Lay Benefit Comparison
Effective January 1, 2019

	PPO Core	PPO Buy-Up	HSA
	IN Network YOU PAY	**IN Network YOU PAY**	**In or Out of Network YOU PAY**
Fund (Contributed by VUMPI)	There is no Fund	There is no Fund	$750 Individual, $1,500 Family HSA participants will receive ½ annual amount each January and July into separate PNC bank account Option of additional HSA personal contri-bution of up to $229 individual/$458 family
Annual Deductible – Individual/Family	$1,000/$2,500 per calendar year	$750/$1,875 per calendar year	$2,250 Individual, $4,500 Family
WELLNESS BENEFITS	**NO DEDUCTIBLE APPLIES**	**NO DEDUCTIBLE APPLIES**	**NO DEDUCTIBLE APPLIES**
Routine Wellness Care	$0 per visit copayment to a Primary Care Physician, $0 copayment to a Specialist, no coinsurance, no deductible.	$0 per visit copayment to a Primary Care Physician, $0 copayment to a Specialist, no coinsurance, no deductible.	$0 per visit copayment to a Primary Care Physician, $0 copayment to a Specialist, no coinsurance, no deductible.
PSA, PAP test	No coinsurance or deductible	No coinsurance or deductible	No coinsurance or deductible
Mammography Screenings	$0 per visit copayment (no coinsurance, no deductible)	$0 per visit copayment (no coinsurance, no deductible)	$0 per visit copayment (no coinsurance, no deductible)
Well Woman Gynecological Visit one every contract year	$0 per visit copayment (no coinsurance, no deductible)	$0 per visit copayment (no coinsurance, no deductible)	$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.	$0 per visit copayment, no coinsurance for screenings, diagnostic tests, or for immunizations (no deductible) $0 per visit copayment to a Specialist.	$0 per visit copayment, no coinsurance for screenings, diagnostic tests, or for immunizations (no deductible) $0 per visit copayment to a Specialist.
Vision Exams	Not covered	Not covered	Not covered
OUTPATIENT CARE			
Doctor's Office Visits	$30 per visit copayment to a Primary Care Physician (PCP) $20 per visit copayment for online medical visit (www.livehealthonline.com) $50 per visit copayment to a Specialist. (deductible does not apply)	$20 per visit copayment to a Primary Care Physician (PCP) $10 per visit copayment for online medical visit (www.livehealthonline.com) $30 per visit copayment to a Specialist. (deductible does not apply)	20% coinsurance (deductible applies) $49 per vision copayment for online medical visit (www.livehealthonline.com)

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Diagnostic lab and x-ray tests, allergy shots, therapeutic injections	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Urgent Care	$50 copay (no deductible)	$30 copay (no deductible)	20% coinsurance (deductible applies)
Outpatient Hospital Care	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Emergency Room	20% coinsurance (deductible applies)	$150 copay (no deductible)	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	20% coinsurance (deductible applies)
Maternity Care	20% coinsurance (deductible applies) Copayment applies for initial office visit	20% coinsurance (deductible applies) Copayment applies for initial office visit	20% coinsurance (deductible applies)
Spinal Manipulations 30 visits per calendar year	20% coinsurance (deductible applies)	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)	20% coinsurance (deductible applies)
Outpatient Speech Therapy	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
INPATIENT CARE			
	Advance Hospital Admission Review 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	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
In-Hospital Physician's Services	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Inpatient Mental Health and Substance Abuse Care	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Skilled Nursing Facility Care 100 days per admission limit	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)

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OTHER COVERED SERVICES			
Durable medical equipment and supplies	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)	20% coinsurance (deductible applies)
Ambulance Services	20% coinsurance (deductible applies)	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)	20% coinsurance (deductible applies)
Outpatient Physical and Occupational Therapy	20% coinsurance (deductible applies)	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	Covered, no copayment
Annual Out-of-Pocket Expense 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	$5,500/Individual $11,000/Family
Lifetime Maximum – for each covered person as long as coverage is in effect	No limit	No limit	No limit
This is only a summary of benefits, for more details refer to the plan document.			

	PPO Core	PPO Buy Up	HSA
	YOU PAY	**IN Network YOU PAY**	**In or Out of 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)	20% coinsurance (deductible applies)
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)	20% coinsurance (deductible applies)

***Notes:**

1) In 2019, the total annual out-of-pocket expense associated with outpatient prescription drugs is combined with the medical out-of-pocket expense.

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

	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