specialist: $15 Copayment per visit

Emergency Department: $50 Copayment per visit
Rx: $10/$20/$35/$35

This document is your Schedule of Benefits. If you enroll in this plan, this Schedule of Benefits will be an important part of your Certificate of Coverage (COC). Your plan may also include a Summary Plan Description (SPD). If your plan has an SPD, it is issued by your employer or labor trust fund. It is not issued by UPMC Health Plan. An SPD either adds to or replaces your COC. It is important that you review and understand your COC and/or SPD because they describe in detail the services your plan covers. The Schedule of Benefits describes what you pay for those services.

For Covered Services to be paid at the level described in your Schedule of Benefits, they must be Medically Necessary. They must also meet all other criteria described in your COC and/or SPD. Criteria may include Prior Authorization requirements.

Please note that your plan may not cover all of your health care expenses, such as copayments and coinsurance. To understand what your plan covers, review your COC and/or SPD. You may also have Riders and Amendments that expand or restrict your benefits.

If you have any questions about your benefits, or would like to find a Participating Provider near you, visit **www.upmchealthplan.com.** You can also call UPMC Health Plan Member Services at the phone number on the back of your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider
Benefit Period	Plan Year
Primary Care Provider (PCP) Required	Encouraged, but not required
Pre-Certification and Prior Authorization Requirements	Provider Responsibility

Member Cost Sharing	Participating Provider
Annual Deductible	
Individual	$0
Family	$0
Coinsurance	
	Covered at 100%; you pay $0.
	Copayments may apply to certain Participating Provider services.
Total Annual Out-of-Pocket Limit	
Individual	$6,350
Family	$12,700

Member Cost Sharing	Participating Provider
Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit is satisfied in one of two ways — whichever comes first: *When an individual within a family reaches his or her individual Out-of-Pocket Limit. At this point, only that person will have benefits covered at 100% for the remainder of the Benefit Period; OR *When a combination of family members' expenses reaches the family Out-of-Pocket Limit. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and Covered Services will be paid at 100% for the remainder of the Benefit Period.	
Out-of-Pocket costs (Copayments, Coinsurance, and Deductibles) for Covered Services apply toward satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits.	

Preventive Services	Participating Provider
Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.	
Pediatric Care and Immunizations	
Preventive/health screening examination	Covered at 100%; you pay $0.
Pediatric immunizations	Covered at 100%; you pay $0.
Well-baby visits	Covered at 100%; you pay $0.
Adult Care and Immunizations	
Preventive/health screening examination	Covered at 100%; you pay $0.
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay $0.
Women's Care	
Screening gynecological exam	Covered at 100%; you pay $0.
Screening Pap test and screening mammogram	Covered at 100%; you pay $0.

Covered Services	Participating Provider
Hospital Services	
Semi-private room, private room (if Medically Necessary and appropriate), surgery, pre-admission testing	Covered at 100%; you pay $0.
Outpatient/ambulatory surgery	Covered at 100%; you pay $0.
Observation stay	Covered at 100%; you pay $0.
Maternity	Covered at 100%; you pay $0.
Emergency Services	
If you would like to speak to a registered nurse about a specific health concern, call our UPMC *My*Health 24/7 Nurse Line at 1-866-918-1591. You may also send an email using the Web Nurse Request system at www.upmchealthplan.com.	
Emergency department	You pay $50 Copayment per visit. Copayment waived if you are admitted to hospital.

Covered Services	Participating Provider
Emergency transportation	Covered at 100%; you pay $0.
Urgent care facility	You pay $15 Copayment per visit.
Physician Surgical Services	
	Covered at 100%; you pay $0.
Provider Medical Services	
Inpatient medical care visits, intensive medical care, consultation, and newborn care	Covered at 100%; you pay $0.
Adult immunizations not required to be covered by the ACA	Covered at 100%; you pay $0.
Primary care provider office visit	You pay $15 Copayment per visit.
Specialist office visit	You pay $15 Copayment per visit.
Convenience care visit	You pay $15 Copayment per visit.
Virtual visit - Level 1 (e.g., non-specialist)	You pay $8 Copayment per visit.
Virtual visit - Level 2 (e.g., specialist)	You pay $15 Copayment per visit.
Allergy Services	
Treatment, injections, and serum	Covered at 100%; you pay $0.
Diagnostic Services	
Advanced imaging (e.g., PET, MRI, etc.)	Covered at 100%; you pay $0.
Other imaging (e.g., x-ray, sonogram, etc.)	Covered at 100%; you pay $0.
Lab	Covered at 100%; you pay $0.
Diagnostic testing	Covered at 100%; you pay $0.
Rehabilitation Therapy Services	
Physical, speech, and occupational Therapy	You pay $15 Copayment per visit.
	Covered up to 60 visits per Benefit Period for all three therapies combined.
Cardiac rehabilitation	Covered at 100%; you pay $0.
	Covered up to 12 weeks per Benefit Period.
Pulmonary rehabilitation	You pay $15 Copayment per visit.
	Covered up to 24 visits per Benefit Period.
Habilitation Therapy Services	
Physical, speech, and occupational Therapy	You pay $15 Copayment per visit.
	Covered up to 60 visits per Benefit Period for all three therapies combined.

