2022/2023 MEDICAL SCHEDULE OF BENEFITS
Listed below is the Medical Schedule of Benefits Comparison 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.

Effective July 1, 2022	Performance Flex Blue PPO			Performance Flex Blue EPO	
Benefit	**In-Network Enhanced Value**	**In-Network Standard Value**	**Out of Network**	**In-Network Enhanced Value**	**In-Network Standard Value**
	General Provisions				
Benefit Period (1)	Contract Year			Contract Year	
Deductible (per benefit period) Individual Family	None None	$1,200 $2,400	$2,000 $4,000	None None	$500 $1,000
Plan Pays – payment based on the plan allowance	100%	80% after deductible	50% after deductible	100%	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	None None	$4,000 $8,000	$8,000 $16,000	None None	$1,600 $3,200
	Office/Clinic/Urgent Care Visits				
Primary Care Provider Office Visits & Virtual Visits	100% after $0 copay	100% after $20 copay	50% after deductible	100% after $0 copay	100% after $20 copay
Specialist Office Visits & Virtual Visits	100% after $10 copay	100% after $50 copay	50% after deductible	100% after $10 copay	100% after $50 copay
Retail Clinic Visits & Virtual Visits	100% after $5 copay	100% after $40 copay	50% after deductible	100% after $5 copay	100% after $40 copay
Virtual Visit Provider Originating Site Fee	100%	80% after deductible	50% after deductible	100%	80% after deductible
Urgent Care Center Visits	100% after $10 copay	100% after $40 copay	50% after deductible	100% after $10 copay	100% after $40 copay
Telemedicine Services (5)	100% after $0 copay	100% after $20 copay	not covered	100% $0 copay	100% after $20 copay
	Preventive Care (2)				
Routine Adult Physical Exams	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Adult Immunizations	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Colorectal cancer screening	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Routine Gynecological Exams, including a Pap Test	100%	100% (deductible does not apply)	50% (deductible does not apply)	100%	100% (deductible does not apply)
Mammograms, Annual Routine	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Mammograms, Medically Necessary	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Diagnostic Services and Procedures	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Routine Pediatric Physical Exams	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Pediatric Immunizations	100%	100% (deductible does not apply)	50% (deductible does not apply)	100%	100% (deductible does not apply)
Diagnostic Services and Procedures	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
	Emergency Services				
Emergency Room Services (6)	100% after $100 copay (waived if admitted)			100% after $100 copay (waived if admitted)	
Ambulance – Emergency (7)	100%			100%	
Ambulance - Non-Emergency (7)	100%			100%	
	Hospital and Medical / Surgical Expenses (including maternity)				
Hospital Inpatient	100%	80% after deductible	50% after deductible	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible	50% after deductible	100%	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible	50% after deductible	100%	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100%	80% after deductible	50% after deductible	100%	80% after deductible
	Therapy and Rehabilitation Services				
Physical Medicine	100%	100% after deductible	50% after deductible	100%	100% after deductible
Respiratory Therapy	100%	80% after deductible	50% after deductible	100%	80% after deductible
Speech Therapy	100%	100% after deductible	50% after deductible	100%	100% after deductible
Occupational Therapy	100%	100% after deductible	50% after deductible	100%	100% after deductible
Spinal Manipulations	100% after $25 copay	100% after $50 copay	50% after deductible	100% after $25 copay	100% after $50 copay
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible	50% after deductible	100%	80% after deductible

Effective July 1, 2022	Performance Flex Blue PPO			Performance Flex Blue EPO	
Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network	In-Network Enhanced Value	In-Network Standard Value
Mental Health / Substance Abuse					
Inpatient Mental Health Services	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Inpatient Detoxification / Rehabilitation	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Outpatient - includes virtual behavioral health visits	100%	100% (deductible does not apply)	50% after deductible	100%	100% (deductible does not apply)
Other Services					
Allergy Extracts and Injections	100%	80% after deductible	50% after deductible	100%	80% after deductible
Assisted Fertilization Procedures	100% benefit maximum of $5,000/family/lifetime	80% after deductible benefit maximum of $5,000/family/lifetime	50% after deductible benefit maximum of $5,000/family/lifetime	100% benefit maximum of $5,000/family/lifetime	80% after deductible benefit maximum of $5,000/family/lifetime
Dental Services Related to Accidental Injury	100%	80% after deductible	Not Covered	100%	80% after deductible
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
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible	50% after deductible	100%	80% after deductible
Home Health Care	100%	80% after deductible	50% after deductible	100%	80% after deductible
Hospice	100%	100% after deductible	50% after deductible	100%	80% after deductible
Infertility Counseling, Testing and Treatment (3)	100%	80% after deductible	50% after deductible	100%	80% after deductible
Private Duty Nursing	100%			100%	
Skilled Nursing Facility Care	100%	80% after deductible	50% after deductible	100%	80% after deductible
Transplant Services	100%	100% after deductible	50% after deductible	100%	80% after deductible
Precertification/Authorization Requirements (4)	Yes	Yes	Yes	Yes	Yes
Questions? Call 1-800-215-7865	**Reference Code: P0040222 (Please have your reference code ready when you call.)**			**Reference Code: P0050222 (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. Treatment does not include Assisted Fertilization Procedures.
(4) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of a 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) 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.
(6) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

(7) Benefits for Ambulance Services provided by air and rendered by an Out-of-Network provider and/or Emergency Ambulance Services rendered by an Out-of-Network Provider, will be paid at the network level and are subject to the deductible amount, if any, that is applicable to network services. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copays, 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).

Special COVID-19 Coverage Variations.

To the extent required by law your program will provide the following at no cost to you:

- Coverage for items and services furnished during healthcare provider office visits (which includes in-person visits and telemedicine visits) that result in an order for or administration of an in vitro diagnostic product, but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need for such product.
- Coverage for the above required items and services that are furnished by providers that have not agreed to accept a negotiated rate as payment in full (i.e., out-of-network providers).
- Coverage for the above required items and services in both traditional and non-traditional health care settings; including telehealth.

In addition, your plan will cover in-patient care at an in-network hospital for COVID-19 treatment without member cost-sharing. This benefit is subject to change at the determination of the ACSHIC Board of Trustees.

Please note, that Performance Blue products including Performance Flex Blue, are high performing network products and those products do not provide full access to all UPMC providers. Please reference separate materials, the Highmark website, or call Highmark Concierge 1-877-258-3123 to determine which UPMC providers are in and out of network.