

WSWHE COUNTIES Health Insurance Trust

2017 - 2018

WSWHE Consortium	PPO		Alternate PPO		HRA		Gold Plan PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefit								
Cost Sharing	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Deductible	N/A	\$200 Individual \$500 Family	N/A	\$200 Individual \$500 Family	\$1,500 Individual \$3,000 Family (Employer funds \$1,000 Individual, \$2,000 Family)	\$1,500 Individual \$3,000 Family (Employer funds \$1,000 Individual, \$2,000 Family)	\$1,000 Individual \$2,500 Family	\$2,000 Individual \$5,000 Family
Coinurance	N/A	20%	N/A	20%	10%	30%	20%	50%
Annual Coinsurance Stop-Loss	N/A	\$5,000 Individual / \$12,500 Family in covered services PCY, payments increase to 100% of U&C	N/A	\$5,000 Individual / \$12,500 Family in covered services PCY, payments increase to 100% of U&C	\$19,250 Individual / \$38,500 Family in covered services PCY, payments increase to 100% of U&C	\$20,000 Individual / \$40,000 Family in covered services PCY, payments increase to 100% of U&C	\$20,000 Individual / \$50,000 Family in covered services PCY	\$25,000 Individual / \$62,500 Family in covered services PCY
Annual Out-of-Pocket Max	\$5,080 Individual / \$12,700 Family	\$1,200 Individual / \$3,000 Family	\$5,080 Individual / \$12,700 Family	\$1,200 Individual / \$3,000 Family	\$3,425 Individual / \$6,850 Family	\$7,500 Individual / \$15,000 Family	\$5,000 Individual / \$12,500 Family	\$14,500 Individual / \$36,250 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Dependent Children	Dependent children covered to age 26 (covered through end of month)	Dependent children covered to age 26 (covered through end of month)	Dependent children covered to age 26 (covered through end of month)	Dependent children covered to age 26 (covered through end of month)	Dependent children covered to age 26 (covered through end of month)	Dependent children covered to age 26 (covered through end of month)	Dependent children covered to age 26 (covered through end of month)	Dependent children covered to age 26 (covered through end of month)

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HOSPITAL BENEFITS	PPO		Alternate PPO		HRA		Gold Plan PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Cost Sharing								
Inpatient <sup>1</sup> (Except Mental Health) Unlimited days, semi-private room and board	\$0 (Covered in full)	Deductible/ Coinsurance	\$0 (Covered in full)	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Inpatient Physical Therapy, Physical Medicine, or Rehabilitation <sup>1</sup>	\$0 90 days PCY	Deductible/ Coinsurance 90 days PCY	\$0 90 days PCY	Deductible/ Coinsurance 90 days PCY	Deductible/ Coinsurance 90 days PCY	Deductible/ Coinsurance 90 days PCY	Deductible/ Coinsurance 90 days PCY	Covered In-network Only
Mental Health <sup>1,2,3</sup>	\$0 Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	\$0 Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY
Alcohol/Substance Abuse Detox <sup>1,2,3</sup>	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY
alcohol/substance rehab <sup>1,2,3</sup>	\$0 Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	\$0 Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY
Outpatient ambulatory surgery <sup>1</sup> , pre-surgical testing, chemotherapy, radiation therapy, mammography, and cervical cancer screening	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	\$25/\$40 copayment will apply to visit services (examinations and evaluations); Other services performed will be subject to In-Network Deductible and Coinsurance	Deductible/ Coinsurance
Emergency Room/Facility Initial visit for emergency care	\$35 per visit (waived if admitted to hospital within 24 hours)	\$35 per visit (waived if admitted to hospital within 24 hours)	\$200 per visit (waived if admitted to hospital within 24 hours)	\$200 per visit (waived if admitted to hospital within 24 hours)	Deductible/ Coinsurance	Deductible/ Coinsurance	\$150 per visit (waived if admitted to hospital within 24 hours)	\$150 per visit (waived if admitted to hospital within 24 hours)
Urgent Care	\$10 copay	\$10 copay	\$50 copay	\$50 copay	Deductible/ Coinsurance	Deductible/ Coinsurance	\$40 copay	\$40 copay

