Summary - PPO – 2019 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.

Unitarian Universalist Association — PPO

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar	
Deductible (per benefit period) Individual Family	$1,000 $2,000	$2,000 $4,000
Plan Pays – payment based on the plan allowance	85%	65%
Total Maximum Out-of-Pocket (includes deductible and coinsurance, and other qualified medical expenses, In Network only)(2) Once met, plan pays 100% for the rest of the benefit period. Individual Family	 $5,000 $10,000	 $5,000 $10,000
Office/Clinic/Urgent Care Visits		
Telemedicine Visit	100% after $10 copayment	65% after deductible
Retail Clinic Visits	100% after $15 copayment	65% after deductible
Primary Care Provider Office Visits	100% after $15 copayment	65% after deductible
Specialist Office Visits	100% after $35 copayment	65% after deductible
Professional Urgent Care Center Visits	100% after $15 copayment	65% after deductible
Facility Urgent Care Center Visits	100% after $20 copayment	65% after deductible
Preventive Care		
Routine Adult		
Physical exams	100% deductible does not apply	Not Covered
Adult immunizations	100% deductible does not apply	65% after deductible
Colorectal cancer screening (includes colonoscopy; sigmoidoscopy; barium enema; blood occult)	100% deductible does not apply	65% after deductible
Routine gynecological exams	100% deductible does not apply	65% 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	65% after deductible
Women's Preventive Health Services (6) (includes Lactation consultation)	100% deductible does not apply	65% after deductible
Diagnostic services and procedures	100% deductible does not apply	65% after deductible Limited to Colorectal Screening Only
Routine Pediatric		
Physical exams	100% deductible does not apply	Not Covered
Pediatric immunizations	100% deductible does not apply	65% deductible does not apply
Diagnostic services and procedures	100% deductible does not apply	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	85% after deductible	65% after deductible
Hospital Outpatient Surgery	85% after deductible	65% after deductible
Hospital Outpatient Diagnostics	100% deductible does not apply	65% after deductible
Maternity (non-preventive facility & professional services)	85% after deductible	65% after deductible
Medical/Surgical (except office visits)	85% after deductible	65% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copayment	
Ambulance	85% after In-Network deductible	
Therapy and Rehabilitation Services		
Physical Medicine	$20 copayment	65% after deductible
	Limit: 30 visits per benefit period	
Occupational Therapy	$20 copayment	65% after deductible
	Limit: 30 visits per benefit period	
Speech Therapy	$20 copayment	65% after deductible
	Limit: 20 visits per benefit period	
Spinal Manipulations/Acupuncture	$20 copayment	65% after deductible

Benefit	Network	Out-of-Network
	Limit: 20 visits per benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy and Dialysis)	85% after deductible	65% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	85% after deductible	65% after deductible
Outpatient	100% after $20 copayment for office visits, all other services 90% after deductible	100% after $20 copayment for office visits, all other services 90% after deductible
Autism	85% after deductible	65% after deductible
Other Services		
Allergy Extracts and injections	85% after deductible	65% after deductible
Assisted Fertilization, limited to IUI and ICI –footnote	100% deductible does not apply	65% after deductible
Comprehensive Routine Eye Exam	100% after $15 copayment	Not Covered
Dental Services Related to Accidental Injury	85% after deductible	65% after deductible
Diagnostic Services *Advanced Imaging* (MRI, CAT, PET scan, etc.)	100% deductible does not apply	65% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% deductible does not apply	65% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	85% after deductible	65% after deductible
Home Health Care/Visiting Nurse	85% after deductible	65% after deductible
Hospice	85% after deductible	65% after deductible
Infertility Counseling, Testing and Treatment(3)	85% after deductible	65% after deductible
Private Duty Nursing	85% after deductible	65% after deductible
Skilled Nursing Facility Care	85% after deductible	65% after deductible
	Limit: 100 days per benefit period	
Transplant Services	85% after deductible	65% after deductible
Hearing Aid	100% Deductible does not apply Limit: $3,000 every 24 months	100% Deductible does not apply Limit: $3,000 every 24 months
Hearing Aid Exam	100% after $20 copayment	100% after $20 copayment
Transgender Services	85% after deductible	65% after deductible
Precertification Requirements(4)	Yes	
Prescription Drug		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program(5) Mandatory Generic *Defined by the Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.*	**Retail Drugs up to 31 day supply** $0 preferred generic copayment $20 non-preferred generic copayment $35 brand formulary copayment $60 brand non-formulary copayment 20% coinsurance, $250 maximum, specialty drugs **Mail Order up to 90-day Supply** $0 preferred generic copayment $40 non-preferred generic copayment $70 brand formulary copayment $120 brand non-formulary copayment 20% coinsurance, $500 maximum, specialty drugs **Women's Preventive Health Services** (6) $0 generic copayment $0 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) 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 $6,850 for individual and $13,700 for two or more persons

(3) 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.

(4) 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.

(5) 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.

(6) Eligible Women's Preventive Health Services are available at HighmarkBCBS.com, or call the customer service number listed above.

Assisted Fertilization Services are limited to IUI, ICI and related procedures, including sperm acquisition from a sperm bank. Contact customer Service for benefit eligibility information.