

2008 Medical Benefits

For an overview of your 2008 medical benefits package, click on the hyperlink at the bottom of this page for the type of coverage you are enrolled in (or wish to enroll in). Effective 1/1/2008 participants in both the PPO and HMO will be eligible for benefits from a new Employee Assistance Plan (EAP), provided through MhNet Behavioral Health. Additional information regarding the EAP will be mailed to all active Clergy and will be available on the Center for Clergy Excellence WEB page.

The **HMO plan** will not have an increase in personal contribution. In addition, the office visit co-pay has been reduced to \$25 for a PCP and \$45 for a specialist. There are no other changes to the HMO plan for 2008. For specific details of the HMO plan, click on the HMO link in the table at the bottom of this page.

The **PPO plan** personal contribution rate will increase 5% (as opposed to 15% as approved at Annual Conference). In addition, the deductible will remain at \$400 (as opposed to increasing to \$500) and the out of pocket expense limitation remains at \$2,200 per person (as opposed to increasing to \$3,000). Other 2008 changes to the PPO include;

- a. Increased benefits include; Mental health and chemical dependency benefits are increased along with speech therapy benefits. Complete details will be sent to each Clergy .
- b. Maintenance drugs will require a co-pay every 30 days unless mail order is used.
- c. The PPO out of network out of pocket is increasing to \$26,000.
- d. There is an increase in co-pays for both retail and mail order prescriptions

Brand on formulary	\$55 + 20% of cost over \$275
Brand off formulary	\$80 + 20% of cost over \$400

The mail order co-pays will increase as shown below (90 day supply)

Generic	\$25 + 20% of cost over \$125
Brand on formulary	\$137.50 plus 20% of cost over \$687.50
Brand off formulary	\$200 plus 20% of cost over \$1,000

- e. An increase in office visit co-pays to \$20 for a PCP and \$30 for a specialist.

For specific details of the PPO plan, click on the link in the table below.

HMO Plan	PPO Plan
High Deductible Plan	2008 Rate Sheet

Texas Annual Conference Unicare HMO Plan Effective 1/1/08

Basics	Your Doctor		Each member should choose a primary care physician from the provider directory. That primary care physician is responsible for providing referrals for specialty care. Female members may access, in addition to her PCP, a network obstetrician/gynecologist to provide care within the scope of that specialty. To make these selections, call Customer Services.		
	Annual Deductible (if applicable)		None		
	Out-of-Pocket Maximum	Individual	Aggregate copays for basic health care services will not exceed \$3,000 per calendar year.		
		Family	Aggregate copays for basic health care services will not exceed \$6,000 per calendar year.		
	Lifetime Maximum		Unlimited		
	Pre-existing Condition Limitations		Does not apply		
Service	Coverage	Description of Coverage	Health Care Plan Covers	You Pay	
Physician Office Visits & Other Services	Doctor's Office Visits; including but not limited to physical exams; treatment of illness and injury; allergy tests/shots; diagnostic tests, imagining or X-rays	Primary Care Physician (PCP), per visit	100% after \$25 copay	\$25 copay	
		Specialist, per visit	100% after \$45 copay	\$45 copay	
	Well Child Care	From birth	100% after \$25 copay	\$25 copay	
	Well Child Immunizations	From birth through six (6) years of	100%	No copay	

		age		
	Pediatric & Adult Immunizations	From age seven (7)	100% after \$25 copay	\$25 copay
	Annual Self-Referred Well-Woman GYN Exam	PCP	100% after \$45 copay	\$45 copay
	CAT, MRI, MRCT or MRMRA, PET scan or Nuclear Cardiac scan	Per procedure	100% after \$150 copay	\$150 copay
Physician Inpatient Visits & Other Services	Physician Visits to a Member	Includes visits that take place in a hospital, emergency room, skilled nursing facility, visits in which surgery is performed and visits to the home	100%	No copay

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Texas Annual Conference Unicare HMO Plan Effective 1/1/08

