Virginia Conference United Methodist Church

Virginia United Methodist Conference Benefit Comparison
Disabled and Surviving Spouses of Active Pastors, under age 65
Effective January 1, 2019

		PPO 500 Plan
		IN Network YOU PAY
Annual Deductible – Individual/Family		$500/$1000 per calendar year
OUTPATIENT CARE		
Doctor's Office and Urgent Care Visits		$15 per visit copayment to a Primary Care Physician (PCP) $15 per visit copayment to a Specialist (deductible does not apply)
Diagnostic lab and x-ray tests, allergy shots, therapeutic injections		20% coinsurance (deductible applies)
Routine Wellness Care		$0 per visit copayment to a Primary Care Physician, $0 copayment to a Specialist (no coinsurance, no deductible)
Wellness Mammography Screenings		$0 per visit copayment (no coinsurance, no deductible)
Well Woman Gynecological Visit (one per year)		$0 per visit copayment (no coinsurance, no deductible)
Well Child Coverage to the date the child reaches age 7		$0 per visit copayment, no coinsurance for screenings, diagnostic tests, or for immunizations (no deductible) $0 per visit copayment to a Specialist
Maternity Care		20% coinsurance (deductible applies), copay applies
Specialist Office Visit		$15 per visit copayment
Accidental Injury Care		$15 per visit copayment in a Primary Care Physician office, $15 per visit copayment in a Specialist office, 20% coinsurance lab and diagnostic tests (deductible applies)
Vision Exams – one every contract year		Not Covered
Outpatient Hospital Care		20% coinsurance (deductible applies)
Outpatient Mental Health and Substance Abuse Care		$0 copayment per visit (deductible does not apply)
Spinal Manipulations		20% coinsurance (deductible applies), 30 visit limit per year maximum
Home Health Care		20% coinsurance (deductible applies), 100 visit limit per calendar year
Outpatient Speech Therapy		20% coinsurance (deductible applies)
INPATIENT CARE		
		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) $500 additional copayment if Hospital Admission Review is not obtained for out-of-network services only
In-Hospital Physician's Services		20% coinsurance (deductible applies)
Inpatient Mental Health and Substance Abuse Care		20% coinsurance (deductible applies) $500 additional copayment if Hospital Admission Review is not obtained for out-of-network services only

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		PPO 500 Plan
		IN Network YOU PAY
Skilled Nursing Facility Care (limited to 100 days per illness or condition)		20% coinsurance (deductible applies), 100 visit limit per calendar year
OTHER COVERED SERVICES		
Durable medical equipment and supplies		20% coinsurance (deductible applies)
Ambulance Services		20% coinsurance (deductible applies)
Private Duty Nursing Visits		20% coinsurance (deductible applies), $500 limit per calendar year)
Outpatient Physical and Occupational Therapy		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 (deductible applies)
Early Intervention Services – no limit when certified: physical therapy, occupational therapy, speech and language therapy, assistive technology devices and services		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.		$2000/Individual** $4000/Family**
Lifetime Maximum – for each covered person as long as coverage is in effect		No limit

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

OUTPATIENT PRESCRIPTION DRUGS *		
PPO 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)
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)

*Notes:

1) In 2019, the total annual out-of-pocket expense associated with outpatient prescription drugs is limited to $3,000 for those enrolled in individual coverage 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

Vision Plan

Anthem EyeMed Network

The plan includes the following in-network coverage features:

- Routine eye exams: $10 copay
- Standard plastic lenses (single, bifocal, trifocal): $10 copay
- Progressive lenses: $50 copay
- $150 allowance towards frames or elective contact lenses
- Medically necessary contact lenses: $0 copay
- Coverage of exam, lenses and frames offered once per calendar year