Washington Counties Insurance Fund

2023 Retiree Benefit Plan Comparison

- **Retiree Medical Plans for Under Age 65 (former WCIF medical enrollees only)**
- **Retiree Medical Plans for Age 65 and over (all eligible retirees)**
- **Retiree Dental Plans (former WCIF dental enrollees only)**
- **Retiree Vision Plan (former WCIF vision enrollees only)**

For additional information including plan summaries and lists of participating providers, visit us at www.wcif.net. For information about billing, eligibility, and other plan administration, please contact Retiree Administration at Vimly.

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2023 PREMERA BLUE CROSS PPO MEDICAL PLANS for under age 65

	WCIF 200	WCIF 750	WCIF 3000
Provider Network	For Out-of-Network benefits, please see full plan summary		
Deductible (Ded) PCY **Individual** **Family**	$200 $400	$750 $1,500	$3,000 $6,000
Coinsurance (Coins)	20%	20%	20%
Out-of-pocket max (includes deductible, coinsurance, and copays) **Individual** **Family**	$2,200 $4,400	$5,750 $11,500	$6,350 $12,700
Office Visit Cost Share	$25 Copay	$30 Copay	$35 Copay
Preventive Care	Covered in Full	Covered in Full	Covered in Full
Manipulations (spinal)	20 visits PCY $25 Copay	20 visits PCY $30 Copay	20 visits PCY $35 Copay
Diagnostic Lab and X-ray Services Some services may require pre-authorization	Ded / Coins	Ded / Coins	Ded / Coins
Inpatient Hospital	Ded / Coins	Ded / Coins	Ded / Coins
Outpatient Surgery Facility	$75 Copay Ded / Coins	$75 Copay Ded / Coins	$75 Copay Ded / Coins
Emergency Care Copay (waive copay if admitted)	$150 Copay Ded / Coins	$150 Copay Ded / Coins	$200 Copay Ded / Coins
Hearing Benefit **1 Exam Per Calendar Year**	$25 Copay	$30 Copay	$35 Copay
Hearing Benefit **Hardware**	Covered in Full up to $3,000 every 3 Calendar Years	Covered in Full up to $3,000 every 3 Calendar Years	Covered in Full up to $3,000 every 3 Calendar Years
Pharmacy 30 day supply			
Generic – Tier 1	$5 Copay	$5 Copay	$5 Copay
Brand Name – Tier 2	$35 Copay	$35 Copay	$35 Copay
Non-formulary – Tier 3	$70 Copay	$70 Copay	$70 Copay
Monthly Rates			
Retiree	$2,081.16	$1,896.21	$1,486.14
Retiree/Spouse*	$4,162.31	$3,792.42	$2,972.29
Retiree/Children	$3,642.04	$3,318.39	$2,600.76
Retiree/Spouse*/Children	$5,723.19	$5,214.59	$4,086.90

**or qualified domestic partner*

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KAISER PERMANENTE

2023 KAISER PERMANENTE MEDICAL PLAN under age 65

	Core 750	Core 5000	ACCESS PPO 5000
Provider Network	HMO In-Network Only	HMO In-Network Only	For Out-of-Network benefits, see full plan summai
Deductible (Ded) **Individual** **Family**	$750 $1,500	$5,000 $10,000	$5,000 $10,000
Coinsurance (Coins)	20%	20%	20%
Out-of-pocket max (Includes deductible, coinsurance, and copays) **Individual** **Family**	$2,700 $5,400	$5,000 $10,000	$5,000 $10,000
Office Visit Cost Share	$20 Copay Ded / Coins	$20 Copay; Ded / Coins	Welcome Rider: First 4 office visits are not subject to deductible and/or coinsurance, $30 Copay ($20 Copay at enhanced provider) only. After the 4th visit, services are subject to the deductible and then coinsurance (copay waived).
Preventive Care	Covered in Full	Covered in Full	Covered in Full
Manipulations (spinal) 20 visits PCY	$20 Copay; Ded / Coins	$20 Copay; Ded / Coins	$30 Copay; Ded / Coins
Outpatient Diagnostic Laboratory and X-ray Services Some services may require pre-authorization	Ded / Coins	Ded / Coins	Welcome Rider: The first $500 of professional lab/x-ray expenses each calendar year are covered in full. After $500 is paid in full, all other x-ray/lab expenses are subject to deductible and then coinsurance.
Inpatient Facility	Ded / Coins	Ded / Coins	$100 Copay, per day for up to 5 days per admit Ded / Coins
Outpatient Surgery Facility	$20 Copay; Ded / Coins	$20 Copay; Ded / Coins	Ded / Coins
Emergency Care (waive copay if admitted)	$100 Copay; Ded / Coins	$100 Copay; Ded / Coins	$100 Copay Ded / Coins
Hearing Benefit **1 Exam Per Calendar Year**	$20 Copay; Ded / Coins	$20 Copay; Ded / Coins	$30 Copay ($20 Copay enhanced benefit); Ded / Coins
Hearing Benefit **Hardware**	$1,500 per ear every 36 months	$1,500 per ear every 36 months	$1,500 per ear every 36 months
Pharmacy 30 day supply			
Preferred Generic – Tier 1	$5 Copay	$5 Copay	$5 Copay
Preferred Brand Name – Tier 2	$25 Copay	$25 Copay	$35 Copay ($30 Copay enhanced benefit)
Non-preferred – Tier 3	$50 Copay	$50 Copay	$70 Copay ($60 Copay enhanced benefit)