Service	Coverage	Description of Coverage	Health Care Plan Covers	You Pay
Hospital & Related Services	In-Patient Room & Board	Semi-Private or Intensive Care Unit	100% after \$1,500 copay per admission	\$1,500 copay per admission
	Other Inpatient Services & Supplies	Normal daily services, x-ray services, laboratory and other diagnostic tests and drugs, medications, and anesthesia	100%	No copay
	Emergency Room Services <i>(Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in serious jeopardy of the person's health, serious impairment to bodily functions, or serious dysfunction of any organ or part)</i>	Copay waived if admitted as an inpatient within 24 hours	100% after \$150 copay	\$150 copay
	Urgent Care Services / After Hours Clinics	Per visit	100% after \$70 copay	\$70 copay
Out-Patient Services & Supplies	Outpatient Surgery	Includes cardiac catheterizations	100% after \$500 copay per admission	\$500 copay per admission
	Diagnostic Tests & X-rays	At a participating hospital or facility	100% after \$75 copay	\$75 copay

	Radiation Therapy, Chemotherapy or Dialysis Services	Specialty Care; per visit	100% after \$75 copay	\$75 copay
Pregnancy Related Services	Services & Supplies Related to Pregnancy	PCP; copay applies to initial visit only	100% after \$25 copay	\$25 copay
		Specialist; copay applies to initial visit only	100% after \$45 copay	\$45 copay
	Services Related to the Treatment of Infertility	After a diagnosis of Infertility has been made	50% of Reasonable Costs	50% of Reasonable Costs

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**Texas Annual Conference Unicare HMO Plan
Effective 1/1/08**

Service	Coverage	Description of Coverage	Health Care Plan Covers	You Pay
Other Services	Physical Therapy, Occupational Therapy and Speech & Hearing Therapy	Specialty care; per visit or service rendered or received on an out-patient basis	100% after \$75 copay	\$75 copay
	Emergency Ambulance Transportation	Transportation to or from the nearest hospital	70% per service	30% per service
	Skilled Nursing Facility Services	60 days maximum per calendar year; copay waived if transferred from another inpatient setting	100% after \$500 copay per admission	\$500 copay per admission
	Home Health Care	Specialty care per visit or service; includes skilled nursing visits, physical and occupational therapy, speech therapy	100% of reasonable charges	No copay
	Hospice Care Services	\$10,000 lifetime maximum; includes bereavement counseling for family members	100% per admission/period of service	No copay

	Durable Medical Equipment (DME), Corrective Appliances and Artificial Aids	\$2,500 calendar year maximum	70% of reasonable charges	30% copay of reasonable charges
	Wigs for Chemotherapy Patients	Up to a limit of \$500	100%	No copay
	TMJ / CMJ	Includes diagnostic and/or surgical treatment	100% after \$1,500 copay per admission	\$1,500 copay per admission

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**Texas Annual Conference Unicare HMO Plan
Effective 1/1/08**

Service	Coverage	Description of Coverage	Health Care Plan Covers	You Pay
Mental Health Services	Treatment of Serious Mental Illness	Coverage for semi-private accommodations subject to a maximum of 45 days of inpatient treatment and 60 visits for outpatient treatment, group and/or individual, per calendar year	100% after \$1,500 copay per admission	\$1,500 copay per admission
	Inpatient Mental Health Services (other than Serious Mental Illness)	Coverage for semi-private accommodations to a maximum of 20 days per calendar year	100% after \$1,500 copay per admission	\$1,500 copay per admission
	Intensive Outpatient Mental Health Services	Includes services in a Psychiatric Day Treatment Facility, Crisis Stabilization Unit or Residential Treatment Center for Children or Adolescents, subject to a maximum of 40 days per calendar year	100% after \$500 copay per inpatient admission/defined outpatient treatment program (waived if a continuation of an inpatient episode)	\$500 copay per inpatient admission/defined outpatient treatment program (waived if a continuation of an inpatient episode)
	Outpatient Short Term	Limited to 20 visits per	100% after \$60 copay per service	\$60 copay per service

	Evaluative or Crisis Intervention or Both	calendar year		
Chemical Dependency Services		Limited to a lifetime maximum of 3 separate series of treatments; includes diagnosis, medical treatment and referral services	100% after \$1,500 copay per admission	\$1,500 copay per admission

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The information provided is only an illustrative summary. Refer to your benefits plan booklet, the Group Service Agreement, (which is provided to you after enrollment) for details of your coverage. To be eligible for benefits, an employee and his/her dependents must reside, live or work within the UNICARE service area. Additional eligibility criteria may be required by the employer's benefits or human resources department(s). In the event information in this Summary of Benefits differs from information in the Group Service Agreement, the information in the Group Service Agreement will prevail.

