BUCKINGHAM COUNTY PUBLIC SCHOOLS
SCHEDULE OF BENEFITS
PPO 2000 PLAN

EFFECTIVE: 07/01/2024

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MAXIMUM PLAN YEAR BENEFIT AMOUNT	None (unlimited)	
DEDUCTIBLE, PER PLAN YEAR		
Individual *(per covered person)*	$2,000	$4,000
Family	$4,000	$8,000

Amounts applied to the Deductible for charges from Network Providers will NOT be used to satisfy the Deductible for charges from Non-Network Providers and vice versa.

For family coverage, the Plan has an embedded individual Deductible Amount. This means the Deductible for a Covered Person in the family unit will be satisfied after the Covered Person meets the deductible. The family unit must satisfy the family Deductible before the Plan considers the Deductible met for all Covered Persons in the family.

MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR		
Individual *(per covered person)*	$5,500 *(includes copays, deductible and coinsurance)*	$13,750 *(includes copays, deductible and coinsurance)*
Family	$11,000 *(includes copays, deductible and coinsurance)*	$27,500 *(includes copays, deductible and coinsurance)*

Amounts applied to the Maximum Out-Of-Pocket Amount for charges from Network Providers will NOT be used to satisfy the Maximum Out-of-Pocket Amount for charges from Non-Network Providers and vice versa.

For family coverage, the Plan has an embedded individual Maximum Out-of-Pocket Amount. This means Covered Services will be paid at 100% for a Covered Person in the family unit after the Covered Person meets a Maximum Out-of-Pocket Amount. The family unit must satisfy the family Maximum Out-of-Pocket Amount before the Plan will pay benefits at 100% for all Covered Persons in the family.

The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.

- Cost containment penalties
- Non-Covered Expenses
- Amounts that exceed an Allowable Charge
- Amounts that exceed benefit maximums

NOTE: Prescription drug co-payments ARE included in the out-of-pocket maximum amount.

COVERED SERVICES

Percentages listed indicate the portion of the Allowable Charge that the Plan will pay in benefits subject to all exclusions and limitations described in this document. Copayments and deductibles are the Covered Person's responsibility to pay.

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
PREVENTIVE CARE The Plan will cover the following preventive services from a Network Provider with no charge for the Covered Person: ➢ Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force *except* for the recommendations issued in or around November of 2009 for breast cancer screening, mammography, and prevention are not considered to be current. ➢ Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. ➢ With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and ➢ With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. *Benefits are subject to frequency guidelines set forth in the Affordable Care Act.*		
Routine Well Adult Care		
Office Visit including physical examination	100%, deductible waived	100%, deductible waived
Immunizations/flu shots	100%, deductible waived	100%, deductible waived
Lab tests and X-rays	100%, deductible waived	100%, deductible waived
Gynecological exam	100%, deductible waived	100%, deductible waived
Pap smear	100%, deductible waived	100%, deductible waived
Mammogram	100%, deductible waived	100%, deductible waived
Prostate exam/PSA	100%, deductible waived	100%, deductible waived
Bone Density	100%, deductible waived	100%, deductible waived
Endoscopic Tests (Sigmoidoscopy/Colonoscopy)	100%, deductible waived	100%, deductible waived
Hearing Screening	Not Covered	Not Covered
Annual Vision Exam	Not Covered	Not Covered
Vision Hardware (frames, lenses, and contacts)	Not Covered	Not Covered
Routine Well Child Care (for individuals from age 0 up to age 18)		
Office Visit including physical exam	100%, deductible waived	100%, deductible waived
Lab tests and X-rays	100%, deductible waived	100%, deductible waived
Immunizations/Flu shots	100%, deductible waived	100%, deductible waived
Hearing Screening	Not Covered except as required under the Affordable Care Act	Not Covered
Vision Services (exams, frames, lenses, etc.)	Not Covered except as required under the Affordable Care Act	

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
HOSPITAL SERVICES		
Room and Board* *Benefits payable at the facility's semi-private room rate.*	80% after deductible	70% after deductible
Intensive Care Unit* *Benefits payable at the facility's ICU rate*	80% after deductible	70% after deductible
Skilled Nursing Facility*	80% after deductible	70% after deductible
Elective Surgery* *In a hospital setting, including Surgeon Charges*	80% after deductible	70% after deductible
Emergency Room *All services rendered during visit*	80% after in-network deductible	
Preadmission Testing	$30 copayment, deductible waived	70% after deductible
Clinic Services *In a hospital setting*	$30 copayment, deductible waived	70% after deductible
Labs *In a hospital setting*	80% after deductible	70% after deductible
X-Rays *In a hospital setting*	80% after deductible	70% after deductible
Diagnostic Test *In a hospital setting*	80% after deductible	70% after deductible
PHYSICIAN SERVICES		
Office Visit – Primary Care Physician	$30 copayment, deductible waived	70% after deductible
Office Visit – Specialist Care Physician	$50 copayment, deductible waived	70% after deductible
Telephonic or Virtual Consultations *Primary Care Physician* *Specialist Care Physician*	 $30 copayment, deductible waived $50 copayment, deductible waived	 70% after deductible 70% after deductible
Telemedicine via Teladoc *General Medicine*	$0 fee	Not Applicable

