

# Unitarian Universalist Association Health Plan



## Summary of High Deductible Health Plan Benefits, January 1, 2010

### Program 1, Qualified High Deductible Health Plan, HSA eligible (HDHP 1)

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year	
<b>Deductible</b> (per benefit period)		
Individual	\$2,000 Combined	
Family	\$4,000 Combined	
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	90% after deductible	70% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)		
Individual	\$4,000 Combined	
Family	\$6,000 Combined	
<b>Lifetime Maximum</b> (per person)	Unlimited	\$1,000,000
<b>Primary Care Physician Office Visits</b>	90% after deductible	70% after deductible
<b>Specialist Office Visits</b>	90% after deductible	70% after deductible
<b>Preventive Care</b>		
<b>Adult</b>		
Routine physical exams, includes preventive diagnostic	90% (deductible does not apply)	Not Covered
Adult Immunizations	90% (deductible does not apply)	70% after deductible
Routine gynecological exams, including a PAP Test	90% (deductible does not apply)	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	70% after deductible
<b>Pediatric</b>		
Routine physical exams	90% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	70% (deductible does not apply)
<b>Emergency Room Services</b>	90% after deductible	
<b>Spinal Manipulations</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Physical Medicine</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Speech Therapy</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Occupational Therapy</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Allergy Extracts and Injections</b>	90% after deductible	70% after deductible
<b>Ambulance</b>	90% after deductible	
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Comprehensive Routine Eye Exam</b>	90% (deductible does not apply)	Not covered
<b>Dental Services Related to Accidental Injury</b>	90% after deductible	70% after deductible
<b>Diabetes Treatment</b>	90% after deductible	70% after deductible
<b>Diagnostic Services (including routine)</b>	90% after deductible	70% after deductible
<b>Advanced Imaging</b> (MRI, CAT Scan, PET scan, etc.)		
<b>Basic Diagnostic Services</b> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	90% after deductible	70% after deductible
<b>Enteral Formulae</b>	90% after deductible	70% after deductible
<b>Home Infusion Therapy</b>	90% after deductible	

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Home Health Care</b>	90% after deductible	70% after deductible
<b>Hospice</b>	90% after deductible	70% after deductible
<b>Hospital Services – Inpatient</b> <sup>③</sup>	90% after deductible	70% after deductible
<b>Hospital Services – Outpatient</b>	90% after deductible	70% after deductible
<b>Infertility Counseling, Testing and Treatment</b> <sup>(2)</sup>	90% after deductible	70% after deductible
<b>Maternity</b> (facility & professional services)	90% after deductible	70% after deductible
<b>Medical/Surgical Expenses</b> (Except Office Visits)	90% after deductible	70% after deductible
<b>Mental Health – Inpatient</b> <sup>③</sup>	90% after deductible	70% after deductible
<b>Mental Health – Outpatient</b>	90% after deductible	70% after deductible
<b>Private Duty Nursing</b>	90% after deductible	
<b>Respiratory Therapy</b>	90% after deductible	
<b>Skilled Nursing Facility Care</b>	90% after deductible	70% after deductible
	Limit: 100 days/benefit period	
<b>Substance Abuse – Inpatient Detoxification</b> <sup>③</sup>	90% after deductible	70% after deductible
<b>Substance Abuse – Inpatient Rehabilitation</b> <sup>③</sup>	90% after deductible	70% after deductible
<b>Substance Abuse – Outpatient</b>	90% after deductible	70% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
<b>Transplant Services</b>	90% after deductible	70% after deductible
<b>Precertification Requirements</b>	Performed by Member <sup>(3)</sup>	
<b>Premier Prescription Drug Program</b>  This is an integrated deductible program. The deductible (medical plus prescription drug) must be satisfied prior to the plan paying 70%. Out of pocket maximums apply.	<p align="center"><b>Defined by Premier Gold National Pharmacy Network - Not Physician Network.</b>  <b>(Prescriptions filled at a non-network pharmacy are not covered.)</b></p> <p align="center"><b>Retail Drugs</b>  Plan pays 70% after deductible per generic  Plan pays 70% after deductible per brand  \$15 minimum member payment  \$100 maximum member payment  <b>Mandatory Generic</b><sup>(4)</sup>  <b>31-day Supply</b></p> <p align="center"><b>Maintenance Drugs through Mail Order</b>  Plan pays 70% after deductible per generic  Plan pays 70% after deductible per brand  \$30 minimum member payment  \$200 maximum member payment  <b>Mandatory Generic</b><sup>(4)</sup>  <b>90-day Supply</b></p>	

## Questions? Call 1-800-796-6502

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. The UUA effective date is January 1.
- (2) 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.
- (3) Member is required to contact Highmark Health Care Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.
- (4) The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.