Medical benefits are NOT payable under the UNICARE HMO plan for any of the following:

1. Any care, treatment, services or supplies received outside of the Service Area – except for emergency health care services or as otherwise provided for under this Group Services Agreement (GSA).
2. Services and supplies not provided, authorized or prescribed by or under the direction of a Member's Primary Care Physician, authorized specialist, or authorized by the Health Plan.
3. Hearing aids, eye glasses, eye refractions, refractive eye surgery or contact lenses, and the fitting thereof, except for the initial pair of eyeglasses or contact lenses up to a retail value of \$100 needed due to cataract surgery, unless coverage for these items is expressly provided by rider to or amendment of the GSA. This will not apply to the necessary diagnostic and follow-up care associated with hearing screenings for a Child from birth through age 24 months.
4. Services and supplies for dental care, oral surgery or treatment of the teeth or periodontium, overbite or malocclusion, oral injury resulting from biting or chewing. The Health Plan will not cover dental braces, dental implants, splints, bridges or any treatment related to the preparation or fitting of dentures, or oral care and supplies, or orthognathic surgery.
5. Injury or Illness arising out of employment when benefits are paid or payable or the Injury or Illness under any Workers Compensation or Occupational Disease Act or Law.

6. Custodial care or respite care.
7. Services such as a private room, television, telephone, barber or beauty service, guest service, and similar incidental services and supplies that are primarily for the convenience of the Member.
8. Prescription and non-prescription Drugs and medicines, unless expressly provided by the GSA and any attachments or riders.
9. Any drug, biological product, device, medical treatment, or procedure that is Experimental or Investigational.
10. Cosmetic surgery or procedures. This will not include reconstructive surgery as shown in the Schedule of Health Services. The presence of a psychological condition will not entitle a Member to coverage for plastic, cosmetic or reconstructive surgery.
11. Elective termination of pregnancy.
12. Infertility treatment and services other than those appearing in the Schedule of Health Services, Item 5, Pregnancy Related Services. Infertility treatments after voluntary sterilization of a Member are not covered. The cost of sperm and its collection are not covered by the Plan.
13. Services and supplies for or related to sex change services.
14. Services and supplies for or related to the reversal of elective sterilization.
15. Sexual therapy programs, or treatment for sexual offenders or perpetrators of sexual or physical violence, treatment of chronic or long-term mental health disorders involving psychological or abusive behavior, or psychosexual problems, including but not limited to child abuse and long-term sexual dysfunction.
16. Services and supplies that are: (a) for mental retardation or a learning or behavioral disability, when such services extend beyond the period necessary for evaluation and diagnosis of the condition; (b) for educational rehabilitation; (c) for marriage counseling, when such services extend beyond the period necessary for short-term evaluation or crisis intervention; or (d) for treatment required by an order of a court of competent jurisdiction, including orders of parole or probation or as an alternative to same or (e) for Intelligence Quotient (IQ) testing; or (f) not authorized by a Primary Care Physician.
17. Services and supplies for routine care and maintenance of the feet, other than medically necessary care associated with diabetes.
18. Enrollment in a health, athletic or similar club.
19. Treatment or surgical procedures intended for the treatment of obesity, morbid obesity or similar condition involving a Member's weight.
20. Hypnosis or Hypnotherapy.
21. Treatment for smoking or nicotine addiction.
22. Biofeedback, or other services, including acupuncture, massage therapy, music therapy, aqua therapy, aromatherapy, or any alternative therapy(ies).
23. Spinal manipulation for chronic neuromusculoskeletal conditions and any non-neuromusculoskeletal conditions.
24. Care for health conditions that are required or directed by state or local authorities to be treated in a public facility.
25. Care or supplies which are furnished by a facility operated for or by the U.S. Government (or its agency) or by a Physician employed by that facility unless for Emergency Care when the Member must pay for those services, for non-service connected disabilities in a Veterans Administration Hospital, or incurred by a U.S. military retiree (covered by this GSA) and his or her covered Dependents, while confined in a military medical facility.

