City of Pittsburgh Active Municipal

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.

12199-01, 05, 06, 07, 08, 09, 10, 14, 21, 29, 30, 72, 74

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 $300 $600
Plan Pays – payment based on the plan allowance	90%	70% after deductible
Out of Pocket Limit (excludes deductible). Once met, plan pays 100% coinsurance (excluding copays) for the rest of the benefit period) Individual Family	 $1,200 $2,400	 $2,400 $4,800
Total Maximum Out of Pocket (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.(8) Individual Family	 $6,600 $13,200	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $20 copayment	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $10 copayment	70% after deductible
Specialist Office Visits & Virtual Visits	100% after $20 copayment	70% after deductible
Virtual Visit Originating Site Fee	90%	70% after deductible
Urgent Care Center Visits	100% after $20 copayment	70% after deductible
Telemedicine Services (3)	100% after $10 copayment	
Preventive Care(4)		
Routine Adult Physical exams	 100%	 Not Covered
Adult immunizations	100%	70% after deductible
Colorectal cancer screening Diagnostic & Medical Services	 100%	 70% after deductible
Routine gynecological exams, including a Pap Test	100%	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	70% after deductible
Diagnostic services and procedures	100%	70% after deductible
Routine Pediatric Physical exams	 100%	 Not Covered
Pediatric immunizations	100%	70% (deductible does not apply)
Diagnostic services and procedures	100%	70% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	90%	70% after deductible
Hospital Outpatient		
Maternity (non-preventive facility & professional services)		
Medical/Surgical (except office visits)		
Emergency Services		
Emergency Room Services	90% after $50 copayment (waived if admitted)	
Ambulance-Emergency	90%	
Ambulance-Non Emergency	90%	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	90%	70% after deductible
	Combined Limit: 30 visits/benefit period	
Respiratory Therapy	90% deductible does not apply	
Speech & Occupational Therapy	90%	70% after deductible
	Limit: 30 visits per therapy/benefit period	
Spinal Manipulations	90%	70% after deductible
	Combined Limit: 20 visits/benefit period	

Benefit	Network	Out-of-Network
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90%	70% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	90%	70% after deductible
Outpatient - Includes Virtual Behavioral Health Visits	90%	70% after deductible
Other Services		
Allergy Extracts and Injections **Applied Behavior Analysis for Autism Spectrum Disorders**(2)	90%	70% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	90%	70% after deductible
Diagnostic Services *Advanced Imaging* (MRI, CAT, PET scan, etc.)	90%	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90%	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics **Hospice** **Infertility Counseling, Testing and Treatment**(5)	90%	70% after deductible
Home Health Care	90%	70% after deductible
	Combined Limit: 100 visits per benefit period	
Private Duty Nursing	90% deductible does not apply	
Skilled Nursing Facility Care	90%	70% after deductible
	Combined Limit: 100 days/benefit period	
Transplant Services	90%	70% after deductible
Precertification Requirements(6)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program(7) Mandatory Generic *Defined by the National Plus Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs (31 day Supply)** $7 generic copayment $15 formulary brand copayment $40 non-formulary brand copayment **Maintenance Drugs through Mail Order (90-day Supply)** $14 generic copayment $30 formulary brand copayment $80 non-formulary brand copayment **Specific Categories of Prescription Drugs** $40 retail / $80 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.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.