# *Summary of* Community Blue Flex PPO Blue *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 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** **7/1/2018**

| Benefit | Enhanced Value | Standard Value | Out-of-Network |
|---|---|---|---|
| **General Provisions** | | | |
| Benefit Period(1) | Contract Year | | |
| Deductible (per benefit period)<br>Individual<br>Family | <br>None<br>None | <br>$1,200<br>$2,400 | <br>$2,000<br>$4,000 |
| Plan Pays – payment based on the plan allowance | 100% | 80% after deductible | 50% after deductible |
| Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period)<br>Individual<br>Family | <br>None<br>None | <br>$4,000<br>$8,000 | <br>$8,000<br>$16,000 |
| **Office/Clinic/Urgent Care Visits** | | | |
| Retail Clinic Visits | 100% after $5 copayment | 100% after $40 copayment | 50% after deductible |
| Primary Care Provider Office Visits | 100% after 0 copayment | 100% after $20 copayment | 50% after deductible |
| Specialist Office Visits | 100% after $10 copayment | 100% after $50 copayment | 50% after deductible |
| Urgent Care Center Visits | 100% after $10 copayment | 100% after $40 copayment | 50% after deductible |
| Telemedicine Services (6) | 100% after $0 copayment | 100% after $20 copayment | Not Covered |
| **Preventive Care(2)** | | | |
| Routine Adult | | | |
| Physical exams | 100% (deductible does not apply) | 100% (deductible does not apply) | 50% after deductible |
| Adult immunizations | 100% (deductible does not apply) | 100% (deductible does not apply) | 50% after deductible |
| Colorectal cancer screening | 100% (deductible does not apply) | 100% (deductible does not apply) | 50% after deductible |
| Routine gynecological exams, including a Pap Test | 100% (deductible does not apply) | 100% (deductible does not apply) | 50% (deductible does not apply) |
| Mammograms, annual routine and medically necessary | Routine: 100% (deductible does not apply)<br>Medically Necessary: 100% (deductible does not apply) | Routine: 100% (deductible does not apply)<br>Medically Necessary: 100% (deductible does not apply) | 50% after deductible |
| Diagnostic services and procedures | 100% (deductible does not apply) | 100% (deductible does not apply) | 50% after deductible |
| Routine Pediatric | | | |
| Physical exams | 100% (deductible does not apply) | 100% (deductible does not apply) | 50% after deductible |
| Pediatric immunizations | 100% (deductible does not apply) | 100% (deductible does not apply) | 50% (deductible does not apply) |
| Diagnostic services and procedures | 100% (deductible does not apply) | 100% (deductible does not apply) | 50% after deductible |
| **Hospital and Medical/Surgical Expenses (including maternity)** | | | |
| Hospital Inpatient | 100% | 80% after deductible | 50% after deductible |
| Hospital Outpatient | 100% | 80% after deductible | 50% after deductible |
| Maternity (non-preventive facility & professional services) including dependent daughter | 100% | 80% after deductible | 50% after deductible |
| Medical Care (including inpatient visits and consultations)/Surgical Expenses | 100% | 80% after deductible | 50% 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 | 50% after deductible |
| Respiratory Therapy | 100% | 80% after deductible | 50% after deductible |
| Speech & Occupational Therapy | 100% | 100% after deductible | 50% after deductible |
| Spinal Manipulations | 100% after $25 copayment | 100% after $50 copayment | 50% after deductible |
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 100% | 80% after deductible | 50% after deductible |
| **Mental Health/Substance Abuse** | | | |
| Inpatient | 100% | 100% | 50% after deductible |
| Inpatient Detoxification/Rehabilitation | 100% | 100% | 50% after deductible |
| Outpatient | 100% | 100% | 50% after deductible |

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

## Questions? Call 1-800-215-7865
## Reference Code: COMM040215

*(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 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. 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.

Please be advised that most eligible consent decree services will process under the Standard Value level of benefits.

**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.*

*REV 2.1.2018*