26. Care and services to the extent furnished or payable under a plan or program operated by the federal or state government or one of its agencies, or while the Member is active in the military. This exclusion will not apply to benefits received under the Medicaid program of the State of Texas.
27. Care and supplies for which no charge is made, or for which the Member would not have to pay if the Member did not have this coverage.
28. Health Services provided prior to the effective date or after the termination date of the Member's coverage under the GSA.
29. Miscellaneous non-covered services and supplies, including but are not limited to:
 - a. Ambulatory blood pressure monitor (unless Member is a diabetic);
 - b. Refractive eye surgery; immunotherapy for food allergy; and genetic testing.
 - c. Items of equipment not primarily used for a medical purpose such as exercise cycles or exercise equipment, air conditioners, humidifiers, personal comfort items, motorized transportation equipment or motorized wheelchairs, escalators or elevators, saunas or swimming pools, and items not authorized by a Participating Physician or Participating Provider.
 - d. Equipment and appliances considered dispensable or convenient for use in the home and not primarily used for a medical purpose, such as dressings or disposable OTC cervical collars, corrective shoes and shoe inserts (unless the Member is diabetic), air filtering units, aphakic lens, bandage lens, blood pressure cuffs/stethoscopes, corset/girdles, intercom systems, battery operated nebulizers, overbed tables, oxygen cylinder racks, pacemaker monitors, restraints/safety equipment, seat lift chairs and similar apparatus, shower bench, stools/chairs, support garments (such as Jobst stockings), toilet rails and seats, urinals/bed pans, vacuum devices for impotence, vacuum systems, vibration/massage units or chairs, or whirlpools.
30. Replacement or repair of Durable Medical Equipment damaged or disabled as a result of circumstances beyond the normal use and/or wear and tear of the equipment.
31. Any service rendered by a Close Relative or someone having the same legal residence as the patient, ("Close Relative" means a Member's spouse, or the brother, sister, parent or child of a Member or Member's Spouse).
32. Thermograms, temperature gradient studies.
33. Exercise for the eyes (orthoptics).
34. Non-emergency transportation.
35. Reduction mammoplasty.
36. Care provided by a Christian Science Practitioner.
37. All over the counter formulas or nutritional supplements to be used for enteral feeding, except for the treatment of PKU or other heritable diseases when this GSA includes a prescription drug rider.
38. Any services or costs related to a Member acting as an organ donor including the determination of the Member's suitability to provide an organ donation.
39. Drugs prescribed, directed or authorized by a Primary Care Physician to be consumed or administered in a physician's office, or while confined in a Participating Hospital or approved health care facility on an inpatient basis.
40. Health Services furnished due to war or an act of war (declared or undeclared).

This plan provides benefits for expenses for non-inpatient Prescription Drugs and Self-Administered Prescription Drugs when prescribed by a Physician or Provider as defined in the Group Service Agreement and obtained from a Participating Pharmacy. In Emergency situations, a 3-day supply of Medically Necessary Prescription Drugs prescribed by a non-participating Physician or provider is covered.

Member is responsible for paying the difference between the Participating Pharmacy's contract rates with UNICARE for the preferred formulary (brand) or non-preferred formulary (brand) and the generic drug cost when a generic equivalent (or similar) drug is available. In addition, Member is also responsible for paying the copayment applicable to the generic drug. This provision will apply whether the request for the preferred formulary (brand) or non-preferred formulary (brand) drug is made by the Member or the Physician.

BENEFITS

Prescription Drug Deductible: Not Applicable per Member per year

Participating Pharmacy Benefits and Copayments after Prescription Drug Deductible:

<p>GENERIC Prescription Drugs Initial or Refill prescriptions up to a 30-day supply</p>	<p>\$10 or the pharmacy's contract rate with the Health Plan, whichever is less</p>	
<p>BRAND Prescription Drugs Initial or Refill prescriptions up to a 30-day supply</p>	<p>Formulary \$30 (including supplies) or the pharmacy's contract rate with the Health Plan, whichever is less</p>	<p>Non-Formulary \$45 or the pharmacy's contract rate with the Health Plan, whichever is less</p>
<p>GENERIC OR BRAND Self-Administered Injectables and Compound Prescription Drugs</p>	<p>20% of Health Plan contracted rate up to a maximum amount of \$100 per covered Prescription with an annual Out-of-Pocket maximum of \$5,000 per Member</p>	
<p>INFERTILITY Oral Prescription Drugs</p>	<p>50% of Reasonable Costs or negotiated rate This amount will not apply towards any Member or Family out- of-pocket copayment maximum listed in the GSA or other Riders</p>	
	<p>Includes only oral Prescription Drugs for the treatment of infertility. There is no coverage for injectable fertility prescriptions. Does not include prescription drug therapy for infertility which involves non-FDA approved indications or non- standard dosages, lengths of treatment or cycles of therapy.</p>	

