Allegheny County School
Health Insurance Consortium

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2019/2020 MEDICAL SCHEDULE OF BENEFITS

Listed below is the 2019/2020 Medical Schedule of Benefits for the

Allegheny County Schools Health Insurance Consortium Health Plans

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.

July 1, 2019

	Community Blue Flex PPO			Community Blue Flex EPO (formerly HMO)	
Program Options	**Enhanced Value**	**Standard Value**	**Out-of-Network**	**Enhanced Value**	**Standard Value**
Benefit Period (1)	Contract Year			Contract Year	
PCP Required for Enrollment	No	No	No	No	No
Deductible	None None	$1,200 Individual $2,400 Family	$2,000 Individual $4,000 Family	None None	$500 Individual $1,000 Family
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period)	None None	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family	None None	$1,600 Individual $3,200 Family
Coinsurance	100%	80% after deductible	50% after deductible	100%	80% after deductible
Primary Care Provider Office Visits	100% after $0 copay	100% after $20 copay	50% after deductible	100% after $0 copay	100% after $20 copay
Specialist Office Visits **Retail Clinic Visits** **Urgent Care Center Visits**	100% after $10 copay 100% after $5 copay 100% after $10 copay	100% after $50 copay 100% after $40 copay 100% after $40 copay	50% after deductible 50% after deductible 50% after deductible	100% after $10 copay 100% after $5 copay 100% after $10 copay	100% after $50 copay 100% after $40 copay 100% after $40 copay
Telemedicine Services (6)	100% after $0 copay	100% after $20 copay	Not Covered	100% after $0 copay	100% after $20 copay
Preventive Care (2)					
Routine Adult					
Physical Exams	100% deductible does not apply	100% deductible does not apply	50% after deductible	100% deductible does not apply	100% deductible does not apply
Adult Immunizations	100% deductible does not apply	100% deductible does not apply	50% after deductible	100% deductible does not apply	100% deductible does not apply
Colorectal cancer screening	100% deductible does not apply	100% deductible does not apply	50% after deductible	100% deductible does not apply	100% deductible does not apply
Routine gynecological exams, including Pap Test	100% deductible does not apply	100% deductible does not apply	50% deductible does not apply	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	50% after deductible	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	50% after deductible	100% deductible does not apply	100% deductible does not apply
Routine Pediatric					
Physical Exams	100% deductible does not apply	100% deductible does not apply	50% after deductible	100% deductible does not apply	100% deductible does not apply
Pediatric Immunizations	100% deductible does not apply	100% deductible does not apply	50% deductible does not apply	100% deductible does not apply	100% deductible does not apply
Diagnostic services and procedures	100% deductible does not apply	100% deductible does not apply	50% after deductible	100% deductible does not apply	100% deductible does not apply
Emergency Room Services	100% after $100 copay (Waived if admitted)			100% after $100 copay (Waived if admitted)	
Hospital/Medical/Surgical Expenses (include maternity)					
Hospital Inpatient **Hospital Outpatient** **Maternity (non preventive facility & professional services)** **Med/Surgical (except ofc visits)**	100%	80% after deductible	50% after deductible	100%	80% after deductible
Assisted Fertilization Procedures	100%	80% after deductible	50% after deductible	100%	80% after deductible
	$5,000 family maximum, per lifetime			$5,000 family maximum, per lifetime	

Therapy and Rehabilitation Services					
Physical Medicine, Speech & Occupational Therapy	100%	100% after deductible	50% after deductible	100%	100% after deductible
	Unlimited visits	Unlimited visits		Unlimited visits	
Respiratory Therapy	100%	80% after deductible	50% after deductible	100%	80% after deductible
	Unlimited visits	Unlimited visits		Unlimited visits	
Spinal Manipulations	100% after $25 copay	100% after $50 copay	50% after deductible	100% after $25 copay	100% after $50 copayment
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy & Dialysis	100%	80% after deductible	50% after deductible	100%	80% after deductible
Mental Health/Substance Abuse					
Inpatient	100%	100%	50% after deductible	100%	100%
Inpatient Detoxification/Rehabilitation	100%	100%	50% after deductible	100%	100%
Outpatient	100%	100%	50% after deductible	100%	100%
Other Services					
Diagnostic Services – Advanced imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible	50% after deductible	100%	80% after deductible
Basic Diagnostic Services - (standard imaging, diagnostic medical, lab, pathology, allergy testing)	100%	80% after deductible	50% after deductible	100%	80% after deductible
Transplant Services	100%	80% after deductible	50% after deductible	100%	80% after deductible
Skilled Nursing Facility Care	100%	80% after deductible	50% after deductible	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible	50% after deductible	100%	80% after deductible
Home Health Care					
Hospice					
Infertility Counseling, Testing and Treatment (3)					
Private Duty Nursing	100%			100%	
Precertification Requirements (4)	YES			YES	
Prescription Drugs (5)					
Prescription Drug Program **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** $8 generic copay $35 brand copay, formulary $60 brand copay, non-formulary Mandatory Generic 34 day supply **Maintenance Drugs – Mail Order** $12 generic copay $50 brand copay, formulary $90 brand copay, non-formulary Mandatory Generic 90 day supply			**Retail Drugs** $8 generic copay $35 brand copay, formulary $60 Brand copay, non-formulary Mandatory Generic 34 day supply **Maintenance Drugs – Mail Order** $12 generic copay $50 brand copay, formulary $90 brand copay, non-formulary Mandatory Generic 90 day supply	
Questions? Call 1-800-215-7865	**REFERENCE CODE: COMM040215** **(please have reference code ready when you call)**			**REFERENCE CODE: COMM030215** **(please have 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 Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity related inpatient admission. Some facility provider will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. 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 and Therapeutics Committee made up of clinical pharmacist and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copay or coinsurance amounts listed above. You are responsible for the payment differential when a generic drug is authorized by you doctor and you elect to 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