

WCIF Options Plan A Retirees



Effective Date 1/1/2009

Health Plan Options

Ref RQ-8775

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please contact our Sales or Customer Service Departments or refer to the plan contract.

Benefits	Inside Network	Outside Network
Plan deductible (PCY) - per calendar year	No Annual Deductible	Individual deductible: \$100 Family deductible: \$200
Plan coinsurance	No Plan Coinsurance	Plan pays 80%, you pay 20%
Pre-existing condition (PEC) waiting period	3 Months	Same as in-network
Out-of-pocket limit	Individual out-of-pocket limit: \$1000 Family out-of-pocket limit: \$2000	Individual out-of-pocket limit: \$1000 Family out-of-pocket limit: \$2000
Lifetime Maximum	\$2 million	Shared with in-network maximum
Outpatient Services (Office visits - OV)	\$5 copay	Coinsurance, deductible and coinsurance apply
Hospital services	Inpatient services: Covered in full Outpatient surgery: \$5 copay	Inpatient services: Deductible and coinsurance apply Outpatient surgery: Coinsurance, deductible and coinsurance apply
Prescription drugs	Formulary generic and/or brand \$5 copay	Formulary generic and/or brand 80%
Prescription mail order	3 x prescription cost share per 90 day supply	Not covered
Acupuncture	Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by plan \$5 copay	Coinsurance, deductible and coinsurance apply
Ambulance Services	80/20% coinsurance	Same as in-network
Chemical Dependency	\$14,500 per 24 months Outpatient: \$5 copay Inpatient: Covered in full	Benefit limits shared with in-network Outpatient: Coinsurance, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Devices, equipment and supplies (DME prosthetics)	Covered in full	Benefits and limits shared with in-network
Diagnostic lab and X-ray Services (outpatient)	Covered in full	Deductible and coinsurance apply
Emergency Services (copay waived if admitted)	\$75 copay	\$125 copay Deductible and coinsurance apply
Growth hormone	Covered at pharmacy cost share; no wait	Covered at pharmacy cost share; no wait
Hearing exams (Routine)	\$5 copay	Coinsurance, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health	Covered in full. No visit limit.	No visit limit Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Self-referred up to 10 visits PCY \$5 copay	10 visit limit PCY Coinsurance, deductible and coinsurance apply
Maternity services	Outpatient: \$5 copay Inpatient: Covered in full	Outpatient: Coinsurance, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Mental Health	Outpatient: 20 visits PCY \$5 copay Inpatient: 12 days PCY Covered in full	Outpatient: Visit limits shared with in-network Coinsurance, deductible and coinsurance apply Inpatient: Visit limits shared with in-network Deductible and coinsurance apply
Naturopathy	Self-referred up to 3 visits per medical diagnosis PCY; additional visits when approved by plan \$5 copay	Coinsurance, deductible and coinsurance apply

Obesity-related surgery (bariatric) When medically necessary and authorized lifetime max	Not covered	Not covered
Organ transplants Donor search & harvest rolls to lifetime max	\$250,000 lifetime max; includes donor search & harvest of \$50,000; 6 month wait Outpatient: \$5 copay Inpatient: Covered in full	Benefit limit shared with in-network Outpatient: Coinsurance, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full	Not covered
Rehabilitation services (Occupational, speech, physical-including massage) Rehab visits are a total of combined therapy visits PCY	Outpatient: 60 visits PCY \$5 copay Inpatient: 60 days PCY Covered in full	Outpatient: Visit limits shared with in-network Coinsurance, deductible and coinsurance apply Inpatient: Day limits shared with in-network Deductible and coinsurance apply
Skilled nursing facility (PCY)	Covered in full up to 120 days	Days shared with in-network, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	\$5 copay	Coinsurance, deductible and coinsurance apply
Temporomandibular Joint (TMJ) Services	\$1,000 PCY; \$5,000 lifetime max Outpatient: \$5 copay Inpatient: Covered in full	Shared with in-network Outpatient: Coinsurance, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Tobacco Cessation See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full	Not Covered
Vision care Routine vision exam (1 visit every 12 months) No limit for medically necessary eye visits	\$5 copay	Not covered
Optical Hardware Lenses, including contact lenses, and frames	Not covered	Not covered

