2019 Summary of Health Insurance Options - Episcopal Diocese of Indianapolis

If you are an employee age 65 or older, please see page 2 for the Medicare Supplement plan.

	Anthem BCBS Bluecard PPO 80		Anthem BCBS CDHP 20 / Health Savings Account	
Annual Insurance Premiums				
Full Premium Single Plan	$10,668		$8,268	
What you pay (employee cost share)	***$2,240***		***$1,736***	
Employer HSA Contribution	*n/a*		*$1,890*	
Full Premium Plus Plan	$19,200		$14,880	
What you pay (employee cost share)	***$4,032***		***$3,125***	
Employer HSA Contribution	*n/a*		*$3,815*	
Full Premium Family Plan	$29,868		$23,148	
What you pay (employee cost share)	***$6,272***		***$4,861***	
Employer HSA Contribution	*n/a*		*$3,815*	
Deductible/Out-of-Pocket	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Annual Medical Deductible	$1000/Person $2,000/Family	$2000/Person $4,000/Family	$2,700/Person $5,450/Family	$3,000/Person $6,000/Family
Annual Out-of-Pocket Maximum	$3,500/Person $7,000/Family	$7,000/Person $14,000/Family	$4,200/Person $8,450/Family	$7,000/Person $13,000/Family
Covered Services Summary*	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Physician Services				
Preventive Care**	No charge	50% coinsurance	No charge	45% coinsurance
Office Visit	$30 copay	50% coinsurance	20% coinsurance	45% coinsurance
Specialist Care	$45 copay	50% coinsurance	20% coinsurance	45% coinsurance
Hospital Services				
Emergency Room Care***	$250 copay		20% coinsurance	
Facility fee	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Physician/Surgeon fee	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Urgent Care	$50 copay		20% coinsurance	
Mental Health & Substance Abuse				
Outpatient	$30 copay	50% coinsurance	20% coinsurance	45% coinsurance
Inpatient	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Other Outpatient Therapy	$30 copay includes speech, hearing, physical, occupational up to 60 visits per yr. for each type of therapy	50% coinsurance includes speech, hearing, physical, occupational up to 60 visits per yr. for each type of therapy	20% coinsurance includes speech, hearing, physical, occupational up to 60 visits per yr. for each type of therapy	45% coinsurance includes speech, hearing, physical, occupational up to 60 visits per yr. for each type of therapy
If you are pregnant				
Office visits**	$30 copay	50% copay	20% coinsurance	45% coinsurance
Childbirth/delivery	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Prescription drug coverage	**Retail (max 30 day supply)**	**Home Delivery (max 90 day supply)**	**Retail (max 30 day supply)**	**Home Delivery (max 90 day supply)**
Generic drugs	up to $10	up to $25	15% (after deductible)	
Preferred brand drugs	up to $40	up to $100	25% (after deductible)	
Non-preferred brand drugs	up to $80	up to $200	50% (after deductible)	
Specialty drugs	Cost depends on whether the specialty drug is a preferred brand or non-preferred brand drug.		Cost depends on whether the specialty drug is a preferred brand or non-preferred brand drug.	

All plans include vision coverage through EyeMed Vision Care, Employee Assistance Plan through Cigna, and medical advocacy through Health Advocate. See cpg.org for details.

This list of services is incomplete. For more information about additional services, limitations, and exceptions, see the plan or policy document at cpg.org.

* All copayment and coinsurance costs shown in this chart are after your deductible has been met, unless otherwise noted.

** In-network deductible does not apply.

*** Deductible does not apply. Copay will be waived if you are admitted as an inpatient within 24 hours.

2019 Medicare Supplement Plan - Episcopal Diocese of Indianapolis

Employees Age 65+ Only

	Anthem BCBS BlueCard PPO 80 Medicare Supplement	
Annual Insurance Premiums		
Full Premium Single Plan	$8,640	
What you pay (employee cost share)	***$1,814***	
Employer HSA Contribution	*n/a*	
Full Premium Plus Plan	$15,552	
What you pay (employee cost share)	***$3,266***	
Employer HSA Contribution	*n/a*	
Full Premium Family Plan	$24,192	
What you pay (employee cost share)	***$5,080***	
Employer HSA Contribution	*n/a*	
Deductible/Out-of-Pocket	**In Network**	**Out of Network**
Annual Medical Deductible	$1000/Person $2,000/Family	$2000/Person $4,000/Family
Annual Out-of-Pocket Maximum	$3,500/Person $7,000/Family	$7,000/Person $14,000/Family
Covered Services Summary*	**In Network**	**Out of Network**
Physician Services		
Preventive Care**	No charge	50% coinsurance
Office Visit	$30 copay	50% coinsurance
Specialist Care	$45 copay	50% coinsurance
Hospital Services		
Emergency Room Care***	$250 copay	
Facility fee	20% coinsurance	50% coinsurance
Physician/Surgeon fee	20% coinsurance	50% coinsurance
Urgent Care	$50 copay	
Mental Health & Substance Abuse		
Outpatient	$30 copay	50% coinsurance
Inpatient	20% coinsurance	50% coinsurance
Other Outpatient Therapy	$30 copay includes speech, hearing, physical, occupational up to 60 visits per yr. for each type of therapy	50% coinsurance includes speech, hearing, physical, occupational up to 60 visits per yr. for each type of therapy
If you are pregnant		
Office visits**	$30 copay	50% copay
Childbirth/delivery	20% coinsurance	50% coinsurance
Prescription drug coverage	**Retail (max 30 day supply)**	**Home Delivery (max 90 day supply)**
Generic drugs	up to $10	up to $25
Preferred brand drugs	up to $40	up to $100
Non-preferred brand drugs	up to $80	up to $200
Specialty drugs	Cost depends on whether the specialty drug is a preferred brand or non-preferred brand drug.	

All plans include vision coverage through EyeMed Vision Care, Employee Assistance Plan through Cigna, and medical advocacy through Health Advocate. See cpg.org for details.
This list of services is incomplete. For more information about additional services, limitations, and exceptions, see the plan or policy document at cpg.org.
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** In-network deductible does not apply.
*** Deductible does not apply. Copay will be waived if you are admitted as an inpatient within 24 hours.