Benefit Plan Offerings for 2008

Clergy & Lay Employees / Diocese of Colorado

	(nationwide coverage)	*(local- check available areas)*	*(Plan available in CO only)*	*(nationwide coverage)*	*(nationwide coverage)*	*(nationwide coverage)*
	Cigna	**Kaiser**	**Blue Advantage**	**Episcopal Care**	**Blue Cross**	**Aetna Choice**
	POS-Open Access Plus	**HMO**	**Colorado HMO**	**PPO**	**EPO II**	**POS II**
Rate Increase for 2008	11.00%	21.6%	18.3%	11.0%	11.0%	11%
Rate: Employee Only	$670	507	866	826	728	628
Emp. + 1	1208	1013	1487	1487	1311	1132
Family	1879	1464	2211	2313	2038	1760
		Annual out-of-pocket maximums include only co-insurance (percentage payments), not co-pays or deductibles.				
Calendar Yr Deductible	None	None	None	$250/500	$200/500	$250/500
(Out of Network)	$500/$1500	n/a		$500/$1,000	N/A	$500/1000
Ann. out-of-pocket max.	None	$2,000/$4,500	$3000/6000	$1,000/$2000	$1500/3000	$1,000/$2,000
(Out of Network)	$3500/$10500			$3,000-$6,000	N/A	$3000/6000
Lifetime Max per person	**$2,000,000**	No limit	No Limit	$2,000,000	$2,000,000	$2,000,000
Out of area dependent cov.	yes	Urgent Care Only	Yes-see AFH Care			
		NO out of network	*limited*	*Network medical covered 90%*	*Network medical 80%*	*Network medical 90%*
		svcs. except emergent care		*non-network coverage 70%*	*NO out of network*	*Non-Network 70% after deductible **
Primary Care:						
Routine Ofc Visit	$20 OVCopay	$20 OVCopay	$20 OV Copay	$25 OVCopay	$25 OVCopay	$25 OVCopay
Specialty Care	$20 OVCopay	$30 Copay	$40 Copay	$25 Copay	$25 Copay	$25 Copay
Preventive Care						
Annual Physical Exam	$20 OVCopay	$20 OVCopay	$20 Copay	$25	$25	$25 OVCopay *
Pediatric Exams	$20 OVCopay	$20 OVCopay	$20 Copay	$25	$25	$25 OVCopay *
Cancer Screenings	$20 OVCopay	Included in OVC	included in OVC	$25	$25	
Cardiovascular Screenings	$20 OVCopay	Included in OVC	$20/$40 Copay	$25	$25	100% coverage
Pap Smears Annually	Included in OVC	Included in OVC	3 years	$25	$25	$25 OVCopay *
Mammography	Included in OVC	covered	included in OVC	$25	$25	100% w/ limits
Immunizations	Included in OVC	Included in OVC	Covered w/ofc visit	Covered with limitations	Covered with limitations	100% w/ limits
Allergy tests & treatments	$20 OVCopay	$20 OV Copay	Covered w/ofc visit	$25	$25	$25 OV Copay *
Outpatient Care:				Vision Care/EyeMed	Vision Care/EyeMed	Vision Care/EyeMed
Second Surgical Opinion	$20 OVCopay	$30 (within network)	$20 Copay			
Lab	covered	covered	Covered w/ofc visit	Covered at 80%	Covered at 80%	covered @ 80%- 100% preventive
X-Ray	covered	diagnos. covered/ therapeutic $30	Covered w/ofc visit	Covered at 80%	Covered at 80%	covered @ 80%- 100% preventive
MRI/MRA/CT/PET Scans	covered	$100	$100	Covered at 80%	Covered at 80%	$100
Outpatient Surgery	no charge in network	$100 Copay	$525	Covered at 90%	Covered at 80%	90% *
O.T./P.T.	$20 OVCopay	$20 Copay, limit 20	$20/$40 Copay	$25 Copay	$25 Copay	$25 Copay *
Speech Therapy	$20 OVCopay	$20 Copay, limit 20	$20/$40 Copay	$25 Copay	$25 Copay	$25 Copay *
Chiropractic Services		Not Covered	Not Covered	$25 Copay limit 20	$25 Copay limit 20	$25 copay *
Perscription Drug:		*Generic requirement*	*Generic requirement*	*(generic or pay / mail order req.)*	*(generic or pay / mail order req.)*	*Generic/mail order required*
Retail:Generic	$10-30 days	$10-60 days	$10-34 days	$10-30	$10-30	$10-30 days
Retail:Formulary	$30-30 days	$20-60 days	$30-34 days	$20-30	$30-30	$30-30 days
Retail:Non-Formulary	$50-30 days	Not Covered+	$50-34 days	$50-30	$50-30	$50-30 days
Mail: Generic	$25-90 days	$10-60 days	$20-90 days	$25-90 days	$25-90 days	$25-90 days
Mail: Formulary	$70-90 days	$20-60 days	$60-90 days	$70-90 days	$70-90 days	$70-90 days
Mail: Non-Formulary	$120-90 days	Not Covered+	$100-90 days	$120-90 days	$120-90 days	$120-90 days
Ann. Ded. Indiv/Fam	$50/200 retail ded.			$50/200 retail ded.	$50/200 retail ded.	$50/200 retail ded.