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Mail Order Pharmacy Benefits and Copayments after Prescription Drug Deductible:

<p align="center">GENERIC Prescription Drugs Initial or Refill prescriptions up to a 90-day supply</p>	<p align="center">\$20 or the pharmacy's contract rate with the Health Plan, whichever is less</p>	
<p align="center">BRAND Prescription Drugs Initial or Refill prescriptions up to a 90-day supply</p>	<p align="center">Formulary \$60 (including supplies) or the pharmacy's contract rate with the Health Plan, whichever is less</p>	<p align="center">Non-Formulary \$90 or the pharmacy's contract rate with the Health Plan, whichever is less</p>
<p align="center">GENERIC OR BRAND Self-Administered Injectables and Compound Prescription Drugs</p>	<p align="center">20% of Health Plan contracted rate up to a maximum amount of \$100 per covered Prescription with an annual Out-of-Pocket maximum of \$5,000 per Member</p>	
<p align="center">INFERTILITY Oral Prescription Drugs</p>	<p align="center">50% of Reasonable Costs or negotiated rate This amount will not apply towards any Member or Family out- of-pocket copayment maximum listed in the GSA or other Riders</p>	
	<p align="center">Includes only oral Prescription Drugs for the treatment of infertility. There is no coverage for injectable fertility prescriptions. Does not include prescription drug therapy for infertility which involves non-FDA approved indications or non- standard dosages, lengths of treatment or cycles of therapy.</p>	

HOW MAIL ORDER WORKS

The mail order feature allows covered employees and their dependents who regularly take one or more types of maintenance prescription medications to order a 90-day supply of a maintenance medication by enclosing a check for one mail-order copayment amount per prescription along with their order to the UniCare Mail Order Drug provider.

GENERICCHOICE PROGRAM

When your first GenericChoice prescription is filled, you will not pay a copayment. The GenericChoice program applies only to the drugs on the GenericChoice list and is not valid for current prescriptions or if the prescription is filled at an out-of-network pharmacy.

For more information regarding this program and for the complete list of GenericChoice drugs visit our website at www.unicare.com or call Pharmacy Customer Service at the phone number listed on your ID card.

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EXCLUSIONS

1. Drugs or medicines that are not Prescription Drugs.
2. Prescription Drugs used for a condition, application, or indication other than those for which approval of the U.S. Food and Drug Administration (FDA) has been given.
3. Extemporaneous prepared combinations of chemicals or drugs in a non-FDA approved dosage form, whether or not such combinations contain Prescription Drugs.
4. Initial prescriptions or prescription refills in excess of standard Health Plan quantity and frequency limits unless approved by Health Plan.
5. Initial prescriptions and prescription refills dispensed more than twelve (12) months after the date of the Physician's original order.
6. Charges for the administration of a Prescription Drug unless for the administration of immunizations or vaccinations.
7. Any pharmaceutical goods or services covered as a benefit as described in the Group Service Agreement.
8. Immunization agents; allergy and biological sera; blood or blood plasma; Injectable medications other than covered Self-Administered Injectable Prescription Drugs.
9. Any drug, product or device that is Experimental or Investigational.
10. Appetite suppressants and sympathomimetic amines prescribed for weight reduction.
11. Nutritional or dietary supplements or formulas and Legend vitamins unless required to be covered by law.
12. Prescription Drugs for cosmetic conditions not covered by the Group Service Agreement.
13. Drugs not requiring a prescription (over-the-counter drugs and their Prescription equivalents, and other substances not requiring a Prescription even if ordered by a Physician via a Prescription, or vitamins, etc.). This will not apply to a Prescription drug whose over-the-counter availability changes during the course of a contract year. Prescription drug benefits will continue to be provided until the plan renewal date at the level specified herein.
14. Anabolic steroids.
15. Dental products.
16. Smoking cessation patches, gum and other such aids.
17. Prescription Drugs obtained from a Non-Participating Pharmacy.