Covered Services	Participating Provider
Medical Therapy Services	
Chemotherapy, radiation therapy, dialysis therapy	Covered at 100%; you pay $0.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	Covered at 100%; you pay $0.
Pain Management	
Pain management program	You pay $15 Copayment per visit.
Mental Health and Substance Abuse Services Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083	
Inpatient (e.g., detoxification, etc.)	Covered at 100%; you pay $0.
Inpatient non-hospital residential services	Covered at 100%; you pay $0.
Outpatient (e.g. therapy)	You pay $15 Copayment per visit.
Outpatient (e.g. rehabilitation)	Covered at 100%; you pay $0.
Other Medical Services	
Acupuncture	Covered at 100%; you pay $0. Covered up to 12 visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.
Corrective appliances	Covered at 100%; you pay $0.
Dental services related to accidental injury	Covered at 100%; you pay $0.
Durable medical equipment	Covered at 100%; you pay $0.
Fertility testing	Covered at 100%; you pay $0.
Home health care	Covered at 100%; you pay $0. Refer to the Certificate of Coverage for specific Benefit Limitations.
Hospice care	Covered at 100%; you pay $0.
Medical nutrition therapy	Covered at 100%; you pay $0. Refer to the Certificate of Coverage for specific Benefit Limitations.
Nutritional counseling	Covered at 100%; you pay $0. Covered up to two visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.
Nutritional products	Covered at 100%; you pay $0. Refer to the Certificate of Coverage for specific Benefit Limitations.
Oral surgical services	Covered at 100%; you pay $0. Refer to the Certificate of Coverage for specific Benefit Limitations.
Podiatry care	You pay $15 Copayment per visit. Refer to the Certificate of Coverage for specific Benefit Limitations.
Private duty nursing	Covered at 100%; you pay $0. Refer to the Certificate of Coverage for specific Benefit Limitations.
Skilled nursing facility	Covered at 100%; you pay $0. Covered up to 100 days per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.
Therapeutic manipulation	You pay $10 Copayment per visit; first visit you pay $15 Copayment. Covered up to 25 visits per Benefit Period. Refer to the Certificate of Coverage for specific Benefit Limitations.

Covered Services	Participating Provider
Diabetic Equipment, Supplies, and Education	
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts Inc., that plan will pay for diabetic supplies and equipment first.)	
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at a Participating Pharmacy. See applicable pharmacy rider for coverage information.
Diabetic education	Covered at 100%; you pay $0.

Prescription Drug Coverage **For additional information on your pharmacy benefits, please reference your Prescription Drug Rider.** **The Your Choice pharmacy program will apply (mandatory generic).** **Not subject to Plan Deductible**	
Retail prescription drug • Prescriptions must be dispensed by a participating pharmacy • 30-day supply	You pay $10 Copayment for generic drugs. You pay $20 Copayment for preferred brand drugs. You pay $35 Copayment for non-preferred brand drugs. 90-day maximum retail supply available for three copayments
Specialty prescription drug • Specialty medications are limited to a 30-day supply • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request)	You pay $35 Copayment for specialty drugs, 30-day maximum supply
Mail-order prescription drug • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy	You pay $20 Copayment for generic drugs. You pay $40 Copayment for preferred brand drugs. You pay $70 Copayment for non-preferred brand drugs. 90-day maximum mail-order supply
If the brand-name drug is dispensed instead of the generic equivalent, you must pay the copayment associated with the brand-name drug as well as the price difference between the brand-name drug and the generic drug.	

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your Certificate of Coverage (COC). Also, the headings under the Covered Services section are the same as those in your COC.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail.

Your plan documents will always include the Schedule of Benefits, the COC, and the Summary of Benefits and Coverage (SBC). You'll find these documents at **www.upmchealthplan.com**. If you have questions, call Member Services.

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.

