Virginia Conference United Methodist Church

Clergy LOA Benefit Comparison
Effective January 1, 2019

	PPO Core Plan	PPO Buy-Up Plan
	IN Network YOU PAY	**IN Network YOU PAY**
Annual Deductible – Individual/Family	$1,000/$2,500 per calendar year	$750/$1,875 per calendar year
OUTPATIENT CARE		
Routine Wellness Care	$0 copayment to PCP or Specialist (no coinsurance, no deductible)	$0 copayment to PCP or Specialist (no coinsurance, no deductible)
Wellness Mammography Screenings (one per year)	$0 copayment (no coinsurance, no deductible)	$0 copayment (no coinsurance, no deductible)
Well Woman Gynecological Visit (one per year)	$0 copayment to PCP or Specialist (no coinsurance, no deductible)	$0 copayment to PCP or Specialist (no coinsurance, no deductible)
Well Child Coverage to the date the child reaches age 7	$0 copayment, no coinsurance for screenings, diagnostic tests, or for immunizations (no deductible) $0 copayment to a Specialist	$0 copayment, no coinsurance for screenings, diagnostic tests, or for immunizations (no deductible) $0 copayment to a Specialist
Maternity Care	20% coinsurance (deductible applies) copayment applies to initial office visit	20% coinsurance (deductible applies) copayment applies to initial office visit
Doctor's Office	$30 per visit copayment to a Primary Care Physician (PCP) (no deductible) $20 per visit copayment for online medical visit (www.livehealthonline.com)	$20 per visit copayment to a Primary Care Physician (PCP) (no deductible) $10 per visit copayment for online medical visit (www.livehealthonline.com)
Specialist Office Visit	$50 per visit copayment (no deductible)	$30 per visit copayment (no deductible)
Emergency Room Visit	20% coinsurance (deductible applies)	$150 copay (no deductible)
Urgent Care	$50 per visit copayment (no deductible)	$30 per visit copayment (no deductible)
Diagnostic lab and x-ray tests, allergy shots, therapeutic injections	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Vision	Not covered	Not covered
Outpatient Hospital Care	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Mental Health and Substance Abuse Care – Doctor Visits, Online Visits (www.livehealthonline.com), Outpatient Facilities	$0 copay; 0% coinsurance	$0 copay; 0% coinsurance
Spinal Manipulations 30 visit maximum per year	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Home Health Care 100 visit limit per calendar year	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Outpatient Speech Therapy	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)

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	PPO Core Plan	PPO Buy-Up Plan
	IN Network YOU PAY	**IN Network YOU PAY**
INPATIENT CARE		
	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	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
In-Hospital Physician's Services	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Inpatient Mental Health and Substance Abuse Care	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
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	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Private Duty Nursing Visits $500 limit per calendar year	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Outpatient Physical and Occupational Therapy	20% coinsurance (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
Early Intervention Services – no limit when certified: physical therapy, occupational therapy, speech and language therapy, assistive technology devices and services	Not Covered	Not Covered
Annual Out-of-Pocket Expense Limit: This limit is reached through your deductibles, coinsurance and copayments for covered services. 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.	$6,500/Individual $13,000/Family	$4,500/Individual $9,000/Family
Lifetime Maximum – for each covered person as long as coverage is in effect	No limit	No limit

This is only a summary of benefits, for more details refer to the plan document.

	PPO Core Plan	PPO Buy-Up Plan
	IN Network YOU PAY	**IN Network YOU PAY**
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 2019, the total annual out-of-pocket expense associated with outpatient prescription drugs is combined with the medical out-of-pocket expenses.

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

Vision Plan Anthem EyeMed Network	
Routine Eye Exams	$10 copay
Standard plastic lenses (single, bifocal, trifocal)	$10 copay
Progressive lenses	$50 copay
Allowance towards frames or elective contact lenses	$150
Medically necessary contact lenses	$0 copay
Coverage of exam, lenses and frames	Offered once per calendar year

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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