Clergy Benefit Comparison
Effective January 1, 2010

	HMO Plan Option 1	PPO Plan Option 2	CMCP Plan Option 3
	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	No deductible	$500/$1500 per calendar year	$750 Individual, $1,500 Note: Deductible does not need to be satisfied until **AFTER** Personal Care Account is exhausted
WELLNESS BENEFITS			
Routine Wellness Care	$15 per visit copayment to your PCP $35 per visit copayment to a specialist	$15 per visit copayment to a Primary Care Physician, $25 copayment to a Specialist, no coinsurance, no deductible.	$0 – Plan pays 100%* * Anthem Allowable Charge
PSA, PAP test	No copayment after the per visit copayment to PCP or referred specialist	No coinsurance or deductible after per visit copayment.	$0 – Plan pays 100%*
Smoking Cessation products, Foot Support Items, Bone Density Test	Bone Density Test- No copayment after the per visit copayment to PCP or referred specialist, Smoking Cessation Products and Foot Support Items not covered	Bone Density Test- No copayment after the per visit copayment to PCP or referred specialist, Smoking Cessation Products and Foot Support Items not covered	$0 – Plan pays 100%*
Mammography Screenings	$35 per visit copayment	$ 0 per visit copayment (no coinsurance, no deductible)	$0 – Plan pays 100%*
Well Woman Gynecological Visit one every contract year	$15 per visit copayment to PCP or specialist	$25 per visit copayment (no coinsurance, no deductible)	$0 – Plan pays 100%*
Well Child Coverage to the date the child reaches age 7	$15 per visit copayment to your PCP (no age limit)	$15 per visit copayment, no coinsurance for screenings, diagnostic tests, or for immunizations (no deductible) $25 per visit copayment to a Specialist.	$0 – Plan pays 100%*
Vision Exams	$15 per visit copayment	Not Covered	$0 – Plan pays 100%*

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one every contract year	Discount on frames, lenses, contacts Blue View Network		*Anthem Allowable Charge applies to any Eligible Charges Blue View Network
OUTPATIENT CARE			
Doctor's Office and Urgent Care Visits	$15 per visit copayment to your Primary Care Physician (PCP) $35 per visit copayment to a Specialist.	$15 per visit copayment to a Primary Care Physician (PCP) $25 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	No copayment after the per visit copayment to PCP or referred specialist Injectable medications – 20% coinsurance (does not apply to allergy shots, serum or chemotherapy dispensed in physician's office) $150 copay for high cost radiology (MRI, CAT Scat, PET Scan, MRA)	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Maternity Care	$100 One time per pregnancy copayment for OB/GYN. $35 per visit copayment for diagnostic testing	20% coinsurance (deductible applies) Copayment applies for initial visit	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Accidental Injury Care	$15 per visit copayment to your PCP $35 per visit copayment to specialist with PCP referral	$15 per visit copayment in a Primary Care Physicians office, $25 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

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	YOU PAY	**IN Network YOU PAY**	**In or Out of Network YOU PAY**
Doctor's Office and Urgent Care Visits	$15 per visit copayment to your Primary Care Physician (PCP) $35 per visit copayment to a Specialist.	$15 per visit copayment to a Primary Care Physician (PCP) $25 per visit copayment to a Specialist. (deductible does not apply)	3. PCA – 100% of allowable charge, then 4. Clergy pays 20% of allowable charge after deductible
Diagnostic lab and x-ray tests, allergy shots, therapeutic injections	No copayment after the per visit copayment to PCP or referred specialist Injectable medications – 20% coinsurance (does not apply to allergy shots, serum or chemotherapy dispensed in physician's office) $150 copay for high cost radiology (MRI, CAT Scat, PET Scan, MRA)	20% coinsurance (deductible applies)	3. PCA – 100% of allowable charge, then 4. Clergy pays 20% of allowable charge after deductible
Maternity Care	$100 One time per pregnancy copayment for OB/GYN. $35 per visit copayment for diagnostic testing	20% coinsurance (deductible applies) Copayment applies for initial visit	3. PCA – 100% of allowable charge, then 4. Clergy pays 20% of allowable charge after deductible
Accidental Injury Care	$15 per visit copayment to your PCP $35 per visit copayment to specialist with PCP referral	$15 per visit copayment in a Primary Care Physicians office, $25 per visit copayment in a Specialist office, 20% coinsurance lab and diagnostic tests (deductible applies)	3. PCA – 100% of allowable charge, then 4. Clergy pays 20% of allowable charge after deductible
Outpatient Hospital Care	$150 Emergency Room per visit copayment (waived if admitted) $150 Facility copayment for outpatient surgery	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible

