



## Summary of PPO HDHP without HSA Benefits – 2022 Plan Year

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. If you enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you enroll as a family, the deductible and out-of-pocket maximums for the "Family Plan" apply and can be satisfied by one or more of your family members.

Unitarian Universalist Association	Not Available In MA	HDHP
Benefit	Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year	
<b>Deductible</b> (per benefit period)		
Individual Family	\$3,200 \$6,400	
<b>Plan Pays</b> – payment based on the plan allowance	90% after deductible	70% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan pays 100% for the rest of the benefit period; includes copayments, deductibles and prescription drug)		
Individual Family	\$6,000 \$12,000	
<b>Total Maximum Out-of-Pocket</b> (includes deductible and coinsurance, and other qualified medical expenses, In Network only) <sup>(2)</sup> Once met, plan pays 100% for the rest of the benefit period.		
Individual Family	\$6,000 \$12,000	
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Telemedicine Visits, including mental health consults</b>	90% after deductible	70% after deductible
<b>Retail Clinic Visits</b>	90% after deductible	70% after deductible
<b>Primary Care Provider Office Visits</b>	90% after deductible	70% after deductible
<b>Specialist Office Visits</b>	90% after deductible	70% after deductible
<b>Urgent Care Center Visits</b>	90% after deductible	70% after deductible
<b>Preventive Care</b>		
<b>Routine Adult</b>		
Physical exams, including annual routine eye exam	100% deductible does not apply	Not Covered
<b>Adult immunizations</b>		
Colorectal cancer screening (includes colonoscopy; sigmoidoscopy; barium enema; blood occult)	100% deductible does not apply	70% after deductible
Routine gynecological exams	100% deductible does not apply	70% deductible does not apply
Routine Pap Test	100% deductible does not apply	100% deductible does not apply
Mammograms, annual routine	100% deductible does not apply	70% after deductible
Women's Preventive Health Services <sup>(6)</sup> (includes Lactation consultation)	100% deductible does not apply	70% after deductible
Diagnostic services and procedures	100% deductible does not apply	70% after deductible Limited to Colorectal Screening Only
<b>Routine Pediatric</b>		
Physical exams	100%	Not Covered
Pediatric immunizations	100%	70% deductible does not apply
Diagnostic services and procedures	100%	Not Covered
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b>	90% after deductible	70% after deductible
<b>Hospital Outpatient</b>	90% after deductible	70% after deductible
<b>Maternity</b> (non-preventive facility & professional services)	90% after deductible	70% after deductible
<b>Medical/Surgical</b> (except office visits)	90% after deductible	70% after deductible
<b>Emergency Services</b>		
<b>Emergency Room Services</b>	90% after deductible	
<b>Ambulance</b>	90% after deductible	
<b>Therapy and Rehabilitation Services</b>		

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Physical Medicine</b>	90% after deductible Limit: 20 visits/ benefit period	70% after deductible
<b>Occupational Therapy</b>	90% after deductible Limit: 20 visits/ benefit period	70% after deductible
<b>Speech Therapy</b>	90% after deductible Limit: 20 visits/ benefit period	70% after deductible
<b>Spinal Manipulations/Acupuncture</b>	90% after deductible Limit: 20 visits/benefit period	70% after deductible
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy and Dialysis)	90% after deductible	70% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient</b>	90% after deductible	70% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>		
<b>Outpatient</b> (includes ADD and ADHD)	90% after deductible	90% after deductible
<b>Autism</b>	90% after deductible	70% after deductible
<b>Other Services</b>		
<b>Allergy Extracts and Injections</b>	90% after deductible	70% after deductible
<b>Assisted Fertilization</b> –footnote	90% after deductible	70% after deductible
<b>Dental Services Related to Accidental Injury</b>	90% after deductible	70% after deductible
<b>Diagnostic Services</b> <i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
<i>Basic Diagnostic Services</i> (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>Home Health Care</b>	90% after deductible	70% after deductible
<b>Hospice</b>	90% after deductible	70% after deductible
<b>Infertility Counseling, Testing and Treatment</b>	90% after deductible	70% after deductible
<b>Private Duty Nursing</b>	90% after In-Network deductible	
<b>Skilled Nursing Facility Care</b>	90% after deductible	70% after deductible
	Limit: 100 days per benefit period	
<b>Transgender Services</b>	90% after deductible	70% after deductible
<b>Transplant Services</b>	90% after deductible	70% after deductible
<b>Precertification Requirements</b> (3)	Yes	
<b>Prescription Drugs</b>		
<b>Prescription Drug Deductible</b>	Individual Family	None None
<b>Prescription Drug Program</b> (4) Mandatory Generic (Defined by National Plus Pharmacy Network - not the Physician Network) Prescriptions filled at a non-network pharmacy are not covered.  Includes Step Therapy Program  The member is responsible for the cost difference between the generic and the brand medication.		<b>Retail Drugs</b> 31 day supply 30% copayment Minimum Copay: \$10 Maximum Copay: \$120 <b>Specialty Drugs</b> – 20% copayment; \$250 maximum <b>Mail Order</b> 90 day supply 30% copayment Minimum Copay: \$20 Maximum Copay: \$240 <b>Specialty Drugs</b> – 20% copayment; \$500 maximum <b>Women's Preventive Health Services</b> (5) \$0 copayment

## Questions? 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. Contact your employer to determine the effective date applicable to your program.
- (2) Effective with plan years beginning on or after January 1, the In Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, reference based benefits that exceed the referenced amount and any qualified medical expenses. The Total Maximum Out of Pocket cannot be more than \$7,050 for individual and \$14,100 for two or more persons
- (3) BCBS Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. 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) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your provider must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review. Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your provider specifies a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.
- (5) Eligible Women's Preventive Health Services are available at HighmarkBCBS.com, or call the customer service number listed above.

**Assisted Fertilization Services** are available to members who have been covered continuously for 12 months. IUI, ICI and related procedures, including sperm acquisition from a sperm bank, are included from the first year forward.