Rates	Retirees	Retirees	Retirees
Retiree	$2,032.05	$1,300.78	$2,091.56
Retiree/Spouse*	$3,292.87	$2,107.88	$3,389.31
Retiree/Children	$3,150.81	$2,016.95	$3,243.10
Retiree/Spouse*/Children	$4,902.39	$3,138.20	$5,046.01

or qualified domestic partner

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2023 RETIREE MEDICAL PLANS age 65 and over

Available to Medicare eligible retirees and eligible spouses only.*

MEDICARE SUPPLEMENTAL PLANS underwritten by United American Insurance Company			
	Plan F	**Plan G**	**High Deductible Plan G**
Eligibility	**Must turn 65 by 1/1/2021**	**Enrollment open to all**	
Overall Deductible	No Deductible	TBD for 2023 (Part B Deductible)	TBD for 2023 (includes Part B Deductible)
Part A Deductible	Covered in Full	Covered in Full	Deductible; then Covered in Full
Hospitalization & Skilled Nursing Coinsurance	Covered in Full	Covered in Full	Deductible; then Covered in Full
Part B Deductible	Covered in Full	TBD (Part B Deductible)	TBD (see Overall Deductible)
Part B Coinsurance	Covered in Full	Covered in Full	Deductible; then Covered in Full
Foreign Travel	$250 Deductible 20% to $50,000 lifetime maximum	$250 Deductible 20% to $50,000 lifetime maximum	$250 Deductible 20% to $50,000 lifetime maximum
Maximum out of pocket expenses (Rx excluded)	All Medicare Eligible Expenses Covered in Full	After Part B Deductible, All Medicare Eligible Expenses Covered in Full	After TBD (includes Part B Deductible); All Medicare Eligible Expenses Covered in Full

Part D prescription drug plan options provided by UnitedHealthcare (UHC)		
Plan Name	WCIF RX Plan A	WCIF RX Plan B
Prescription Deductible	No Deductible	$480 Deductible
Generics (30-day supply)	$5 Copay	$15 Copay
Preferred Brands (30-day supply)	$40 Copay	$47 Copay
Non-Preferred Brands (30-day supply)	$75 Copay	$100 Copay
Mail Order (90-day supply)	$10 Generics / $80 Preferred / $180 Non-Preferred	$30 Generics / $94 Preferred / $200 Non-Preferred
Specialty Drugs (retail or mail order)	33% Coinsurance	33% Coinsurance
Maximum Benefit	Unlimited	Unlimited

2022 Monthly Rates			
Plan name (with WCIF RX Plan A)	**Plan F (with WCIF RX Plan A)**	**Plan G (with WCIF RX Plan A)**	**High Deductible Plan G (with WCIF RX Plan A)**
Per participant	$449.83	$434.83	$245.83
Plan name (with WCIF RX Plan B)	**Plan F (with WCIF RX Plan B)**	**Plan G (with WCIF RX Plan B)**	**High Deductible Plan G (with WCIF RX Plan B)**
Per participant	$397.43	$382.43	$193.43