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Outpatient Mental Health and Substance Abuse Care	$15 per visit copayment to your Primary Care Physician (PCP) $35 per visit copayment to a Specialist	$15 per visit copayment to a Primary Care Physician (PCP) $25 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
Spinal Manipulations	$25 copay Covered for 30 visits per year (PCP referral required)	20% coinsurance (deductible applies) $500 year max	1. PCA – 100% of allowable charge then 2. Clergy pays 20% of allowable charge after deductible ($1000 year max)
Home Health Care	Covered, no copayment	20% coins(deductible applies) 90 visit limit per calendar year	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Outpatient Speech Therapy	$25 per visit copayment (limited to 30 visits per year)	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 to be covered	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

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In-Hospital Physician's Services	Covered, no copayment	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Mental Health and Substance Abuse Care	$200 per day copayment, $1,000 per admission maximum, requires pre-admission certification by the HMO to be covered	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 90 day maximum per year
Skilled Nursing Facility Care (limited to 100 days per illness or condition)	Covered, no copayment	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
OTHER COVERED SERVICES			
Durable medical equipment and supplies	Covered, no copayment. Limited to $2,000 per year. (Prosthetics 20% coins, not included in the $2,000 DME limit)	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge after deductible
Ambulance Services	Covered, no copayment, no dollar limit	20% coinsurance (deductible applies, $3000 limit per calendar year)	1. PCA – 100% of allowable charge, then 2. Clergy pays 20% of allowable charge, after deductible

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Private Duty Nursing Visits	Covered, no copayment (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
Outpatient Physical and Occupational Therapy	$25 per visit copayment (limited to combined 30 visits per year)	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	20% coinsurance (deductible applies)	1. PCA – 100% of allowable charge then 2. Clergy pays 20% of allowable charge after deductible
Annual Out-of-Pocket Expense Limit This limit is reached through your deductibles, coinsurance, (for PPO plan) 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	$2500/Individual* $5000/Family*	$2500/Individual** $5000/Family**	$2500/Individual $5000/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. This is only a summary of benefits, for more details refer to the plan document. ** **Does not include copayments for prescriptions or office visit copayments.**			

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OUTPATIENT PRESCRIPTION DRUGS *	HMO	PPO	CHP
Retail Prescription Drugs (up to a 30-day supply per prescription or refill)	$12 copayment for each prescription (Tier 1) $25 copayment for each prescription (Tier 2) $40 copayment for each prescription (Tier 3)	$12 copayment for each prescription (Tier 1) $25 copayment for each prescription (Tier 2) $40 copayment for each prescription (Tier 3)	1. PCA – 100% of discounted cost, then 2. Clergy pays 20% of discounted cost after deductible
Mail Order Program (up to a 90-day supply per prescription or refill)	$40 copayment for each prescription (Tier 1) $50 copayment for each prescription (Tier 2) $80 copayment for each prescription (Tier 3)	$40 copayment for each prescription (Tier 1) $50 copayment for each prescription (Tier 2) $80 copayment for each prescription (Tier 3)	1. PCA – 100% of discounted cost, then 2. Clergy pays 20% of discounted cost after deductible

*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