Virginia Conference United Methodist Church

Clergy Benefit Comparison
Effective January 1, 2017

	HMO-POS Plan Option 1	PPO Plan Option 2	CMCP Plan Option 3
	IN Network YOU PAY	**IN Network YOU PAY**	**In or Out of Network YOU PAY**
Personal Care Account (Provided by VUMPI)	There is no Personal Care Account	There is no Personal Care Account	$750 Individual, $2,250 Family CMCP participants will receive $ credits
Annual Deductible – Individual/Family	$500/$1000 per calendar year	$1000/$2500 per calendar year	$1750 Individual, $4250 Family Note: Deductible does not need to be satisfied until **AFTER** Personal Care Account is exhausted
WELLNESS BENEFITS	**NO DEDUCTIBLE APPLIES**	**NO DEDUCTIBLE APPLIES**	**NO DEDUCTIBLE APPLIES**
Routine Wellness Care	$0 per visit copayment to your PCP $0 per visit copayment to a specialist	$0 per visit copayment to a Primary Care Physician, $0 copayment to a Specialist, no coinsurance, no deductible.	$0 – Plan pays 100%* * Anthem Allowable Charge
PSA, PAP test	No copayment	No coinsurance or deductible	$0 – Plan pays 100%*
Smoking Cessation products, Bone Density Test	Bone Density Test - No copayment Smoking Cessation Products not covered	Bone Density Test - No copayment Smoking Cessation Products not covered	$0 – Plan pays 100%*
Mammography Screenings	$0 per visit copayment	$ 0 per visit copayment (no coinsurance, no deductible)	$0 – Plan pays 100%*
Well Woman Gynecological Visit one every contract year	$0 per visit copayment to PCP or specialist	$0 per visit copayment (no coinsurance, no deductible)	$0 – Plan pays 100%*
Well Child Coverage to the date the child reaches age 7	$0 per visit copayment to your PCP (no age limit)	$0 per visit copayment, no coinsurance for screenings, diagnostic tests, or for immunizations (no deductible) $0 per visit copayment to a Specialist.	$0 – Plan pays 100%*
Vision Exams one every contract year	$15 per visit copayment Discount on frames, lenses, contacts Blue View Network	Not Covered	$15 per visit copayment *Anthem Allowable Charge applies to any Eligible Charges Blue View Network must be used

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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 **no referral needed** (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)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Diagnostic lab and x-ray tests, allergy shots, therapeutic injections	$35 copayment 20% coinsurance for high cost radiology (MRI, CAT Scat, PET Scan, MRA) (deductible applies) Injectable medications – 20% coinsurance (does not apply to allergy shots or serum dispensed in physician's office) (deductible applies)	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
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 for office visits	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Accidental Injury Care	$20 per visit copayment to your PCP $40 per visit copayment to specialist **no referral needed** Deductible does not apply	$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	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Outpatient Hospital Care	$200 Emergency Room per visit copayment (waived if admitted) $150 Facility copayment for outpatient surgery (deductible applies to physician charges)	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Outpatient Mental Health and Substance Abuse Care	$20 per visit copayment No charge partial day program	$ 0 per visit copayment to a Primary Care Physician (PCP) $ 0 per visit copayment to a Specialist. (deductible does not apply)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible

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Spinal Manipulations	$25 copay Covered for 30 visits per year (no deductible applies)	20% coinsurance (deductible applies) 30 visits per calendar year.	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible (60 visits per calendar year)
Home Health Care	20% coinsurance (deductible applies) 100 visit limit per calendar year	20% coinsurance (deductible applies) 100 visit limit per calendar year	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible 3. 100 visit limit per calendar year
Outpatient Speech Therapy	$25 per visit copayment (limited to 30 visits per year) (no deductible applies)	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
INPATIENT CARE			
	Pre-admission Certification Required	Advance Hospital Admission Review 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	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
In-Hospital Physician's Services	Covered, no copayment (deductible applies)	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
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	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Skilled Nursing Facility Care (limited to 100 days per confinement or admission)	20% coinsurance (deductible applies) 100 day per stay limit	20% coinsurance (deductible applies) 100 day per stay limit	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible 3. 100 visit limit per calendar year

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OTHER COVERED SERVICES			
Durable medical equipment and supplies	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Ambulance Services	Covered, $150 copayment, no dollar limit (no deductible applies)	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Private Duty Nursing Visits	20% coinsurance (deductible applies) (covered through home health care benefits only)	20% coinsurance (deductible applies, $500 limit per calendar year)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible 3. $500 calendar year limit
Outpatient Physical and Occupational Therapy	$25 per visit copayment (limited to combined 30 visits per year) (no deductible applies)	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Hospice Services for members diagnosed with a terminal illness with a life expectancy of 6 months or less	Covered, no copayment	Covered, no copayment	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Annual Out-of-Pocket Expense 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**	$3000/Individual $6000/Family
Lifetime Maximum – for each covered person as long as coverage is in effect	No limit	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.

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	YOU PAY	**IN Network YOU PAY**	**In or Out of Network YOU PAY**
OUTPATIENT PRESCRIPTION DRUGS *	HMO-POS	PPO	CHP
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)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
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)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible

*Notes:

1) In 2017, 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 under the HMO-POS or PPO plan. Total OOP costs for outpatient prescription drugs for those enrolled in the CMCP are limited by that plan's combined OOP limit of $3,000 for those enrolled as individuals and $6,000 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.

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	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