



# Washington Counties Insurance Fund 2021 Benefit Plan Comparison for Retirees

- **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](http://www.wcif.net). For information about billing, eligibility, and other plan administration, please contact Retiree Administration at Vimly.*



BLUE CROSS

## 2021 PREMERA BLUE CROSS PPO MEDICAL PLANS for under age 65

	WCIF 200	WCIF 750	WCIF 3000
<b>Provider Network</b>	For Out-of-Network benefits, please see full plan summary		
<b>Deductible (Ded) PCY</b>			
Individual	\$200	\$750	\$3,000
Family	\$400	\$1,500	\$6,000
<b>Coinsurance (Coins)</b>	20%	20%	20%
<b>Out-of-pocket max</b> (includes deductible, coinsurance, and copays)			
Individual	\$2,200	\$5,750	\$6,350
Family	\$4,400	\$11,500	\$12,700
<b>Office Visit Cost Share</b>	\$25 Copay	\$30 Copay	\$35 Copay
<b>Preventive Care</b>	Covered in Full	Covered in Full	Covered in Full
<b>Manipulations (spinal)</b>	20 visits PCY \$25 Copay	20 visits PCY \$30 Copay	20 visits PCY \$35 Copay
<b>Diagnostic Lab and X-ray Services</b> Some services may require pre-authorization	Ded / Coins	Ded / Coins	Ded / Coins
<b>Inpatient Hospital</b>	Ded / Coins	Ded / Coins	Ded / Coins
<b>Outpatient Surgery Facility</b>	\$75 Copay Ded / Coins	\$75 Copay Ded / Coins	\$75 Copay Ded / Coins
<b>Emergency Care Copay</b> (waive copay if admitted)	\$150 Copay Ded / Coins	\$150 Copay Ded / Coins	\$200 Copay Ded / Coins
<b>Hearing Benefit</b> 1 Exam Per Calendar Year	\$25 Copay	\$30 Copay	\$35 Copay
<b>Hearing Benefit</b> 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
<b>Pharmacy 30 day supply</b>			
<b>Generic – Tier 1</b>	\$5 Copay	\$5 Copay	\$5 Copay
<b>Brand Name – Tier 2</b>	\$35 Copay	\$35 Copay	\$35 Copay
<b>Non-formulary – Tier 3</b>	\$70 Copay	\$70 Copay	\$70 Copay
<b>Monthly Rates</b>			
<b>Retiree</b>	\$1,645.61	\$1,499.37	\$1,111.06
<b>Retiree/Spouse*</b>	\$3,291.21	\$2,998.72	\$2,222.14
<b>Retiree/Children</b>	\$2,879.82	\$2,623.89	\$1,944.37
<b>Retiree/Spouse*/Children</b>	\$4,525.42	\$4,123.25	\$3,055.43

\*or qualified domestic partner

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## 2021 KAISER PERMANENTE MEDICAL PLAN under age 65

	Core 750		Core 5000		ACCESS PPO 5000	
<b>Provider Network</b>	HMO In-Network Only		HMO In-Network Only		For Out-of-Network benefits, see full plan summary	
<b>Deductible (Ded)</b>						
<b>Individual</b>	\$750		\$5,000		\$5,000	
<b>Family</b>	\$1,500		\$10,000		\$10,000	
<b>Coinsurance (Coins)</b>	20%		20%		20%	
<b>Out-of-pocket max</b> (Includes deductible, coinsurance, and copays)						
<b>Individual</b>	\$2,700		\$5,000		\$5,000	
<b>Family</b>	\$5,400		\$10,000		\$10,000	
<b>Office Visit Cost Share</b>	\$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).	
<b>Preventive Care</b>	Covered in Full		Covered in Full		Covered in Full	
<b>Manipulations (spinal)</b> 20 visits PCY	\$20 Copay; Ded / Coins		\$20 Copay; Ded / Coins		\$30 Copay; Ded / Coins	
<b>Outpatient Diagnostic Laboratory and X-ray Services</b> 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.	
<b>Inpatient Facility</b>	Ded / Coins		Ded / Coins		\$100 Copay, per day for up to 5 days per admit Ded / Coins	
<b>Outpatient Surgery Facility</b>	\$20 Copay; Ded / Coins		\$20 Copay; Ded / Coins		Ded / Coins	
<b>Emergency Care</b> (waive copay if admitted)	\$100 Copay; Ded / Coins		\$100 Copay; Ded / Coins		\$100 Copay Ded / Coins	
<b>Hearing Benefit</b> 1 Exam Per Calendar Year	\$20 Copay; Ded / Coins		\$20 Copay; Ded / Coins		\$30 Copay (\$20 Copay enhanced benefit); Ded / Coins	
<b>Hearing Benefit Hardware</b>	\$1,500 per ear every 36 months		\$1,500 per ear every 36 months		\$1,500 per ear every 36 months	
<b>Pharmacy 30 day supply</b>						
<b>Preferred Generic – Tier 1</b>	\$5 Copay		\$5 Copay		\$5 Copay	
<b>Preferred Brand Name – Tier 2</b>	\$25 Copay		\$25 Copay		\$35 Copay (\$30 Copay enhanced benefit)	
<b>Non-preferred – Tier 3</b>	\$50 Copay		\$50 Copay		\$70 Copay (\$60 Copay enhanced benefit)	
<b>Rates</b>	<b>Retirees</b>	<b>LEOFF 1 Retirees</b>	<b>Retirees</b>	<b>Retirees</b>	<b>LEOFF 1 Retirees</b>	
<b>Retiree</b>	\$1,873.60	\$2,039.19	\$1,199.35	\$1,928.47	\$2,094.07	
<b>Retiree/Spouse*</b>	\$3,036.09	\$3,201.69	\$1,943.51	\$3,125.02	\$3,290.62	
<b>Retiree/Children</b>	\$2,905.12	\$3,070.71	\$1,859.67	\$2,990.21	\$3,155.81	
<b>Retiree/Spouse*/Children</b>	\$4,520.11	\$4,685.71	\$2,893.49	\$4,652.52	\$4,818.12	

