Washington Counties Insurance Fund

2020 Benefit Plan Comparison for Retirees

- **Retiree Medical Plans for Under Age 65 (former WCIF medical enrollees only)**
- **Retiree Medical Plans for Over Age 65 (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.

PREMERA BLUE CROSS

2020 PREMERA BLUE CROSS PPO MEDICAL PLANS for under age 65

	WCIF 750	WCIF 3000	LEOFF 1 Only WCIF 200
Provider Network	**For Out-of-Network benefits, please see full plan summary**		
Deductible (Ded) PCY **Individual** **Family**	$750 $1,500	$3,000 $6,000	$200 $400
Coinsurance (Coins)	20%	20%	20%
Out-of-pocket max (includes deductible, coinsurance, and copays) **Individual** **Family**	$5,750 $11,500	$6,350 $12,700	$2,200 $4,400
Office Visit Cost Share	$30 Copay	$35 Copay	$25 Copay
Preventive Care	Covered in Full	Covered in Full	Covered in Full
Manipulations (spinal)	20 visits PCY $30 Copay	20 visits PCY $35 Copay	20 visits PCY $25 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	$200 Copay Ded / Coins	$150 Copay Ded / Coins
Hearing Benefit **1 Exam Per Calendar Year**	**$30 Copay**	**$35 Copay**	**$25 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
Rates	**Retirees**	**Retirees**	**LEOFF 1 Retirees**
Retiree	$1,314.97	$974.43	$1,443.23
Retiree/Spouse*	$2,662.82	$1,973.22	$2,922.54
Retiree/Children	$2,301.21	$1,705.25	$2,525.66
Retiree/Spouse*/Children	$3,616.17	$2,679.68	$3,968.87

**or qualified domestic partner*

KAISER PERMANENTE® 2020 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 summary**	
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**	**$1,000 per ear every 36 months**		**$1,000 per ear every 36 months**	**$1,000 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**	**LEOFF 1 Retirees**	**Retirees**	**Retirees**	**LEOFF 1 Retirees**
Retiree	$1,771.55	$1,944.27	$1,134.03	$1,823.44	$1,996.15
Retiree/Spouse*	$2,870.73	$3,043.45	$1,837.66	$2,954.81	$3,127.54
Retiree/Children	$2,746.88	$2,919.60	$1,758.38	$2,827.35	$3,000.07
Retiree/Spouse*/Children	$4,273.92	$4,446.64	$2,735.90	$4,399.12	$4,571.84

**or qualified domestic partner*

2020 RETIREE MEDICAL PLANS over age 65

Available to >65 Medicare eligible retirees and eligible spouses only.*

MEDICARE SUPPLEMENTAL PLANS underwritten by United American Insurance Company			
	Plan F	**High Deductible Plan F**	**Plan G**
Eligibility	**Must be eligible (age 65) prior to 1/1/2020 to elect Plan F**		**Enrollment open to all**
Overall Deductible	No Deductible	$2,240 (includes Part B Deductible)	Part B Deductible
Part A Deductible	Covered in Full	Deductible; then Covered in Full	Covered in Full
Hospitalization	Covered in Full	Deductible; then Covered in Full	Covered in Full
Skilled Nursing Coinsurance	Covered in Full	Deductible; then Covered in Full	Covered in Full
Part B Deductible	Covered in Full	Deductible; then Covered in Full	Part B Deductible
Part B Coinsurance	Covered in Full	Deductible; then Covered in Full	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)	No Deductible; Medicare Eligible Expenses Only	$2,240 (includes Part B Deductible); Medicare Eligible Expenses Only	Part B Deductible; Medicare Eligible Expenses Only

Part D prescription drug plan provided by UnitedHealthcare (UHC)		
Prescription Deductible	No Deductible	
Generics	$5 Copay	Mail Order: $10 Copay
Preferred Brands	$40 Copay	Mail Order: $80 Copay
Non-Preferred Brands	$75 Copay	Mail Order: $180 Copay
Specialty Drugs	33% Coinsurance	Mail Order: 33% Coinsurance
Maximum Benefit	Unlimited	

Monthly plan rates include Part D prescription drug plan			
Plan name	**Plan F**	**High Deductible Plan F**	**Plan G**
Per participant	$434.50	$246.50	$421.50

**or qualified domestic partner*

2020 RETIREE DENTAL and VISION PLANS

Delta Dental of Washington	DELTA DENTAL	
Deductible	$50 per person $150 per family	
Annual Maximum	$2,000*	
Class I * Diagnostic & Preventive (Sealants covered to age 15)	80% PPO dentists 80% Premier dentists 80% 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	$62.05
	Retiree/Spouse	$124.03
	Retiree/Child(ren)	$123.18
	Retiree/Spouse /Child(ren)	$185.15

** 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 Group	WILLAMETTE DENTAL	
Deductible	No Deductible	
Annual Maximum	No Annual Maximum	
General Office Visit	$15 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	
Specialty Office Visit	$30 copay per visit	
Orthodontia	$2,800 Copay $150 copay for Pre-Orthodontic Service; fee is credited towards orthodontic copay if patient accepts treatment plan.	
Rates	Retiree	$57.63
	Retiree/Spouse	$115.15
	Retiree/Child(ren)	$114.43
	Retiree/Spouse /Child(ren)	$171.96

VSP	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 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.