*****Requires Precertification*

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER SERVICES		
Ambulance Services	80% after in-network deductible	
Organ Transplants*	80% after deductible	70% after deductible
Elective Surgery* *All services rendered during an Ambulatory Surgery Center visit*	80% after deductible	70% after deductible
Labs *In an office setting, free-standing facility, or independent lab*	100%, deductible waived	70% after deductible
X-Rays *In an office setting or free-standing facility*	100%, deductible waived	70% after deductible
Diagnostic Test *In an office setting, free-standing facility, or independent lab*	100%, deductible waived	70% after deductible
Advanced Imaging*	$250 copayment, deductible waived	70% after deductible
Maternity Services	80% after deductible *Deductible and coinsurance are waived for services included in the recommendations and guidelines listed above in this Schedule under preventive care (e.g., preventive prenatal and breastfeeding support services).*	70% after deductible
Termination of Pregnancy *When Medically Necessary*	80% after deductible	Not covered
Family Planning	100%, deductible waived	Not covered
Home Health Care* *Plan Year maximum: 60 visits*	80% after deductible	70% after deductible
Infusion Therapy *Home or Office setting*	80% after deductible	70% after deductible
Hospice Care *Includes bereavement services: 6 visits*	80% after deductible	70% after deductible
Spinal Manipulation/Chiropractic *Plan Year maximum: 30 visits*	$50 copayment, deductible waived	70% after deductible
Massage Therapy	$50 copayment, deductible waived	70% after deductible
Physical Therapy *Plan Year maximum: 30 visits combined with Speech and Occupational Therapy*	80% after deductible	70% after deductible
Speech Therapy *Plan Year maximum: 30 visits combined with Physical and Occupational Therapy*	80% after deductible	70% after deductible
Occupational Therapy *Plan Year maximum: 30 visits combined with Physical and Speech Therapy*	80% after deductible	70% after deductible
Cardiac Therapy *Plan Year maximum: 30 visits*	80% after deductible	70% after deductible

*****Requires Precertification*

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER SERVICES		
Urgent Care	$50 copayment, deductible waived	70% after deductible
Chemotherapy*	80% after deductible	70% after deductible
Radiation Therapy*	80% after deductible	70% after deductible
Diabetes Self-Management Training and Education	$30 copayment, deductible waived	70% after deductible
Second Surgical Option	$50 copayment, deductible waived	70% after deductible
Medical and Enteral Formula*	100%, deductible waived	Not covered
Dialysis *Limit: First 40 visits for outpatient renal dialysis*	80% after deductible	70% after deductible
Allergy Services *Includes serum and injections*	80% after deductible	70% after deductible
Allergy Testing	$50 copayment, deductible waived	70% after deductible
Durable Medical Equipment*	80% after deductible	70% after deductible
Hearing Aids	80% after deductible	70% after deductible
Wigs *Plan Year maximum: 1 wig*	80% after deductible	70% after deductible

Requires Precertification

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MENTAL HEALTH DISORDERS		
Inpatient/Partial Hospitalization*	80% after deductible	70% after deductible
Outpatient Facility	80% after deductible	70% after deductible
Office Visit	$30 copayment, deductible waived	70% after deductible
SUBSTANCE USE DISORDER		
Inpatient/Partial Hospitalization*	80% after deductible	70% after deductible
Outpatient Facility	80% after deductible	70% after deductible
Office Visit	$30 copayment, deductible waived	70% after deductible

Requires Precertification

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
ALL OTHER COVERED SERVICES	80% after deductible	70% after deductible

PRESCRIPTION DRUG BENEFITS
PPO 2000 PLAN

NOTE: If a Covered Person requests a Brand Name Drug instead of a Generic Drug recommended by the pharmacy, the Covered Person will pay the Brand Name Drug copayment as well as the prescription cost between the Brand Name and the Generic Drug. A Covered Person will not be required to pay the difference in price between a Brand Name and Generic Drug when the Physician writes "DAW," or "Dispense as Written" on the prescription.

PRESCRIPTION DRUGS		
	RETAIL PHARMACY *30-day supply*	**RETAIL/MAIL ORDER PHARMACY** *90-day supply*
Generic (Tier 1)	$15 copayment, deductible waived	$38 copayment, deductible waived
Preferred Brand Name (Tier 2)	$50 copayment, deductible waived	$125 copayment, deductible waived
Non-Preferred Brand Name (Tier 3)	$85 copayment, deductible waived	$213 copayment, deductible waived
Preventive Drugs (Prescription Drugs classified as a Preventive Drug by HHS)	$0 copayment, deductible waived	$0 copayment, deductible waived
SPECIALTY DRUGS		
	SPECIALTY PHARMACY *30- day supply*	
Specialty Generic	20% up to $300 copayment, deductible waived	
Specialty Preferred Brand Name	20% up to $300 copayment, deductible waived	
Specialty Non-Preferred Brand Name	20% up to $300 copayment, deductible waived	

Please note, all Specialty medication must be obtained via the CVS Caremark Specialty Pharmacy.

FY25 JHP/WellNet-CIGNA NETWORK RATES

Effective July 1, 2024

HEALTH	Employee Portion	Employer Portion	Total
PPO 30/2000/20% $2000 Deductible			
Employee	$ 185.73	$ 780.37	$ 966.10
Employee + Children	$ 315.70	$ 1,279.63	$ 1,595.33
Employee + Spouse	$ 388.73	$ 1,616.55	$ 2,005.28
Family	$ 589.74	$ 2,337.08	$ 2,926.82
PPO 30/4000/20% $4,000 Deductible			
Employee	$ 104.04	$ 800.76	$ 904.80
Employee + Children	$ 176.17	$ 1,308.96	$ 1,485.13
Employee + Spouse	$ 218.38	$ 1,650.76	$ 1,869.14
Family	$ 329.72	$ 2,389.63	$ 2,719.35