



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	In-Network	Out-of-Network
General Provisions		
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$200	\$400
Family	\$400	\$800
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period)		
Individual	None	\$1,600
Family	None	\$3,200
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after \$20 copayment	80% after deductible
Primary Care Provider Office Visits	100% after \$5 copayment	80% after deductible
Specialist Office Visits	100% after \$20 copayment	80% after deductible
Urgent Care Center Visits	100% after \$20 copayment	80% after deductible
Preventive Care (2)		
Routine Adult		
Physical exams	100% (deductible does not apply)	Not Covered
Adult immunizations	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient		
Hospital Outpatient		
Maternity (non-preventive facility & professional services)	100% after deductible	80% after deductible
Medical/Surgical (except office visits)		
Emergency Services		
Emergency Room Services	100% after \$40 copayment (waived if admitted)	
Ambulance	100% after In-Network deductible	
Therapy and Rehabilitation Services		
Physical Medicine	100% after deductible	80% after deductible
	Unlimited visits	
Respiratory Therapy	100% after In-Network deductible	
Speech & Occupational Therapy	100% after deductible	80% after deductible
	Unlimited visits	
Spinal Manipulations	100% after \$20 copayment	80% after deductible
	Unlimited visits	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation		
Outpatient	100% after deductible	80% after deductible

Benefit	In-Network	Out-of-Network
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Assisted Fertilization Procedures	100% after deductible	80% after deductible
\$5,000 Family Maximum, per Lifetime		
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics		
Home Health Care	100% after deductible	80% after deductible
Hospice		
Infertility Counseling, Testing and Treatment (3)		
Private Duty Nursing	100% after In-Network deductible	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements (4)	Yes	
Prescription Drugs		
Prescription Drug Deductible		
Individual	None	
Family	None	
Prescription Drug Program (5)		
Defines by the Premier 2012 Pharmacy Network – Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered	Retail Drugs \$5 generic copayment \$25 brand copayment-formulary \$40 brand copayment, non-formulary Mandatory generic 34 day supply	
<i>Your plan uses the Comprehensive Formulary.</i>	Maintenance Drugs through Mail Order \$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:P0130412

(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. 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.
- (6) 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 doctor and you elect to purchase a brand name drug. Your payment is the price difference between the brand name drug and generic in addition to the brand name drug copayment or coinsurance amounts, which may apply.