Virginia Conference United Methodist Church

Lay Employee Benefit Comparison
Effective January 1, 2016

	HMO-POS Plan **Option 1**	**PPO Plan** **Option 2**
	IN Network YOU PAY	**IN Network YOU PAY**
Annual Deductible – Individual/Family	$500/$1000 per calendar year	$1000/$2500 per calendar year
OUTPATIENT CARE		
Doctor's Office and Urgent Care Visits	$20 per visit copayment to your Primary Care Physician (PCP) $40 per visit copayment to a Specialist (deductible does not apply)	$20 per visit copayment to a Primary Care Physician (PCP) $30 per visit copayment to a Specialist (deductible does not apply)
Diagnostic lab and x-ray tests, allergy shots, therapeutic injections	$35 copayment 20% coinsurance for high cost radiology injectable medications - 20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Routine Wellness Care	$0 copayment to your PCP $0 copayment to a specialist no deductible	$0 copayment to a Primary Care Physician $0 copayment to a Specialist (no coinsurance, no deductible)
Mammography Screenings	$0 copayment no deductible	$0 copayment (no coinsurance, no deductible)
Well Woman Gynecological Visit (one per year)	$0 copayment to PCP or specialist no deductible	$0 copayment (no coinsurance, no deductible)
Well Child Coverage to the date the child reaches age 7	$0 copayment to your PCP (no age limit) no deductible	$0 copayment, no coinsurance for screenings, diagnostic tests, or for immunizations (no deductible) $0 copayment to a Specialist
Maternity Care	$150 one-time per pregnancy copayment for OB/GYN (no deductible applies) $35 per visit copayment for diagnostic testing (no deductible applies)	20% coinsurance (deductible applies) copayment applies to office visits
Specialist Office Visit	$40 per visit copayment with a PCP referral no deductible	$30 per visit copayment (no deductible)
Accidental Injury Care	$20 per visit copayment to your PCP (no deductible) $40 per visit copayment to specialist with PCP referral (no deductible)	$20 per visit copayment in a Primary Care Physicians office, $30 per visit copayment in a Specialist office, 20% coinsurance lab and diagnostic tests (deductible applies)
Vision Exams – one every contract year	$15 per visit copayment (no deductible)	Not Covered
Outpatient Hospital Care	$150 Facility copayment for outpatient surgery (deductible applies to physician charges)	20% coinsurance (deductible applies)

Virginia Conference United Methodist Church

	HMO-POS Plan Option 1	PPO Plan Option 2
	IN Network YOU PAY	**IN Network YOU PAY**
Outpatient Mental Health and Substance Abuse Care	$20 copayment medication management, individual therapy session up to 30 minutes, group therapy $30 All other outpatient mental health and substance abuse visits	$ 0 per visit copayment to a Primary Care Physician (PCP) $ 0 per visit copayment to a Specialist (deductible does not apply)
Spinal Manipulations	$25 copay 30 visit maximum per year, referral (no deductible applies)	20% coinsurance (deductible applies) 30 visit maximum per year
Home Health Care	20% coinsurance (deductible applies) 100 visit limit per calendar year	20% coinsurance (deductible applies) 100 visit limit per calendar year
Outpatient Speech Therapy	$25 per visit copayment (limited to 30 visits per calendar year) (no deductible applies)	20% coinsurance (deductible applies)
INPATIENT CARE		
	Pre-admission Certification Required	Advance Hospital Admission Review Required
Inpatient Hospital Care for illness, injury or maternity. Semi-private room, ancillaries, intensive care unit or similar unit	$200 per day copayment, $1,000 per admission maximum, requires pre-admission certification by the HMO-POS to be covered (no deductible applies)	20% coinsurance (deductible applies) $500 additional copayment if Hospital Admission Review is not obtained for out-of-network services only
In-Hospital Physician's Services	covered, no copayment (deductible applies)	20% coinsurance (deductible applies)
Inpatient Mental Health and Substance Abuse Care	$200 per day copayment, $1,000 per admission maximum, requires pre-admission certification by the HMO-POS to be covered (no deductible applies)	20% coinsurance (deductible applies) $500 additional copayment if Hospital Admission Review is not obtained for out-of-network services only
Skilled Nursing Facility Care (limited to 100 days per confinement or admission)	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
OTHER COVERED SERVICES		
Durable medical equipment and supplies	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Ambulance Services	covered, $150 copayment, no dollar limit (no deductible applies)	20% coinsurance (deductible applies)
Private Duty Nursing Visits	20% coinsurance (covered through home health care benefits only) deductible applies	20% coinsurance (deductible applies, $500 limit per calendar year)
Outpatient Physical and Occupational Therapy	$25 per visit copayment, therapy benefits are combined for up to 30 visits per calendar year (no deductible applies)	20% coinsurance (deductible applies)
Hospice Services for members diagnosed with a terminal illness with a life expectancy of 6 months or less	covered, no copayment	covered, no copayment

