Plan M- Wider Church Ministries

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	Coverage
General Provisions	
Effective Date	1/1/2022
Benefit Period(1)	Calendar Year
Deductible (per benefit period) Individual Family	 $200 $400
Plan Pays – payment based on the plan allowance	85% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $2,000 $4,000
Office/Clinic/Urgent Care Visits	
Retail Clinic Visits & Virtual Visits	100% after $25 copay
Primary Care Provider Office Visits	100% after $25 copay
Virtual Visits (with your PCP)	100% after $25 copay
Specialist Office Visits	100% after $25 copay
Virtual Visits (with your Specialist)	100% after $25 copay
Urgent Care Center Visits	100% after $25 copay
Telemedicine Services- Teladoc (3)	100% after $10 copay
Preventive Care (4)	
Routine Adult Physical Exams	 100% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)
Routine Pediatric Physical Exams	 100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)
Emergency Services	
Emergency Room Services	85% after deductible
Ambulance - Emergency and Non-Emergency	85% after deductible
Hospital and Medical / Surgical Expenses (including maternity)	
Hospital Inpatient	85% after deductible limit: unlimited
Hospital Outpatient	85% after deductible
Maternity (non-preventive facility & professional services)	100% after deductible
Maternity for Dependent Daughters	100% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	85% after deductible
Therapy and Rehabilitation Services	
Physical Medicine	85% after deductible
Respiratory Therapy	85% after deductible
Speech Therapy	85% after deductible
Occupational Therapy	85% after deductible
Spinal Manipulations	85% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	85% after deductible
Mental Health / Substance Abuse	
Inpatient Mental Health Services	85% after deductible

Benefit	Coverage
Inpatient Detoxification / Rehabilitation	85% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $25 copay
Outpatient Substance Abuse Services	100% after $25 copay
Other Services	
Allergy Extracts and Injections	85% after deductible
Assisted Fertilization Procedures	85% 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	not covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	85% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	85% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	85% after deductible
Home Health Care	85% after deductible
Hospice	85% after deductible
Infertility Counseling, Testing and Treatment (5)	85% after deductible
Private Duty Nursing	85% after deductible
Skilled Nursing Facility Care	85% after deductible limit: unlimited
Transplant Services	85% after deductible
Precertification Requirements (6)	No

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 Calendar Year which runs from January 1 to December 31.

(2) Not Applicable

(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.