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	PPO		Alternate PPO		HRA		Gold Plan PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>OTHER FACILITY BENEFITS</b>								
Cost Sharing	Member Pays Outpatient facility: \$0 copay Office setting: \$10 copay Unlimited visits PCY	Member Pays Deductible/ Coinsurance Unlimited visits PCY	Member Pays Outpatient facility: \$0 copay Office setting: \$30 copay Unlimited visits PCY	Member Pays Deductible/ Coinsurance Unlimited visits PCY	Member Pays Deductible/ Coinsurance Unlimited visits PCY	Member Pays Outpatient facility: 20% coinsurance Office setting: \$25 copay Unlimited visits PCY	Member Pays Outpatient facility: 20% coinsurance Office setting: \$25 copay Unlimited visits PCY	Member Pays Deductible/ Coinsurance Unlimited visits PCY
Home Health Care	\$0 Up to 200 visits PCY	20% Coins only. No Deductible 200 visits PCY	\$0 200 visits PCY	20% Coins only. No Deductible 200 visits PCY	Coinsurance No Deductible 200 visits PCY	20% Coins only. No Deductible 100 visits PCY	20% Coins only. No Deductible 101 visits PCY	20% Coins only. No Deductible 101 visits PCY
Home Infusion Therapy	\$0	Not covered	\$0	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance	Not covered	Not covered
Outpatient Kidney Dialysis	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Hospice	\$0 210 days per lifetime	Not covered	\$0 210 days per lifetime	Not covered	Deductible/ Coinsurance 210 days per lifetime	Deductible/ Coinsurance 210 days per lifetime	Not covered	Not covered
Skilled Nursing Facility	\$0 120 days PCY	Not covered	\$0 120 days PCY	Not covered	Deductible/ Coinsurance 120 days PCY	Deductible/ Coinsurance 120 days PCY	Not covered	Not covered
<b>MEDICAL BENEFITS</b>								
Cost Sharing	Member Pays \$10 co-pay	Member Pays Deductible/ Coinsurance	Member Pays \$30/\$50 co-pay	Member Pays Deductible/ Coinsurance	Member Pays Deductible/ Coinsurance	Member Pays Deductible/ Coinsurance	Member Pays Deductible/ Coinsurance	Member Pays Deductible/ Coinsurance
Home/Office Visits	\$0	Not covered	\$0	Not covered	\$0 (Covered in full)	\$0	\$0	Not covered
Annual Physical Exam	\$0	Not covered	\$0	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance	\$25/\$40 co-pay	Deductible/ Coinsurance
Well Child Care (Including necessary immunizations)	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	\$0	\$0	\$0	Deductible/ Coinsurance

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MEDICAL BENEFITS cont'd	PPO		Alternate PPO		HRA		Gold Plan PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Cost Sharing								
Well Woman Care	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance
Inpatient Visits	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Diagnostic Screening & Mammography	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Maternity	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Surgery	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Infertility (Artificial Insemination is covered, IVF is excluded)	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Surgical Assistant	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance

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MEDICAL BENEFITS cont'd	PPO		Alternate PPO		HRA		Gold Plan PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Cost Sharing								
Anesthesiology	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Lab, X-ray	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
MRI <sup>1</sup>	\$0	Deductible/ Coinsurance	\$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Mental Health <sup>2,3</sup>	Outpatient facility: \$0 copay Office setting: \$10 copay Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	Outpatient facility: \$0 copay Office setting: \$30 copay Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY	Outpatient facility: 20% coinsurance Office setting: \$25 copay Unlimited visits PCY	Deductible/ Coinsurance Unlimited visits PCY
Allergy Testing & Treatment	\$10 copay (waived for treatment)	Deductible/ Coinsurance	\$30/\$50 copay (waived for treatment)	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	\$25/\$40 copayment testing subject to deductible & coinsurance	Deductible/ Coinsurance
Second Surgical Opinion	\$10 co-pay	Deductible/ Coinsurance	\$30/\$50 co-pay	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	\$25/\$40 copayment will apply to visit services, other services performed will be subject to In-Network Deductible and Coinsurance	Deductible/ Coinsurance