\*or qualified domestic partner

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## 2021 RETIREE MEDICAL PLANS age 65 and over

Available to Medicare eligible retirees and eligible spouses\* only.

<b>MEDICARE SUPPLEMENTAL PLANS</b> underwritten by United American Insurance Company			
	<b>Plan F</b>	<b>Plan G</b>	<b>High Deductible Plan G</b>
<b>Eligibility</b>	<b>Must turn 65 by 1/1/2020</b>	<b>Enrollment open to all</b>	
Overall Deductible	No Deductible	\$203 (Part B Deductible)	<b>\$2,370 (includes Part B Deductible)</b>
Part A Deductible	Covered in Full	Covered in Full	<b>Deductible; then Covered in Full</b>
Hospitalization & Skilled Nursing Coinsurance	Covered in Full	Covered in Full	<b>Deductible; then Covered in Full</b>
Part B Deductible	Covered in Full	\$203 (Part B Deductible)	<b>\$203 (see Overall Deductible)</b>
Part B Coinsurance	Covered in Full	Covered in Full	<b>Deductible; then Covered in Full</b>
Foreign Travel	\$250 Deductible 20% to \$50,000 lifetime maximum	\$250 Deductible 20% to \$50,000 lifetime maximum	<b>\$250 Deductible</b> <b>20% to \$50,000 lifetime maximum</b>
Maximum out of pocket expenses (Rx excluded)	All Medicare Eligible Expenses Covered in Full	After \$203 Part B Deductible, All Medicare Eligible Expenses Covered in Full	<b>After \$2,370 (includes Part B Deductible);</b> <b>All Medicare Eligible Expenses Covered in Full</b>

<b>Part D prescription drug plan options provided by UnitedHealthcare (UHC)</b>		
Plan Name	WCIF RX Plan A	<b>WCIF RX Plan B - <u>NEW OPTION FOR 2021</u></b>
Prescription Deductible	No Deductible	<b>\$445 Deductible</b>
Generics (30-day supply)	\$5 Copay	<b>\$15 Copay</b>
Preferred Brands (30-day supply)	\$40 Copay	<b>\$47 Copay</b>
Non-Preferred Brands (30-day supply)	\$75 Copay	<b>\$100 Copay</b>
Mail Order (90-day supply)	\$10 Generics / \$80 Preferred / \$180 Non-Preferred	<b>\$30 Generics / \$94 Preferred / \$200 Non-Preferred</b>
Specialty Drugs (retail or mail order)	33% Coinsurance	<b>33% Coinsurance</b>
Maximum Benefit	Unlimited	<b>Unlimited</b>


<b>2021 Monthly Rates</b>			
Plan name (with WCIF RX Plan A)	<b>Plan F (with WCIF RX Plan A)</b>	<b>Plan G (with WCIF RX Plan A)</b>	<b>High Deductible Plan G (with WCIF RX Plan A)</b>
Per participant	\$446.18	\$431.18	\$242.18
Plan name (with WCIF RX Plan B)	<b>Plan F (with WCIF RX Plan B)</b>	<b>Plan G (with WCIF RX Plan B)</b>	<b>High Deductible Plan G (with WCIF RX Plan B)</b>
Per participant	\$399.01	\$384.01	\$195.01

\*or qualified domestic partner

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## 2021 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 Fillings, 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		
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	
<b>Dental Implant Surgery</b>	<b>\$1,500 per calendar year</b>	
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

 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  <u>Costco / Walmart / Sam's Club</u> 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.*