



## Summary - PPO HDHP w/HSA Benefits – 2020 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

### 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 \$3,000 Family \$6,000	
<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 \$5,000 Family \$10,000	
<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 \$5,000 Family \$10,000	N/A
<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
Adult immunizations	100% deductible does not apply	70% after deductible
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>Physical Medicine</b>	90% after deductible	70% after deductible
	Limit: 20 visits/ benefit period	

Benefit	Network	Out-of-Network
Occupational Therapy	90% after deductible	70% after deductible
	Limit: 20 visits/ benefit period	
Speech Therapy	90% after deductible	70% after deductible
	Limit: 20 visits/ benefit period	
Spinal Manipulations/Acupuncture	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy and Dialysis)	90% after deductible	70% after deductible
<b>Mental Health/Substance Abuse</b>		
Inpatient	90% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation		
Outpatient (includes ADD and ADHD)	90% after deductible	90% after deductible
Autism	90% after deductible	70% after deductible
<b>Other Services</b>		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Assisted Fertilization –footnote	90% after deductible	70% after deductible
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diagnostic Services <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
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment <sup>(3)</sup>	90% after deductible	70% after deductible
Private Duty Nursing	90% after In-Network deductible	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 100 days per benefit period	
Transgender Services	90% after deductible	70% after deductible
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements <sup>(4)</sup>	Yes	
<b>Prescription Drugs</b>		
Prescription Drug Deductible	Individual Family	\$3,000 Integrated with Medical \$6,000 Integrated with Medical
Premier Prescription Drug Program <sup>(5)</sup>  <i>(Defined by Premier Pharmacy Network - Not Physician Network)</i>  <i>Includes Step Therapy Program</i>		<b>Retail Drugs</b> 31 day supply 30% copayment after deductible Minimum Copay: \$10 Maximum Copay: \$120 <b>Specialty Drugs</b> – 20% copayment after deductible; \$250 maximum <b>Mail Order</b> 90 day supply 30% copayment after deductible Minimum Copay: \$20 Maximum Copay: \$240 <b>Specialty Drugs</b> – 20% copayment after deductible; \$500 maximum <b>Women's Preventive Health Services</b> <sup>(6)</sup> \$0 copayment, deductible does not apply

## 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 \$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 available to members who have been covered continuously for 12 months.