**or qualified domestic partner*

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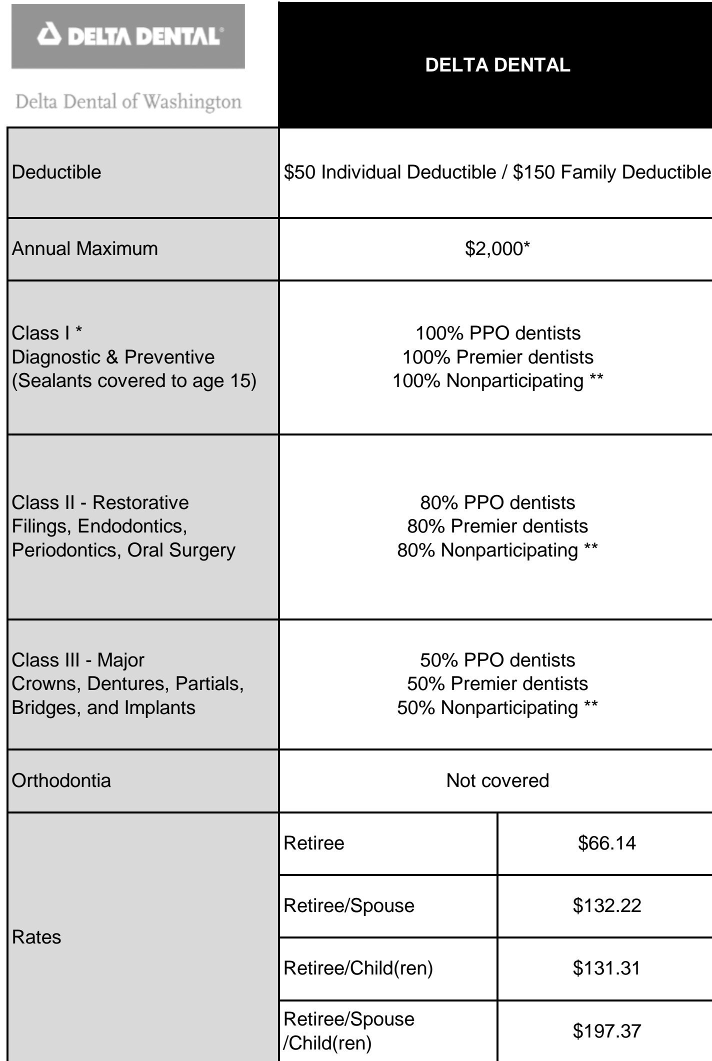
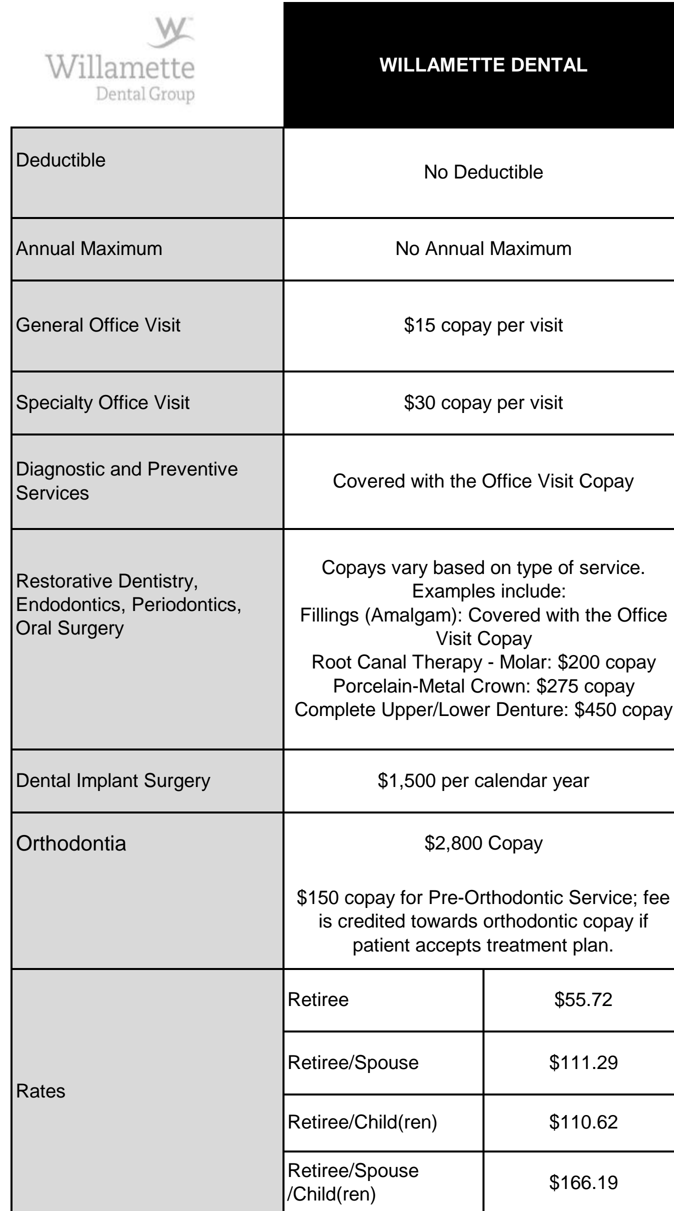
2023 RETIREE DENTAL and VISION PLANS



