

## City of Pittsburgh Active Police Premium

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

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Benefit	Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b> <sup>(1)</sup>	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	\$100	\$300
Family	\$300	\$900
<b>Plan Pays</b> – payment based on the plan allowance	100% after deductible	80% after deductible
<b>Out of Pocket Limit</b> (excludes deductible). Once met, plan pays 100% coinsurance (excluding copays) for the rest of the benefit period)		
Individual	None	\$2,000
Family	None	\$4,000
<b>Total Maximum Out-of-Pocket</b> (includes deductible, coinsurance, copays and other qualified medical/prescription drug expenses. Once met, plan pays 100% of covered services for the rest of the benefit period. <sup>(8)</sup> )		
Individual	\$6,600	Not Applicable
Family	\$13,200	Not Applicable
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits &amp; Virtual Visits</b>	100% after \$15 copayment	80% after deductible
<b>Primary Care Provider Office Visits &amp; Virtual Visits</b>	100% after \$15 copayment	80% after deductible
<b>Specialist Office Visits &amp; Virtual Visits</b>	100% after \$15 copayment	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
<b>Urgent Care Center Visits</b>	100% after \$15 copayment	80% after deductible
<b>Telemedicine Services</b> <sup>(3)</sup>	100% after \$15 copayment	
<b>Preventive Care</b> <sup>(4)</sup>		
<b>Routine Adult</b>		
Physical exams	100% deductible does not apply	80% after deductible
Adult immunizations	100% deductible does not apply	80% after deductible
Colorectal cancer screening		
Diagnostic & Medical Services	100% deductible does not apply	80% after deductible
Routine gynecological exams, including a Pap Test	100% deductible does not apply	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% deductible does not apply	80% after deductible
Diagnostic services and procedures	100% deductible does not apply	80% after deductible
<b>Routine Pediatric</b>		
Physical exams	100% deductible does not apply	80% after deductible
Pediatric immunizations	100% deductible does not apply	80% (deductible does not apply)
Diagnostic services and procedures	100% deductible does not apply	80% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b>		
<b>Hospital Outpatient</b>	100% after deductible	80% after deductible
<b>Medical/Surgical</b> (except office visits)		
<b>Maternity</b> (non-preventive facility & professional services)	100% deductible does not apply	80% after deductible
<b>Emergency Services</b>		
<b>Emergency Room Services</b>	100% after \$75 copayment (waived if admitted)	
<b>Ambulance- Emergency</b>	100% after deductible	
<b>Ambulance- Non Emergency</b>	100% deductible does not apply	80% after deductible
<b>Therapy and Rehabilitation Services</b>		
<b>Physical Medicine</b>	100% after deductible	80% after deductible Limit: 100 visits/benefit period
<b>Respiratory Therapy</b>	100% after Network deductible	
<b>Speech &amp; Occupational Therapy</b>	100% after deductible	80% after deductible
<b>Spinal Manipulations</b>	100% after \$15 copayment after deductible	80% after deductible Limit: 20 visits per benefit period

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient</b>	100% after deductible	80% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>		
<b>Outpatient- Includes Virtual Behavioral Health Visits</b>	100% after deductible	80% after deductible
<b>Other Services</b>		
<b>Allergy Extracts and Injections</b>		
<b>Applied Behavior Analysis for Autism Spectrum Disorders<sup>(2)</sup></b>	100% after deductible	80% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	100% after deductible	80% after deductible
<b>Diagnostic Services</b>	100% after deductible	
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)		80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>		
<b>Home Health Care</b>	100% after deductible	80% after deductible
<b>Hospice</b>		
<b>Infertility Counseling, Testing and Treatment<sup>(5)</sup></b>		
<b>Private Duty Nursing</b>	100% after Network deductible	
<b>Skilled Nursing Facility Care</b>	100% after deductible	80% after deductible
<b>Transplant Services</b>	100% after deductible	80% after deductible
<b>Precertification Requirements<sup>(6)</sup></b>	Yes	
<b>Prescription Drugs</b>		
<b>Prescription Drug Deductible</b>		
Individual	None	
Family	None	
<b>Prescription Drug Program<sup>(7)</sup></b>		
Mandatory Generic <i>Defined by the Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	<b>Retail Drugs (30 day Supply)</b> Generic 10% copayment min of \$0, max of \$7 Brand-Formulary 15% copayment min \$0, max \$15 Non-formulary brand 20% copayment min \$0, max \$40	
<i>Your plan uses the Comprehensive Formulary.</i>	<b>Maintenance Drugs through Mail Order (90-day Supply)</b> \$14 generic copayment \$30 formulary brand copayment \$40 non-formulary brand copayment	
	<b>Specific Categories of Prescription Drugs</b> \$40 retail / \$40 mail order Antihistamine & Antihistamine/Decongestant combination Proton Pump Inhibitor	

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance Abuse benefit.
- (4) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (5) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (6) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (7) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.
- (8) Effective with plan years beginning on or after January 1, 2016 the Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, and any qualified medical expenses. The Total Maximum Out of Pocket cannot be more than \$6,850 for individual and \$13,700 for two or more persons.