Summary of PPO HDHP without 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 **Not Available In MA** **HDHP**

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $3,000 $6,000	
Plan Pays – payment based on the plan allowance	90% after deductible	70% 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	 $5,000 $10,000	
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	 N/A
Office/Clinic/Urgent Care Visits		
Telemedicine Visits, including mental health consults	90% after deductible	70% after deductible
Retail Clinic Visits	90% after deductible	70% after deductible
Primary Care Provider Office Visits	90% after deductible	70% after deductible
Specialist Office Visits	90% after deductible	70% after deductible
Urgent Care Center Visits	90% after deductible	70% 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	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 (6) (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
Routine Pediatric		
Physical exams	100%	Not Covered
Pediatric immunizations	100%	70% deductible does not apply
Diagnostic services and procedures	100%	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional services)	90% after deductible	70% after deductible
Medical/Surgical (except office visits)	90% after deductible	70% after deductible
Emergency Services		
Emergency Room Services	90% after deductible	
Ambulance	90% after deductible	
Therapy and Rehabilitation Services		

Benefit	Network	Out-of-Network
Physical Medicine	90% after deductible	70% after deductible
	Limit: 20 visits/ benefit period	
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
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	90% after deductible	70% after deductible
Outpatient (includes ADD and ADHD)	90% after deductible	90% after deductible
Autism	90% after deductible	70% after deductible
Other Services		
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 *Advanced Imaging* (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% 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(3)	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(4)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 None None	
Premier Prescription Drug Program(5) *(Defined by Premier Pharmacy Network - Not Physician Network)* *Includes Step Therapy Program*	**Retail Drugs** 31 day supply 30% copayment Minimum Copay: $10 Maximum Copay: $120 Specialty Drugs – 20% copayment; $250 maximum **Mail Order** 90 day supply 30% copayment Minimum Copay: $20 Maximum Copay: $240 Specialty Drugs – 20% copayment; $500 maximum **Women's Preventive Health Services** (6) $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 $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