

City of Pittsburgh
Active Police
737433-12-002, 082
Benefits administered by



DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible		
Individual	None	\$300
Family (aggregate)	None	\$600
Out-of-Pocket Coinsurance Maximum		
Individual	\$1,200	\$2,400
Family	\$2,400	\$4,800
Total Out-of-Pocket Maximum (includes deductibles, copays and coinsurance for both medical and pharmacy)		
Individual	\$6,850	Not Applicable
Family (aggregate)	\$13,700	Not Applicable
Autism Spectrum Disorders (ASD) Maximum	Subject to Benefit Maximum and Prior Authorization requirements	
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Physician Services (for illness or injury)		
Primary Care Visit (PCP)	\$10 Copay	30% Eligible Charges (after annual deductible)
Specialist Visit (SCP)	\$20 Copay	30% Eligible Charges (after annual deductible)
Retail Visit+	\$20 Copay	30% Eligible Charges (after annual deductible)
Teledoc	\$10 Copay	30% Eligible Charges (after annual deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	\$0 Copay	30% Eligible Charges
Well Child Visit	\$0 Copay	Not Covered
Adult Physical Visit	\$0 Copay	Not Covered
Routine Pediatric Immunizations	0%	30% Eligible Charges
Hearing Exams (under age 18)	0%	30% Eligible Charges (after annual deductible)
Routine Mammograms	0%	30% Eligible Charges (after annual deductible)
Routine Colonoscopies***	0%	30% Eligible Charges (after annual deductible)
Diagnostic Services & Procedures	0%	20% Eligible Charges (after annual deductible)
Allergy Testing & Allergy Serum	10%	30% Eligible Charges (after annual deductible)
Chiropractic Care		
Maximum 20 visits per contract year	10%	30% Eligible Charges (after annual deductible)
Outpatient Surgery	10%	30% Eligible Charges (after annual deductible)
Lab Services	10%	30% Eligible Charges (after annual deductible)
Diagnostic X-ray	10%	30% Eligible Charges (after annual deductible)
Radiology (CAT, MRI, Ultrasound, PET)	10%	30% Eligible Charges (after annual deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Hospital Care		
Semi-private room (private room if medically necessary)	10%	30% Eligible Charges (after annual deductible)
Physician and Surgeon Fees	10%	30% Eligible Charges (after annual deductible)
Surgery	10%	30% Eligible Charges (after annual deductible)
Lab and X-ray services	10%	30% Eligible Charges (after annual deductible)
All Medically Necessary Ancillary Services	10%	30% Eligible Charges (after annual deductible)
Anesthesia	10%	30% Eligible Charges (after annual deductible)
Administration of Blood	10%	30% Eligible Charges (after annual deductible)
Blood Products	10%	30% Eligible Charges (after annual deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	10%	30% Eligible Charges (after annual deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Pregnancy Care (PCP/SCP) (copay for the first office visit only)	\$10/\$20 Copay	30% Eligible Charges (after annual deductible)
Delivery	10%	30% Eligible Charges (after annual deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Infertility Counseling/Testing/Services	10%	30% Eligible Charges (after annual deductible)
Tubal Ligation	0%	30% Eligible Charges (after annual deductible)
Vasectomy	10%	30% Eligible Charges (after annual deductible)

PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed formulary. Mandatory generic substitution applies – member is responsible for the payment differential when a generic drug is available, but a brand name drug is utilized).	Refer to the Aetna Premier Plus formulary to identify which drugs require authorization. Quantity limits still apply. Retail (31 day supply): Generic \$7; Formulary Brand \$15; Non-Formulary \$40 Mail Order (90 day supply): Generic \$14; Formulary Brand \$30; Non-Formulary \$80 Specific Categories: Antihistamine and Antihistamine/Decongestant combination, Proton Pump Inhibitors \$40 Retail (Max)/\$80 Mail (Max) COVERED ONLY AT PARTICIPATING PHARMACIES	
EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	\$20 Copay	30% Eligible Charges (after annual deductible)
Emergency Room Services (not subject to deductible)	10% after \$50 Copay (ER Copay waived if admitted)	
REHABILITATION SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Occupational, Speech, Physical Therapy	10%	30% Eligible Charges (after annual deductible)
	<i>30 outpatient visits per contract year per therapy type</i>	
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
General Mental Health:	<i>(Mental health services must be preauthorized)</i>	
Inpatient	10%	30% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	10%	30% Eligible Charges (after annual deductible)
Serious Mental Health:	10%	30% Eligible Charges (after annual deductible)
Inpatient	10%	30% Eligible Charges (after annual deductible)
Physician Services (Outpatient)	10%	30% Eligible Charges (after annual deductible)
Substance Abuse:		
Inpatient Detoxification	10%	30% Eligible Charges (after annual deductible)
Inpatient Rehabilitation	10%	30% Eligible Charges (after annual deductible)
Transitional Partial Hospitalization	10%	30% Eligible Charges (after annual deductible)
OTHER BENEFITS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Claim Forms Required	No	Yes
Durable Medical Equipment (DME)	10%	30% Eligible Charges (after annual deductible)
Corrective Appliances	10%	30% Eligible Charges (after annual deductible)
Home Health Care Services	10%	30% Eligible Charges (after annual deductible)
	<i>100 visits combined per contract year</i>	
Hospice Care	10%	30% Eligible Charges (after annual deductible)
Skilled Nursing Facility	10%	30% Eligible Charges (after annual deductible)
	<i>100 inpatient days combined maximum per contract year</i>	
Dental Services		
Emergency treatment of dental injury	10%	30% Eligible Charges (after annual deductible)
Removal of Third Molars	10%	30% Eligible Charges (after annual deductible)
PRECERTIFICATION REQUIREMENT	By Physician	By Patient
When using a nonparticipating provider, the member must obtain precertification of nonemergency hospital and other facility (e.g., skilled nursing facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services as stated in the Group Contract. If these services or admissions are not precertified and the service is not medically necessary, the member may be responsible for 100% of the cost of the services.		
LIFETIME MAXIMUM	Unlimited	
Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more employees. This is not a contract. It is intended solely to provide you with an overview of the plan. Complete details of benefits, terms and exclusions are governed by your Group Contract. This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. Benefits are administered on a contract year basis. In addition to your copay or coinsurance, you are responsible for paying nonparticipating providers the difference between our out-of-network rate and their actual charge for nonemergency services. Your out-of-pocket costs for nonemergency care from nonparticipating providers may be substantial. *** The physician must bill the claim with a preventive diagnosis code in order to apply under preventive benefits coverage. This document neither affirmatively nor negatively amends, extends, or alters the terms of or the coverage afforded by policy referenced herein **Reimbursement for Weight Management programs is limited to \$350 per calendar year per member. + Retail visits include drug store minute-clinics.		