In Hospital Care						
Hospital Copay	$250	$250 per admission	$700 per admission	$100/day $600/max then 90%	80% subject to annual ded	$100/600 then 90%
Deductible	N/A	N/A	N/A	none	none	N/A
Out of network				70% after ded.	70% after ded.	$100/600 then 70%
Emergency Care:						
In Area-Admitted	waived	See Hospital Copay	See Hospital Copay	See Hospital Copay	See Hospital Copay	See Hospital Copay
In Area-Not Admitted	$75 copay	$100	$100 Copay	$50 Copay	$50 Copay	$50
Out of Area-Admitted	waived	See Hospital Copay	See Hospital Copay	See Hospital Copay	See Hospital Copay	See Hospital Copay
Out of Area-Not Admitted		$100	$100 Copay	$50 Copay	$50 Copay	$50
Urgent Care Clinic Visit	$40 OVCopay	$20/ $50 after hours	$40 Copay			
Ambulance-Admittted	waived	80% covered up to $500	100% Covered	Covered at 90%	Covered at 90%	90%
Ambulance-Not Admitted	waived	80% covered up to $500	$100 Copay	Covered at 90%	Covered at 90%	90%
WEB SITE INFO	www.cigna.com	www.kp.org	www.anthem.com	www.firsthealth.com	www.empireblue.com	www.aetna.com
		+If you are currently taking a name brand, non-formulary drug, be aware that Kaiser does not cover it!				

	Miscellaneous		**Dental**	**IRP (Income Protection)****	**LTD (Long Term Disability)**	**Life + AD&D**
			Cigna Basic PPO	**Paid benefit for active, salaried clergy.	Monthly Premium	
		Monthly Rates	Emp = $40	Compensation / Monthly premium	Compensation / 25% opt / 50% opt	*$50,000 limit = $26.50
			Emp +1 = $76	under $25000 $6	under $25000 $12 $18	**$25,000 limit = $13.25
			Family = $119	$25000-44999 $15	$25000-44999 $22 $37	**$15,000 limit = $7.95
		Eligible employees		Over $45000 $30	Over $45000 $43 $72	
		work at least 20 hrs/wk	*non-PPO deductible:	Benefits = 70% of employee comp	LTD25- benefit = 25% income	* Clergy and Diocesan emp.
			$50 individual	with max of $1000/wk	LTD50- benefit = 50% income	**Lay employees
			$150 family			
		Note: Misc. insurance	*applies to basic and major	Benefit pd weekly beginning	Benefits payable after	Retired clergy or lay employee
		available to clergy and lay	svcs but not preventive svc	31st day of disability; may	12 mos of certified disability	$2000 limit for .98 month
		employees at time of hire	Basic Svc @ 85%	continue up to 52 weeks	and are additional to Pension	
		but not offered during	Major Svcs @ 50%		and Social Security benefits	**Long Term Care Coverage**
		annual Open Enrollment	Annual Benefit $1500 indiv.	If employee pays premium		Available--
		unless specified.		payable benefits are tax free	May have LTD without IRP	Contact The Medical Trust
						1-800-223-6602

Helpful Information:

HMO = Health Maintenance Organization
No out of network care except emergency services and you must select one of their doctors.

PPO = Preferred Provider Organization
You receive care from any provider without coordinating your care through a primary care physician (PCP). The plan pays greater benefits if you receive care in-network.

POS = Point of Service
In-network care similar to an HMO with usually only copayments required for most services, but includes the option for out-of-network care also.

EPO = Exclusive Provider Organization
You reaceive care only from the plan's network, similar to an HMO, except EPO uses the same national provider network as the PPO and you do not need to select a PCP.

Your share of payment for covered services:

Copayment: A set amount you pay each time for doctor's visits and prescription drugs.

Deductible: The amount you pay toward non-office visit services (not including copayments) before the plan pays a benefit.

Coinsurance: The percentage of eligible expenses covered by the plan after you pay the annual deductible. Example: if the plan pays 90% coinsurance, you pay 10%.

Out-of-pocket-maximum: The maximum amount you will pay for covered medical expenses (not including copayments or deductibles) during a year. Once you reach your out-of-pocket maximums, the plan covers 100% of eligible expenses for the rest of the year. Out-of-pocket maximums are designed to protect plan participants from severe financial hardship.