

Summary of PPO Benefits



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 levels that apply during your benefit period.

Effective 1-1-2012

Unitarian Universalist Association

Benefit	Network	Out-of-Network
Benefit Period (1)	Calendar Year	
Deductible (per calendar year)		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
Plan Payment Level – Based on the provider's reasonable charge (UCR)	90% after deductible	70% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%.)		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
Lifetime Maximum (per member)	Unlimited	
Primary Care Physician Office Visits	100% after \$20 copayment	70% after deductible
Specialist Office Visits	100% after \$35 copayment	70% after deductible
Preventive Care		
<i>Adult</i>		
Routine physical exams	100% after \$20 copayment	Not Covered
Adult Immunizations	100% deductible does not apply	70% after deductible
Routine gynecological exams including PAP smears	100% after \$20 copayment	70% deductible does not apply
Mammograms, annual routine	100% deductible does not apply	70% after deductible
Colorectal Cancer Screening	100% deductible does not apply	70% after deductible
Diagnostic services and procedures	100% deductible does not apply	Not Covered
<i>Pediatric</i>		
Routine physical exams	100% after \$20 copayment	Not Covered
Pediatric immunizations	100% deductible does not apply	70% deductible does not apply
Diagnostic services and procedures	100% deductible does not apply	Not Covered
Emergency Room Services	100% after \$50 copayment (waived if admitted)	
Spinal Manipulations	100% after \$20 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Physical Therapy	100% after \$20 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Speech Therapy	100% after \$20 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Occupational Therapy	100% after \$20 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Allergy Extracts	90% after deductible	70% after deductible
Allergy Injections	90% after deductible	70% after deductible
Ambulance	90% after Network deductible	
Assisted Fertilization Procedures	Not Covered	
Comprehensive Routine Eye Exam	100% after \$20 copayment	Not covered
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diagnostic Services		
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% deductible does apply	70% after deductible
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)		
Durable Medical Equipment, Orthotics and Prosthetics (wigs-benefit maximum of \$500 at 100% for medical condition and treatment)	90% after deductible	70% after deductible
Enteral Formula	90% deductible does not apply	70% deductible does not apply

Benefit	Network	Out-of-Network
Hearing Aids	100% Limit: \$2,000 maximum every 24 months	Not Covered
Hearing Aid Exam	100% after \$20 copayment	Not Covered
Home Infusion Therapy	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Hospital Services – Inpatient	90% after deductible	70% after deductible
Hospital Services – Outpatient	90% after deductible	70% after deductible
Infertility Counseling and Testing (2)	90% after deductible	70% after deductible
Maternity (facility & professional services)	90% after deductible	70% after deductible
Medical/Surgical Expenses	90% after deductible	70% after deductible
Mental Health – Inpatient	90% after deductible	70% after deductible
Mental Health – Outpatient	Office Visit 100% after \$20 copayment Non-Office Visit 90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
Respiratory Therapy	90% after deductible	70% after deductible
Skilled Nursing Facility Care	90% after deductible Limit: 100 days/benefit period	70% after deductible
Substance Abuse – Inpatient Rehabilitation/Detoxification	90% after deductible	70% after deductible
Substance Abuse – Outpatient	Office Visit 100% after \$20 copayment Non-Office Visit 90% after deductible	70% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Transplant Services	90% after deductible	70% after deductible
Transsexual Surgery	90% after deductible	70% after deductible
	Combined limit:\$25,000 per lifetime maximum	
Precertification Requirements (3)	Performed by Member	
Premier Prescription Drug Program (4) <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	Retail Drugs - 31-day Supply \$10 generic copayment \$25 brand copayment \$40 non-formulary brand copayment Maintenance Drugs through Mail Order - 90-day Supply \$20 generic copayment \$50 brand copayment \$80 non-formulary brand copayment	

Questions? 1-800-796-6502

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) Treatment includes coverage for the correction of a physical or medical problem associated with infertility.
- (3) BCBS 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.
- (4) 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 Therapeutic 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 purchase a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.

*This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.
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