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

www.upmchealthplan.com

EPO - Premium Network: UPMC Health Plan

Summary of Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 - 12/31/2017
Coverage for: All coverage levels | **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.upmchealthplan.com or by calling 1-888-876-2756.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Participating Provider: **$6,350 Person/$12,700 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.upmchealthplan.com or call 1-888-876-2756 for a list of **in-network providers.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 3. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	Not Covered	none
	Specialist visit	$15 copay/visit	Not Covered	none
	Other practitioner office visit	$15 copay/visit	Not Covered	none
	Preventive care/screening/immunization	No Cost	Not Covered	none
If you have a test	Diagnostic test (x-ray, blood work)	No Cost	Not Covered	none
	Imaging (CT/PET scans, MRIs)	No Cost	Not Covered	none
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.upmchealthplan.com.	Generic drugs	$10.copay/prescription (Retail), $20 copay/prescription (Mail order)	Not Covered	90 day maximum mail order supply
	Preferred brand drugs	$20 copay/prescription (Retail), $40 copay/prescription (Mail order)	Not Covered	90 day maximum mail-order supply
	Non-preferred brand drugs	$35 copay/prescription (Retail), $70 copay/prescription (Mail order)	Not Covered	90 day maximum mail-order supply
	Specialty drugs	$35 copay/prescription	Not Covered	none

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Cost	Not Covered	none
	Physician/surgeon fees	No Cost	Not Covered	none
If you need immediate medical attention	Emergency room services	$50 copay/visit	$50 copay/visit	Copayment waived if admitted
	Emergency medical transportation	No Cost	No Cost	none
	Urgent care	$15 copay	Not Covered	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No Cost	Not Covered	none
	Physician/surgeon fee	No Cost	Not Covered	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Cost	Not Covered	none
	Mental/Behavioral health inpatient services	No Cost	Not Covered	none
	Substance use disorder outpatient services	$15 copay/office visit	Not Covered	none
	Substance use disorder inpatient services	No Cost	Not Covered	none
If you are pregnant	Prenatal and postnatal care	No Cost	Not Covered	none
	Delivery and all inpatient services	No Cost	Not Covered	none
If you need help recovering or have other special health needs	Home health care	No Cost	Not Covered	none
	Rehabilitation services	$15 copay/visit	Not Covered	Limit of 60 visits per Benefit Period.
	Habilitation services	$15 copay/visit	Not Covered	Limit of 60 visits per Benefit Period.
	Skilled nursing care	No Cost	Not Covered	Limit of 100 days per Benefit Period
	Durable medical equipment	No Cost	Not Covered	none
	Hospice service	No Cost	Not Covered	none
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	none
	Glasses	Not Covered	Not Covered	none
	Dental check-up	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Questions: Call 1-888-876-2756 or visit us at www.upmchealthplan.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-888-876-2756 to request a copy.

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Hearing aids	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult) • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Abortion Services • Acupuncture only covered for specific diagnosis	• Bariatric surgery subject to medical review • Chiropractic care covered with limitations	• Private-duty nursing subject to medical review • Routine foot care only covered for specific diagnosis

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-876-2756. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at 1-888-876-2756. You can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform For questions about your rights, this notice, or assistance, you can contact your state insurance department at 1-877-881-6388. Additionally, a consumer assistance program can help you file your appeal. Contact 1-877-881-6388.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Questions: Call 1-888-876-2756 or visit us at www.upmchealthplan.com.
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ATTACHMENT 1

Medical/RX Insurance for HACP Employees Rebid
RFP# 650-15-17REBID
HACP Large Claims Report

UPMC Health Plan

High Claimant Report - Housing Authority Cop

Members with total claims expenditures greater than $25,000 from July 2016 - June 2017, paid through June 2017

Membership current as of June 15th, 2017

Specifications

Date Range Selected:	Claims incurred July 2016 - June 2017, paid through June 2017
Date Range Applied*:	Claims incurred July 2016 - June 2017, paid through June 2017
Corporation:	H491
Group(s):	All

Report Status

Report successfully created.

**If date range applied differs from date range selected, some data within the selected date range was not available*

UPMC Health Plan

High Claimant Report - Housing Authority Cop

Members with total claims expenditures greater than $25,000 from July 2016 - June 2017, paid through June 2017

Membership current as of June 15th, 2017

Member	Current Member	Total Paid
1	Y	$111,852.74
2	N	$108,005.71
3	Y	$95,836.90
4	Y	$76,723.14
5	Y	$76,050.32
6	Y	$61,422.01
7	Y	$56,043.15
8	N	$54,215.33
9	Y	$49,934.02
10	N	$47,988.26
11	Y	$33,096.78
12	Y	$31,335.83
13	Y	$30,470.40
14	Y	$30,163.97
15	Y	$29,879.94
16	Y	$28,794.61
17	Y	$25,893.49
18	Y	$25,808.80
19	Y	$25,597.42