HIGHMARK. | PPO Blue

2022 Pension Boards United Church of Christ, Inc.

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). 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.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	1/1/2022	
Benefit Period(1)	Contract Year Begins January 1 and Ends December 31	
Deductible (per benefit period. (Includes prescription drug expenses). Individual Family	 $3,000 $6,000	 $9,000 $18,000
Plan Pays – payment based on the plan allowance	60% after deductible	50% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period). Individual Family	 $6,900 $13,800	 $20,000 $40,000
Total Maximum Out-of-Pocket (Includes prescription drug expenses, deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period). Network only: Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,900 $13,800	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	60% after deductible	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	60% after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	60% after deductible	50% after deductible
Urgent Care Center Visits	60% after deductible	50% after deductible
Telemedicine Services-Teladoc (3)	100% after deductible and $10 copayment	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 not covered
Adult Immunizations	100% (deductible does not apply)	not covered
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	not covered
Mammograms, Annual Routine	100% (deductible does not apply)	not covered
Mammograms, Medically Necessary	60% after deductible	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	not covered
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 not covered
Pediatric Immunizations	100% (deductible does not apply)	not covered
Diagnostic Services and Procedures	100% (deductible does not apply)	not covered
Emergency Services		
Emergency Room Services	60% after deductible	60% after in-network deductible
Ambulance - Emergency and Non-Emergency	60% after deductible	50% after deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	60% after deductible	50% after deductible
Hospital Outpatient	60% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	60% after deductible	50% after deductible
Therapy and Rehabilitation Services		

Benefit	In Network	Out of Network
Physical Medicine	60% after deductible	50% after deductible
	limit: 20 visits/benefit period including rehabilitative services and habilitative services	
Respiratory Therapy	60% after deductible	50% after deductible
Speech Therapy	60% after deductible	50% after deductible
	limit: 20 visits/benefit period including rehabilitative services and habilitative services	
Occupational Therapy	60% after deductible	50% after deductible
	limit: 20 visits/benefit period including rehabilitative services and habilitative services	
Spinal Manipulations	60% after deductible	50% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	60% after deductible	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	60% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	60% after deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	60% after deductible	50% after deductible
Outpatient Substance Abuse Services	60% after deductible	50% after deductible
Other Services		
Allergy Extracts and Injections	60% after deductible	50% after deductible
Assisted Fertilization Procedures	60% after deductible	50% after deductible
	Lifetime maximum benefit: $20,000 (combined procedures and prescriptions) Limitations apply: Limited to 3 IVF cycles when medically necessary up to age 40.	
Dental Services Related to Accidental Injury	60% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	60% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	60% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	60% after deductible	50% after deductible
Home Health Care	60% after deductible	50% after deductible
Hospice	60% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (5)	60% after deductible	50% after deductible
	limit: $5,000/lifetime	
Private Duty Nursing	60% after deductible	50% after deductible
	limit: $10,000/benefit period	
Skilled Nursing Facility Care	60% after deductible	50% after deductible
Transplant Services	60% after deductible	50% after deductible
Precertification Requirements (6)	Yes	Yes

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(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) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Treatment includes coverage for the correction of a physical or medical problem associated with infertility.
(6) Highmark 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 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.