

	Western PA Conference of Methodist Ministers Option A-199969		Western PA Conference of Methodist Ministers Option B-193127	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Plan Deductible</b>	\$0		\$0	
<b>Plan Coinsurance (Member Cost Sharing)</b>	No Plan level coinsurance applied	20%	No Plan level coinsurance applied	20%
<b>In Network Out-of-Pocket Max</b>	\$0		\$0	
<b>Total In and Out of Network Out-of-Pocket</b>	\$3,400		\$3,400	

**Outpatient Services**

<b>Doctor Office Visit</b>	\$15 PCP, \$20 Specialist cost sharing	20% coinsurance	\$15 PCP, \$15 Specialist cost sharing	20% coinsurance
<b>Preventive Testing/ Screenings</b>	Covered in Full	Covered in Full	Covered in Full	Covered in Full
<b>Diagnostic Testing including Lab, X-Rays and Advanced Imaging</b>	\$0 cost sharing	20% coinsurance	\$0 cost sharing	20% coinsurance
<b>Outpatient Surgery</b>	\$0 cost sharing	20% coinsurance	\$0 cost sharing	20% coinsurance

**Emergent and Urgent Services**

<b>Ambulance</b>	\$25 cost sharing	20% coinsurance	\$25 cost sharing	20% coinsurance
<b>Emergency Room</b>	\$50 cost sharing	\$50 cost sharing	\$50 cost sharing	\$50 cost sharing
<b>Inpatient Hospital Stay</b>	\$0 per stay	20% coinsurance	\$0 per stay	20% coinsurance
<b>Skilled Nursing Facility</b> (days 1-100 per benefit period)	\$0 per day	20% coinsurance	\$0 per day	20% coinsurance

**Your 2013 Benefits at a Glance**

	<b>Western PA Conference of Methodist Ministers Option A-199969</b>		<b>Western PA Conference of Methodist Ministers Option B-193127</b>	
	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>

**Supplies and Additional Services**

<b>Durable Medical Equipment</b>	15% coinsurance	50% coinsurance	15% coinsurance	50% coinsurance
<b>Routine Vision</b> (covered every two calendar years)	Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses.	\$100 benefit maximum for specialty frames or specialty contact lenses.	Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses.	\$100 benefit maximum for specialty frames or specialty contact lenses.
<b>Hearing Aids</b> (covered every three calendar years)	\$500 coverage per ear			

## Your 2013 Benefits at a Glance

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	In-Network	Out-of-Network	In-Network	Out-of-Network

## Medicare Part D Drugs (Up to 34 Day Supply)

<b>Initial Coverage</b> (Up to \$2970 in total drug costs)	<ul style="list-style-type: none"> <li>• \$15 Generic</li> <li>• \$30 Pref. Brand</li> <li>• \$60 Non-Pref. Brand</li> <li>• 33% Specialty</li> </ul>	<p>Please see Summary of Benefits for detailed Information</p> <p>* See below</p>	<ul style="list-style-type: none"> <li>• \$15 Generic</li> <li>• \$30 Pref. Brand</li> <li>• \$60 Non-Pref. Brand</li> <li>• \$60 Specialty</li> </ul>	<p>Please see Summary of Benefits for detailed Information</p> <p>* See below</p>
<b>Coverage Gap</b>	<ul style="list-style-type: none"> <li>• \$15 Generic</li> <li>• \$30 Pref. Brand</li> <li>• \$60 Non-Pref. Brand</li> <li>• 33% Specialty</li> </ul>		<ul style="list-style-type: none"> <li>• \$15 Generic Brand Drugs 47.5% Coinsurance after 50% discount</li> </ul>	
<b>Catastrophic Coverage</b>	<p>During this stage, the plan will pay most of the cost for your drugs.</p> <ul style="list-style-type: none"> <li>•\$10 copayment for a generic drug or a drug that is treated like a generic.</li> <li>•Or a \$10 copayment for all other drugs.</li> </ul> <p><b>Our plan pays the rest of the cost.</b></p>		<p>During this stage, the plan will pay most of the cost for your drugs.</p> <ul style="list-style-type: none"> <li>•-Either - coinsurance of 5% of the cost of the drug</li> <li>•-Or- \$2.65 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.60 copayment for all other drugs.</li> </ul> <p><b>Our plan pays the rest of the cost.</b></p>	

**Questions? Call 1-866-456-7739 (TTY Users, call 711) 7 days a week between 8 a.m. - 8 p.m. Eastern Reference Code 13FB9969** Please have this number ready when you call.

**Please see Summary of Benefits for detailed information.**

**\*Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy.**