Summary of PPO HDHP w/HSA *Benefits – Bronze Level - 2020*

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
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	$5,000 $10,000	
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period; includes copayments, deductibles and prescription drug) Individual Family	 $6,550 $13,100	
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	 $6,550 $13,100	 N/A
Office/Clinic/Urgent Care Visits		
Telemedicine Visits, including mental health consults	80% after deductible	60% after deductible
Retail Clinic Visits	80% after deductible	60% after deductible
Primary Care Provider Office Visits	80% after deductible	60% after deductible
Specialist Office Visits	80% after deductible	60% after deductible
Urgent Care Center Visits	80% after deductible	60% after deductible
Preventive Care		
Routine Adult		
Physical exams, including annual routine eye exam	100% deductible does not apply	Not Covered
Adult immunizations	100% deductible does not apply	60% after deductible
Colorectal cancer screening (includes colonoscopy; sigmoidoscopy; barium enema; blood occult)	100% deductible does not apply	60% after deductible
Routine gynecological exams	100% deductible does not apply	60% deductible does not apply
Routine Pap Test	100% deductible does not apply	60% deductible does not apply
Mammograms, annual routine	100% deductible does not apply	60% after deductible
Women's Preventive Health Services (6) (includes Lactation consultation)	100% deductible does not apply	60% after deductible
Diagnostic services and procedures	100% deductible does not apply	60% after deductible Limited to Colorectal Screening Only
Routine Pediatric		
Physical exams, including annual routine eye exam	100%	Not Covered
Pediatric immunizations	100%	60%deductible does not apply
Diagnostic services and procedures	100%	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services)	80% after deductible	60% after deductible
Medical/Surgical (except office visits)	80% after deductible	60% after deductible
Emergency Services		
Emergency Room Services	80% after deductible	
Ambulance	80% after deductible	
Therapy and Rehabilitation Services		
Physical Medicine	80% after deductible	60% after deductible
	Limit: 20 visits/ benefit period	

Benefit	Network	Out-of-Network
Occupational Therapy	80% after deductible	60% after deductible
	Limit: 20 visits/ benefit period	
Speech Therapy	80% after deductible	60% after deductible
	Limit: 20 visits/ benefit period	
Spinal Manipulations/Acupuncture	80% after deductible	60% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy and Dialysis)	80% after deductible	60% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	80% after deductible	60% after deductible
Outpatient (includes ADD and ADHD)	80% after deductible	80% after deductible
Autism	80% after deductible	60% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Assisted Fertilization –footnote	80% after deductible	60% after deductible
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diagnostic Services *Advanced Imaging* (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60%after deductible
Infertility Counseling, Testing and Treatment(3)	80% after deductible	60% after deductible
Private Duty Nursing	90% after In-Network deductible	
Skilled Nursing Facility Care	80% after deductible	60% after deductible
	Limit: 100 days per benefit period	
Transgender Services	90% after deductible	70% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements(4)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 $4,500 Integrated with Medical $9,000 Integrated with Medical	
Premier Prescription Drug Program(5) *(Defined by Premier Pharmacy Network - Not Physician Network)* *Includes Step Therapy Program*	**Retail Drugs** 31 day supply 30% copayment after deductible Minimum Copay: $10 Maximum Copay: $120 Specialty Drugs – 20% copayment after deductible; $250 maximum **Mail Order** 90 day supply 30% copayment after deductible Minimum Copay: $20 Maximum Copay: $240 Specialty Drugs – 20% copayment after deductible; $500 maximum **Women's Preventive Health Services** (6) $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.