

# Allegheny County Schools Health Insurance Consortium (NG)

## 7/1/2012

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.

Benefit	Network
<b>General Provisions</b>	
<b>Benefit Period (1)</b>	Contract Year
<b>Deductible</b> (per benefit period)	
Individual	None
Family	None
<b>Plan Pays</b> – payment based on the plan allowance	100%
<b>Out-of-Pocket Maximums</b> (Once met, plan pays 100% for the rest of the benefit period)	
Individual	None
Family	None
<b>Office/Clinic/Urgent Care Visits</b>	
<b>Retail Clinic Visits</b>	100% after \$20 copayment
<b>Primary Care Provider Office Visits</b>	100% after \$5 copayment
<b>Specialist Office Visits</b>	100% after \$20 copayment
<b>Urgent Care Center Visits</b>	100% after \$20 copayment
<b>Preventive Care (2)</b>	
<b>Routine Adult</b>	
Physical exams	100%
Adult immunizations	100%
Colorectal cancer screening	100%
Routine gynecological exams, including a Pap Test	100%
Mammograms, annual routine and medically necessary	100%
Diagnostic services and procedures	100%
<b>Routine Pediatric</b>	
Routine physical exams	100%
Pediatric immunizations	100%
Diagnostic services and procedures	100%
<b>Hospital and Medical/Surgical Expenses (including Maternity)</b>	
<b>Hospital Inpatient</b>	
<b>Hospital Outpatient</b>	
<b>Maternity</b> (non-preventive facility & professional services)	100%
<b>Medical/Surgical Expenses</b> (except office visits)	
<b>Emergency Services</b>	
<b>Emergency Room Services</b>	100% after \$40 copayment (waived if admitted)
<b>Ambulance</b>	100%
<b>Therapy and Rehabilitation Services</b>	
<b>Physical Medicine</b>	100%
	Unlimited
<b>Respiratory Therapy</b>	100%
<b>Speech &amp; Occupational Therapy</b>	100%
	Unlimited
<b>Spinal Manipulations</b>	100% after \$20 copayment
	Unlimited
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%
<b>Mental Health/Substance Abuse</b>	
<b>Inpatient</b>	100%
<b>Inpatient Detoxification/Rehabilitation</b>	
<b>Outpatient</b>	100%
<b>Other Services</b>	
<b>Allergy Extracts and Injections</b>	100%
<b>Assisted Fertilization Procedures</b>	100%
	\$5,000 Family Maximum, per Lifetime
<b>Dental Services Related to Accidental Injury</b>	100%

<b>Benefit</b>	<b>Network</b>
<b>Diagnostic Services</b> <i>Advanced Imaging (MRI, CAT, PETscan, etc.)</i>	100%
<i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i>	100%
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100%
<b>Home Health Care</b>	100%
<b>Hospice</b>	100%
<b>Infertility Counseling, Testing and Treatment (3)</b>	100%
<b>Private Duty Nursing</b>	100%
<b>Skilled Nursing Facility Care</b>	100%
<b>Transplant Services</b>	100%
<b>Precertification Requirements (4)</b>	Performed by Provider
<b>Prescription Drugs</b>	
<b>Prescription Drug Deductible</b> Individual Family	None None
<b>Prescription Drug Program (5)</b>  <i>Defined by the <b>Premier 2012 Pharmacy Network</b> - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>  <i>Your plan uses the Comprehensive Formulary.</i>	<b>Retail Drugs</b> \$5 generic copayment \$25 brand copayment-formulary \$40 brand copayment-non formulary Mandatory Generic 34 day supply  <b>Maintenance Drugs through Mail Order</b> \$5 generic copayment \$30 brand copayment-formulary \$45 brand copayment-non formulary Mandatory generic 90 day supply

**Questions? Call 1-800-215-7865**

**Reference Code: 0412001K**

*(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 1<sup>st</sup> and ending June 30<sup>th</sup>.
- (2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits 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 providers 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 copayment or coinsurance amounts listed above. You are responsible for the payment differential when a generic drug is authorized by your 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.