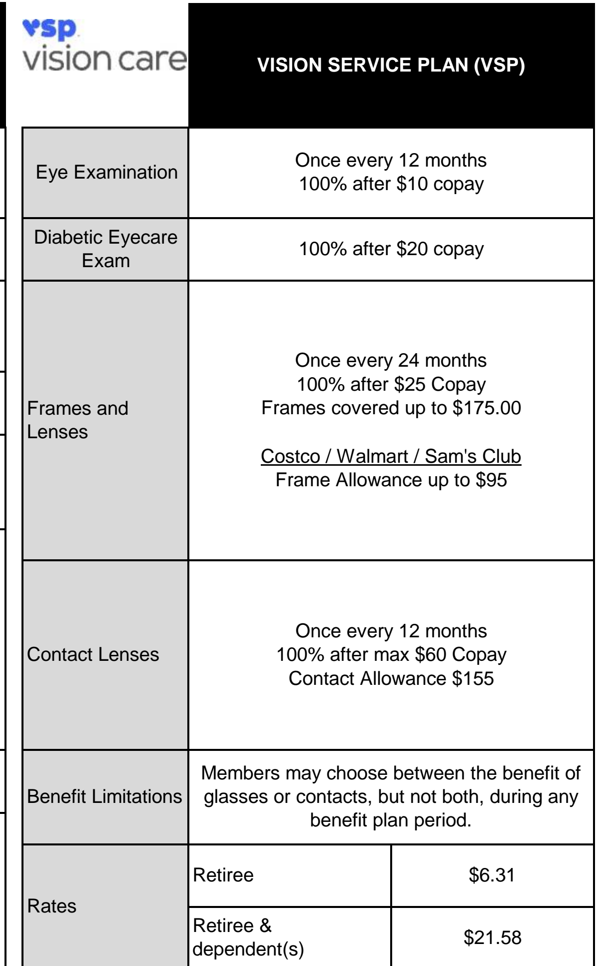
	DELTA DENTAL	
Deductible	$50 Individual Deductible / $150 Family Deductible	
Annual Maximum	$2,000*	
Class I * Diagnostic & Preventive (Sealants covered to age 15)	100% PPO dentists 100% Premier dentists 100% Nonparticipating **	
Class II - Restorative Filings, Endodontics, Periodontics, Oral Surgery	80% PPO dentists 80% Premier dentists 80% Nonparticipating **	
Class III - Major Crowns, Dentures, Partials, Bridges, and Implants	50% PPO dentists 50% Premier dentists 50% Nonparticipating **	
Orthodontia	Not covered	
Rates	Retiree	$66.14
	Retiree/Spouse	$132.22
	Retiree/Child(ren)	$131.31
	Retiree/Spouse /Child(ren)	$197.37

Class 1 services do not calculate against Annual Maximum.

*** You will be responsible for any balance remaining. Please be aware that Delta Dental of Washington has no control over nonparticipating dentists' charges or billing practices.*



	WILLAMETTE DENTAL	
Deductible	No Deductible	
Annual Maximum	No Annual Maximum	
General Office Visit	$15 copay per visit	
Specialty Office Visit	$30 copay per visit	
Diagnostic and Preventive Services	Covered with the Office Visit Copay	
Restorative Dentistry, Endodontics, Periodontics, Oral Surgery	Copays vary based on type of service. Examples include: Fillings (Amalgam): Covered with the Office Visit Copay Root Canal Therapy - Molar: $200 copay Porcelain-Metal Crown: $275 copay Complete Upper/Lower Denture: $450 copay	
Dental Implant Surgery	$1,500 per calendar year	
Orthodontia	$2,800 Copay $150 copay for Pre-Orthodontic Service; fee is credited towards orthodontic copay if patient accepts treatment plan.	
Rates	Retiree	$55.72
	Retiree/Spouse	$111.29
	Retiree/Child(ren)	$110.62
	Retiree/Spouse /Child(ren)	$166.19



	VISION SERVICE PLAN (VSP)	
Eye Examination	Once every 12 months 100% after $10 copay	
Diabetic Eyecare Exam	100% after $20 copay	
Frames and Lenses	Once every 24 months 100% after $25 Copay Frames covered up to $175.00 Costco / Walmart / Sam's Club Frame Allowance up to $95	
Contact Lenses	Once every 12 months 100% after max $60 Copay Contact Allowance $155	
Benefit Limitations	Members may choose between the benefit of glasses or contacts, but not both, during any benefit plan period.	
Rates	Retiree	$6.31
	Retiree & dependent(s)	$21.58

NOTE: Extra discounts, value-added benefits, and savings apply when using a VSP provider. Please refer to the plan summary for more information. If you decide to use an Out-of-Network provider, you are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. Benefit frequency limits apply for both VSP and Out-of-Network coverage.

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