The information provided is only an illustrative summary. Refer to your benefits plan booklet, the Group Service Agreement, (which is provided to you after enrollment) for details of your coverage. To be eligible for benefits, an employee and his/her dependents must reside, live or work within the UNICARE service area. Additional eligibility criteria may be required by the employer's benefits or human resources department(s). In the event information in this Summary of Benefits differs from information in the Group Service Agreement, the information in the Group Service Agreement will prevail.

2008 Rate Schedule

	UniCare HMO	Boon Chapman PPO
Traditional Plan		
Church Contribution (with housing)	4.8%	4.8%
Clergy Contribution (with housing)		
Up to \$44,999	11.02%	6.24%
\$45,000 and up	13.43%	7.59%
High Deductible Plan		
Up to \$44,999	N/A	4.57%
\$45,000 and up	N/A	5.38%
Medicare Primary for Incorporated Churches with less than 20 employees	UniCare Private Fee For Service	Boon Chapman PPO
Clergy Contribution with Medicare primary		
Up to \$44,999		
Clergy over 65 with under 65 spouse	4.62%	4.62%
Clergy & Spouse over 65	3.64%	3.64%
\$45,000 and above		
Clergy over 65 with under 65 spouse	5.34%	5.34%
Clergy & Spouse over 65	3.57%	3.57%
Monthly direct billing rates	UniCare HMO	Boon Chapman PPO
Active employee		
Employee	\$595.59	\$856.81
Employee & Spouse	\$1,325.17	\$1,639..89
Employee & Children	\$909.16	\$1,639..89
Employee and Family	\$1,729.20	\$1,639..89

Retirees	UniCare Private fee For Service	Boon Chapman PPO
40 + Years of Service		
Single & over 65	\$120.63	\$172.81
Family	Based on age of dependents	Based on age of dependents
Retiree 65 with Medicare Primary		
Single	\$120.63	\$172.81
Retiree & spouse age 65		
Family	\$223.38	\$288.02
Retiree with under age 65 dependent or – Retiree under age 65 with dependent on Medicare (Under age 65 individual on Boon Chapman)	\$570.57	\$635.21
Retiree under 65	UniCare HMO	Boon Chapman PPO
Single	N/A	\$856.81
Family	N/A	\$1,639.89
	UniCare Private Fee For Service	
Surviving Spouse over 65		
Single	\$120.63	\$172.81
Children not on Medicare	\$419.86	\$484.50
Surviving spouse under 65		
Single	N/A	\$430.68
Children	N/A	\$484.50
Pre 92 Retirees with subsidy approved at 2007 Annual Conference	UniCare Private Fee For Service	Boon Chapman PPO
Retiree and spouse over 65		
Single	\$75.63	\$127.81
Retiree & Spouse	\$178.38	\$243.02
Retiree with under age 65 dependent(Under age 65 dependent on Boon Chapman)	\$525.57	\$590.21
Contingent Annuitants over 65		
Single	\$86.88	\$139.06

With under 65 dependent	\$386.11	\$452.45
Contingent Annuitants under 65		
Single	N/A	\$396.93
With dependents	N/A	\$450.75
COBRA	UniCare HMO	Boon Chapman PPO
Single	\$609.24	\$875.68
Employee & Spouse	\$1,353.41	\$1,674.42
Employee & Children	\$929.08	\$1,674.42
Employee & Family	\$1,765.52	\$1,674.42
COBRA rates include EAP cost		

The Group Health Benefits Plan has a self insured PPO, a self insured prescription drug plan and a fully insured HMO which covers clergy, laity, retirees and surviving spouses who meet the eligibility requirements. The Group Health Benefits Plan is not a form of entitlement and it should be noted that the Group Health Benefits Committee, with the approval of Annual Conference, reserves the right to amend or possibly eliminate both the active and retiree plan of benefits.

**Incapacitated
Extension Ministries**

**See policy 106
See policy 102**

- Based on Total Compensation Package (TCP)

Revised October 4, 2004

PPO Benefits

Participants living within 50 miles of the Methodist Hospital Fannin facility have a \$1,000 inpatient co-pay if admitted to a hospital other than Methodist (or its 4 subsidiaries) for a non-emergency admission.

