Butler Area School District

Overview of Current PPOBlue Medical Plan

Non-Grandfathered

BENEFIT	PPOBlue Medical Plan Group Numbers: Active Support - 107752-00; Active Professional - 107752-01; Active Administration - 107752-02; Inactive - 107752-03	
	In-Network Care[1]	**Out-of-Network Care[1,2]**
	Policy Provisions	
Benefit Period	Contract Year	
Calendar Year Deductible (Individual/Family)[3]	$200 / $400	$2,000 / $4,000
Co-Insurance (The Plan Pays:)[3]	100% after deductible	50% after deductible
Annual Out-of-Pocket Maximum (Individual/Family)	Not Applicable *Does not apply when the in-network co-insurance is 100% after deductible*	$8,000 / $16,000[4] (not including deductibles) (not including balance billing)
Total Maximum Out-of-Pocket (Individual/Family)[5] (Includes medical & prescription drug deductible, coinsurance, & copays)	$6,350 / $12,700	Not Applicable
Lifetime Maximum Per Person	Unlimited	
Dependent Eligibility	Dependents up to age 26	
Precertification Requirements	Yes (provider responsibility)	Yes[6]
	Preventive Care Services	
Routine Physical Exams (adult & pediatric)	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including PAP Test	100% (deductible does not apply)	50% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Childhood Immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms - Routine	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening - Routine	100% (deductible does not apply)	50% after deductible
	Hospital / Physician Services	
Primary Care Physician Office Visits	100% after $0 copay per visit	50% after deductible
Specialist Office Visits	100% after $20 copay per visit	50% after deductible
Retail Clinic Office Visits	100% after $5 copay per visit	50% after deductible
Urgent Care Center Visits	100% after $10 copay per visit	50% after deductible
Telemedicine Services[7]	100% after $0 copay per visit	Not Covered
Maternity Care (facility & professional)	100% after deductible	50% after deductible
Inpatient Hospital Services	100% after deductible	50% after deductible
Outpatient Hospital Services	100% after deductible	50% after deductible
Medical/Surgical Services (except office visits)	100% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT Scan, PET Scan, etc.)	100% after deductible	50% after deductible
Basic Diagnostic Services (Standard Imaging, Diagnostic Medical, Lab/Pathology, Allergy Testing)	100% after deductible	50% after deductible
Mammograms - Medically Necessary	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening - Medically Necessary	100% (deductible does not apply)	50% after deductible
Allergy Extracts	100% after deductible	50% after deductible
Transplant Services	100% after deductible	50% after deductible
	Emergency Services	
Emergency Room Services[8]	100% after $125 copay per visit (waived if admitted) *Notes: If inpatient admission occurs, deductible will apply.* *If outpatient observation occurs, copay will apply.*	
Ambulance - Emergency	100% after deductible	
Ambulance - Non Emergency	100% after deductible	
	Therapy Services	
Spinal Manipulation Services	100% after $25 copay per visit	50% after deductible
	Note: Specialist office visit copay may apply, if an office visit is billed.	
Physical, Speech, & Occupational Therapy Services	100% after deductible	50% after deductible
	Note: Specialist office visit copay may apply, if an office visit is billed.	
Cardiac Rehabilitation, Chemotherapy, & Dialysis Treatment	100% after deductible	50% after deductible
Infusion & Radiation Therapy Services	100% after deductible	50% after deductible
Respiratory Therapy Services	100% after deductible	50% after deductible
	Behavioral Health Services	
Mental Health - Inpatient	100% after deductible	50% after deductible
Mental Health - Outpatient	100% after deductible	50% after deductible
Substance Abuse - Inpatient Detoxification	100% after deductible	50% after deductible
Substance Abuse - Inpatient Rehabilitation	100% after deductible	50% after deductible
Substance Abuse - Outpatient Rehabilitation	100% after deductible	50% after deductible

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	In-Network Care[1]	**Out-of-Network Care[1,2]**
	Other Services	
Assisted Fertilization Procedures	100% after deductible	50% after deductible
	Note: benefit maximum of $5,000/family/lifetime	
Dental Services Related to Accidental Injury	100% after deductible	Not Covered
Diabetes Treatment	100% after deductible	50% after deductible
Durable Medical Equipment	100% after deductible	50% after deductible
Enteral Formulae	100% after deductible	50% after deductible
Home Infusion Therapy	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
Hospice Care	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment[9]	100% after deductible	50% after deductible
Orthotics	100% after deductible	50% after deductible
Pediatric Extended Care Services	100% after deductible	50% after deductible
	Combined Limit: 100 days per benefit period	
Private Duty Nursing	100% after deductible	
Prosthetics	100% after deductible	50% after deductible
Skilled Nursing Facility	100% after deductible	50% after deductible
	Prescription Drugs	
Prescription Drug Deductible	None	
Prescription Drug (retail)	$8 Generic / $35 Brand Formulary / $60 Brand Non-Formulary Copays Up to a 34 day supply Advantage Pharmacy Network Comprehensive Formulary with Soft Mandatory Generic Provision[10]	
Prescription Drug (mail order)	$12 Generic / $50 Brand Formulary / $90 Brand Non-Formulary Copays Up to a 90 day supply Comprehensive Formulary with Soft Mandatory Generic Provision[10]	

[1] 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.

[2] Precertification may be required for services rendered by out-of-network providers.

[3] Does not include prescription drug benefits.

[4] Non-participating providers or those who are not in the Highmark network can bill members for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services that are performed by the non-participating provider. This is referred to as balance billing and the member's liability is not limited by the health plan. Balance billing liabilities are above and beyond the out-of-pocket maximum listed on this benefit grid.

[5] The in-network total maximum out-of-pocket as mandated by the federal government must include medical and prescription drug deductible, coinsurance, & copays.

[6] HMS must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. 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 not be responsible for payment of any costs incurred.

[7] Services must be performed by a Highmark approved telemedicine provider. 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.

[8] Emergency service is any health care service provided to a member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

[9] 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. Treatment does not include Assisted Fertilization Procedures.

[10] Under the Soft Mandatory Generic Provision, the member is responsible for the payment differential when a generic drug is available and the **patient** elects to purchase a brand name drug. The member payment is the price difference between the generic and the brand name, in addition to copayment or coinsurance amounts which apply.

NOTE: *This grid is only provided as a brief overview of benefits. All services must be medically necessary and appropriate, as determined by Highmark Blue Cross Blue Shield, for benefits to apply.*
For questions concerning your benefits, please contact The Reschini Group at 1-800-442-8047.