Unitarian Universalist Association Health Plan

Summary of PPO Benefits

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Benefit	Network	Out-of-Network
Benefit Period[1]	Calendar Year	
Deductible (per benefit period) Individual Family	 $500 $1,000	 $1,000 $2,000
Plan Payment Level – Based on the provider's reasonable charge (PRC)	90% after deductible	70% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%) Individual Family	 $2,000 $4,000	 $4,000 $8,000
Lifetime Maximum (per person)	Unlimited	$1,000,000
Primary Care Physician Office Visits	100% after $20 copayment	70% after deductible
Specialist Office Visits	100% after $35 copayment	70% after deductible
Preventive Care ***Adult*** Routine physical exams, includes preventive diagnostic	 100% after $20 copayment	 Not Covered
Adult Immunizations	90% after deductible	70% after deductible
Routine gynecological exams, including a PAP Test	100% after $20 copayment	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	70% after deductible
Pediatric Routine physical exams	 100% after $20 copayment	 Not Covered
Pediatric immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Emergency Room Services	100% after $50 copayment (waived if admitted)	
Spinal Manipulations	100% after $35 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after $35 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Speech Therapy	100% after $35 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Occupational Therapy	100% after $35 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Allergy Extracts and Injections	90% after deductible	70% after deductible
Ambulance	90% after network deductible	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diabetes Treatment	90% after deductible	70% after deductible
Diagnostic Services (including routine) ***Advanced Imaging*** (MRI, CAT Scan, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible

Benefit	Network	Out-of-Network
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Enteral Formulae	90% (deductible does not apply)	70% (deductible does not apply)
Home Infusion Therapy	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Hospital Services – Inpatient(3)	90% after deductible	70% after deductible
Hospital Services – Outpatient	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment(2)	90% after deductible	70% after deductible
Maternity (facility & professional services)	90% after deductible	70% after deductible
Medical/Surgical Expenses (Except Office Visits)	90% after deductible	70% after deductible
Mental Health – Inpatient(3)	90% after deductible	70% after deductible
	Limit: 30 days/benefit period	
Mental Health – Outpatient	100% after $35 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Private Duty Nursing	90% after deductible	70% after deductible
Respiratory Therapy	90% after deductible	70% after deductible
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Combined limit: 100 days/benefit period	
Substance Abuse – Inpatient Detoxification(3)	90% after deductible	70% after deductible
	Limit: 7 days/admission; 4 admissions/lifetime	
Substance Abuse – Inpatient Rehabilitation(3)	90% after deductible	70% after deductible
	Limit: 30 days/benefit period; 90 days/lifetime	
Substance Abuse – Outpatient	100% after $35 copayment	70% after deductible
	Limit: 60 visits/benefit period; 120 visits/lifetime	
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements	Performed by Member(3)	
Premier Prescription Drug Program	***Defined by Premier Gold NationalPharmacy Network - Not Physician Network.*** ***(Prescriptions filled at a non-network pharmacy are not covered.)*** **Retail Drugs** $15 generic copayment $25 brand copayment $40 non-formulary brand copayment **Mandatory Generic(4)** **31-day Supply** **Maintenance Drugs through Mail Order** $30 generic copayment $50 brand copayment $80 non-formulary brand copayment **Mandatory Generic(4)** **90-day Supply**	

Questions? Call 1-800-215-7865

Reference Code: P0120306

(Please have your Reference Code ready when you call)

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) 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.

(3) Member is required to contact Highmark Health Care Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

(4) The formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.