Virginia Conference
United Methodist Church

	HMO-POS Plan Option 1	PPO Plan Option 2
	IN Network YOU PAY	**IN Network YOU PAY**
Early Intervention Services – no limit when certified: physical therapy, occupational therapy, speech and language therapy, assistive technology devices and services	copayment determined by services received	Not Covered
Annual Out-of-Pocket Expense Limit: This limit is reached through your deductibles, coinsurance and copayments for covered services. Exceptions are noted below this chart. After the out-of-pocket expense limit has been reached, benefits will be provided at 100% of the allowable charge for covered services for the remainder of the calendar year.	$4500/Individual* $9000/Family*	$4500/Individual** $9000/Family**
Lifetime Maximum – for each covered person as long as coverage is in effect	No limit	No limit

***Does not include copayments for prescriptions, any vision benefits. ** Does not include copayments for prescriptions.**
This is only a summary of benefits, for more details refer to the plan document.

OUTPATIENT PRESCRIPTION DRUGS *		
Retail Prescription Drugs (up to a 30-day supply per prescription or refill)	$15 copayment for each prescription (Tier 1) $30 copayment for each prescription (Tier 2) $50 copayment for each prescription (Tier 3)	$15 copayment for each prescription (Tier 1) $30 copayment for each prescription (Tier 2) $50 copayment for each prescription (Tier 3)
Mail Order Program (up to a 90-day supply per prescription or refill)	$30 copayment for each prescription (Tier 1) $60 copayment for each prescription (Tier 2) $100 copayment for each prescription (Tier 3)	$30 copayment for each prescription (Tier 1) $60 copayment for each prescription (Tier 2) $100 copayment for each prescription (Tier 3)

*Notes:

1) In 2016, the total annual out-of-pocket ("OOP") expense associated with outpatient prescription drugs is limited to $2,000 for those enrolled in individual coverage and $4,000 for those enrolled in family coverage.

2) Diabetic supplies including syringes, lancets, test strips and one glucometer each 12-month period are available through the prescription drug program.

Virginia Conference United Methodist Church

	DENTAL Core Option 1	DENTAL High Option 2
YOUR DENTAL BENEFITS		
Annual Dental Benefits Maximum for each enrolled family member	$750	$1000
Diagnostic and Preventive Care, such as: Two exams annually. Oral exam, normal exam x-rays (full x-ray of the mouth is covered once every 36 months), cleaning the teeth (prophylaxis), palliative tooth pain care, biopsies, space maintainers, and fluoride treatments under age 19	No Deductible, no coinsurance	No Deductible, no coinsurance
Primary Dental Care, such as: Fillings, amalgam or tooth colored materials, extracting teeth, root canal treatment (endodontics), denture repairs, oral surgery and anesthesia (except when given by the dentists performing the surgery), care of the gums (periodontics), recementing crowns, inlays and bridges	20% coinsurance after $50 annual deductible	20% coinsurance after $50 annual deductible
Prosthetic and Complex Restorative Services, such as: Inlays, onlays, crowns, dentures, bridges, relining dentures to improve fit	Not covered	50% coinsurance after $50 annual deductible
Orthodontic Services, such as: Installation of orthodontic appliances, treatment to correct malocclusions and side effects, diagnostic services. There is a separate lifetime benefit limit for orthodontic care of $1000 per person	Not covered	50% coinsurance after $50 annual deductible