	PPO (1 & 2)	Non-PPO
Lifetime Maximum	\$2,000,000 per member	
Calendar Year Deductible		
Single	\$400	
Family	\$1,200	
Co-Insurance	80%	60%
Maximum out of Pocket (Not including the deductible)		
Single	\$2,200	\$26,000
Family	Unlimited	Unlimited
Physician Office Visit Charge	\$20 co-pay for PCP and \$30 for Specialist/ then 100%	60% after deductible
Other services at Physician	80% after deductible	60% after deductible
Inpatient hospital	80% after deductible	60% after deductible
Emergency room services	80% after deductible	60% after deductible
Wellness benefit (\$200 maximum benefit per year)	\$20 co-pay / 100% no deductible	100%, no deductible
Well child care (limited to children under the age of 3)	\$20 co-pay / 100% no deductible	100%, no deductible
All other services	80% after deductible	60% after deductible
Mental Health	80% after deductible	60% after deductible
Chemical Dependency	80% after deductible Limited to a lifetime maximum of 3 separate series of treatments; includes diagnosis, medical treatment and referral services	60% after deductible Limited to a lifetime maximum of 3 separate series of treatments; includes diagnosis, medical treatment and referral services
Prescription Drug Program		
Calendar year deductible	ScriptCare	Mail Order
Single	\$50	
Family	\$100	
Generic	\$10 plus 20% of coast over \$50	\$25 plus 20% of coast over \$125
Preferred Brand on Formulary	\$55 plus 20% of coast over \$220	\$137.50 plus 20% of coast over \$687.50
Non- Preferred Brand (off formulary)	\$80 plus 20% of coast over \$350	\$200 plus 20% of coast over \$1,000
1. PPO benefits are obtained when the participant uses a PPO provider from the PPO to which they are assigned.		

2. The Preferred Provider Organization (PPO) or network of providers for both plan options is Private HealthCare Systems (PHCS) for the Greater Houston and Tyler/Longview areas. To verify network providers contact PHCS at 888-719-7427 or visit their website at www.phcs.com. All other areas will access the HealthSmart Preferred Care PPO. To verify network providers for HealthSmart call 800-687-0500 or visit their website www.healthsmart.net.

3. See plan document for further details of the program.

The prescription drug plan requires specialty pharmaceuticals be purchased through ScriptCare. The PPO also has a disease management and Wellness program providing incentives for participating in the respective programs.

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High Deductible Plan

	PPO (1 & 2)	Non-PPO
Lifetime Maximum	\$2,000,000 per member	
Calendar Year Deductible		
Single	\$2,650	
Family	\$5,250	
Co-Insurance	80%	60%
Maximum out of Pocket (Not including the deductible)		
Single	\$2,200	\$20,000
Family	Unlimited	Unlimited
Physician Office Visit Charge	\$20 co-pay for PCP and \$30 for Specialist/ then 100%	60% after deductible
Other services at Physician	80% after deductible	60% after deductible
Inpatient hospital	80% after deductible	60% after deductible
Emergency room services	80% after deductible	60% after deductible
Wellness benefit (\$200 maximum benefit per year)	\$20 co-pay / 100% no deductible	100%, no deductible
Well child care (limited to children under the age of 3)	\$20 co-pay / 100% no deductible	100%, no deductible
Mental Health	80% after deductible	60% after deductible
Chemical Dependency	80% after deductible Limited to a lifetime maximum of 3 separate series of treatments; includes diagnosis, medical treatment and referral services	60% after deductible Limited to a lifetime maximum of 3 separate series of treatments; includes diagnosis, medical treatment and referral services
All other services	80% after deductible	60% after deductible
Prescription Drug Program		
Calendar year deductible	ScriptCare	Mail Order
Single	N/A	
Family	N/A	
Generic	100% co-pay, which can be applied to the medical deductible, then payable at 80%.	
Preferred Brand on Formulary		
Non- Preferred Brand (off formulary)		
<p>1. PPO benefits are obtained when the participant uses a PPO provider from the PPO to which they are assigned.</p>		

2. The Preferred Provider Organization (PPO) or network of providers for both plan options is Private HealthCare Systems (PHCS) for the Greater Houston and Tyler/Longview areas. To verify network providers contact PHCS at 888-719-7427 or visit their website at www.phcs.com. All other areas will access the HealthSmart Preferred Care PPO. To verify network providers for HealthSmart call 800-687-0500 or visit their website www.healthsmart.net.

3. See the plan document for further details regarding the plan.

FOR CUSTOMER SERVICE – Please call the toll-free number on your ID card