Allegheny County School
Health Insurance Consortium

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HIGHMARK. BCBS
Community Blue Flex EPO

Summary of Community Blue Flex EPO Benefits

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value®. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out of pocket. *You are responsible for paying for non-emergency services received from an out-of-network provider.* 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.

Allegheny County Schools Health Insurance Consortium **7/1/2019**

Benefit	Enhanced Value	Standard Value
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 $500 $1,000
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 None None	 $1,600 $3,200
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $5 copayment	100% after $40 copayment
Primary Care Provider Office Visits	100% after $0 copayment	100% after $20 copayment
Specialist Office Visits	100% after $10 copayment	100% after $50 copayment
Urgent Care Center Visits	100% after $10 copayment	100% after $40 copayment
Telemedicine Services (6)	100% after $0 copayment	100% after $20 copayment
Preventive Care(2)		
Routine Adult		
Physical exams	100% (deductible does not apply)	100% (deductible does not apply)
Adult immunizations	100% (deductible does not apply)	100% (deductible does not apply)
Colorectal cancer screening	100% (deductible does not apply)	100% (deductible does not apply)
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)
Routine Pediatric		
Physical exams	100% (deductible does not apply)	100% (deductible does not apply)
Pediatric immunizations	100% (deductible does not apply)	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible
Medical Care (including inpatient visits and consultations)/**Surgical Expenses**	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copayment (waived if admitted)	
Ambulance	100%	
Ambulance – Non-Emergency	100%	
Therapy and Rehabilitation Services		
Physical Medicine	100%	100% after deductible
Respiratory Therapy	100%	80% after deductible
Speech & Occupational Therapy	100%	100% after deductible
Spinal Manipulations	100% after $25 copayment	100% after $50 copayment
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100%	100%
Inpatient Detoxification/Rehabilitation	100%	100%
Outpatient	100%	100%

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	Enhanced Value	Standard Value
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Assisted Fertilization Procedures	100%	80% after deductible
	$5,000 Family maximum per lifetime	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Home Health Care	100%	80% after deductible
Hospice	100%	80% after deductible
Infertility Counseling, Testing and Treatment(3)	100%	80% after deductible
Private Duty Nursing	100%	
Skilled Nursing Facility Care	100%	80% after deductible
Transplant Services	100%	80% after deductible
Precertification Requirements(4)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program(5) *Defined by the Advantage Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.*	**Retail Drugs 34-day Supply (Mandatory Generic)** $8 generic copayment $35 brand copayment - formulary $60 brand copayment – non-formulary **Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic)** $12 generic copayment $50 brand copayment - formulary $90 brand copayment – non-formulary	

Questions? Call 1-800-215-7865
Reference Code: COMM030215
(Please have your Reference Code ready when you call.)

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning July 1st and ending June 30th.
(2) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(3) 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.
(4) 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 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.
(5) 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 & Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copay or coinsurance amounts listed above. Under the soft mandatory generic provision, 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.
(6) 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 benefit.

The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

**The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions may apply. The policy / plan documents control in the event of a conflict with this benefit summary.*

The benefit grid has numerous benefits listed at 100% paid. This can include: hospitals, doctors, ambulance, therapies/physical medicine, mental health, durable medical equipment, etc. to name a few. However, that 100% paid is 100% of Highmark's allowance. The important fact is Highmark is paying 100% of an allowance not 100% of the billed charge. If your provider is participating in-network at the Enhanced tier they should accept our 100% payment as payment in full minus any benefit copay. However, if your provider is out of network or non-participating, they may bill you for balance bills which you will be responsible for. You pay the least if you use a provider in the Enhanced Network. You pay more if you use a provider in the Standard Network. You will pay the most if you use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).

REV 1.30.2019