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MEDICAL BENEFITS cont'd	PPO		Alternate PPO		HRA		Gold Plan PPO	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Cost Sharing	\$10 co-pay	Not covered	\$30/\$50 co-pay	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance	\$25/\$40 copayment will apply to visit services, other services performed will be subject to In-Network Deductible and Coinsurance	Member Pays Not covered
Physical Therapy <sup>1</sup>	90 visits PCY	Not covered	90 visits PCY	Not covered	90 visits PCY	90 visits PCY	90 visits PCY	90 visits PCY Not covered
Other Therapies <sup>1</sup>	\$10 co-pay	Not covered	\$30/\$50 co-pay	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance	\$25/\$40 copayment will apply to visit services, other services performed will be subject to In-Network Deductible and Coinsurance	Member Pays Not covered
(Occupational, Speech)	30 visits PCY	Not covered	30 visits PCY	Not covered	30 visits PCY	30 visits PCY	30 visits PCY	30 visits PCY Not covered
Cardiac Rehabilitation	\$10 co-pay per outpatient visit	Deductible/ Coinsurance	\$30/\$50 co-pay per outpatient visit	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	\$25/\$40 copayment will apply to visit services, other services performed will be subject to In-Network Deductible and Coinsurance	Member Pays Deductible/ Coinsurance
Medical Supplies	\$0	Difference between the allowed amount and the total charge (ded/coins do not apply)	\$0	Difference between the allowed amount and the total charge (ded/coins do not apply)	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance In-network benefits apply
Durable Medical Equipment	\$0	Not covered	\$0	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance	50% coinsurance (not subject to deductible)	Member Pays Not covered
Prosthetics, & Orthotics <sup>1</sup>	\$0	Not covered	\$0	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance	50% coinsurance (not subject to deductible)	Member Pays Not covered

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MEDICAL BENEFITS cont'd	PPO		Alternate PPO		HRA		Gold Plan PPO	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Cost Sharing	\$0	You pay the difference between the allowed amount and the total charge	\$0	You pay the difference between the allowed amount and the total charge	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	In-network benefits apply
Ambulance	\$0		\$0					
Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Air Ambulance	\$0 up to the allowed amount	Subject to in-network benefits	\$0 up to the allowed amount	Subject to in-network benefits	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	In-network benefits apply
Chiropractic Care	\$10 co-pay	Deductible/ Coinsurance	\$30/\$50 co-pay	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	\$25/\$40 co-pay	Deductible/ Coinsurance
Hearing Aids	Not Covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Prescription Drug	\$5 generic \$10 brand \$25 non-formulary brand	Not covered	\$10 generic \$25 brand \$50 non-formulary brand	Not covered	After deductible is met: \$10 generic \$20 brand \$40 non-formulary brand	Covered in-network only	\$100 deductible per person per calendar year (deductible does not apply to tier 1 generic drugs)  \$10 generic \$35 brand \$70 non-formulary brand	Not covered
	Mail Order - 2 copays per 90 day supply		Mail Order - 2 copays per 90 day supply		Mail Order - 2 copays per 90 day supply		Mail Order - 2 copays per 90 day supply	
	\$5 copay for 1 exam every 24 months, \$115 allowance for frames	Up to \$30 reimbursement for exams Up to \$64 reimbursement for frames	\$5 copay for 1 exam every 24 months, \$115 allowance for frames	Up to \$30 reimbursement for exams Up to \$64 reimbursement for frames	\$5 copay for 1 exam every 24 months, \$115 allowance for frames	\$5 copay for 1 exam every 24 months, \$115 allowance for frames	\$5 copay for 1 exam every 24 months, \$115 allowance for frames	Up to \$30 reimbursement for exams Up to \$64 reimbursement for frames
Routine Vision Benefits through Blue View Vision Must use the BVV - Insight Network	\$10 copay lenses, \$75 allowance for contact lenses	Up to \$25 reimbursement for Single vision lenses, \$35 for bifocal lenses, and \$45 for trifocal lenses	\$10 copay lenses, \$75 allowance for contact lenses	Up to \$25 reimbursement for Single vision lenses, \$35 for bifocal lenses, and \$45 for trifocal lenses	\$10 copay lenses, \$75 allowance for contact lenses	\$10 copay lenses, \$75 allowance for contact lenses	\$10 copay lenses, \$75 allowance for contact lenses	Up to \$25 reimbursement for Single vision lenses, \$35 for bifocal lenses, and \$45 for trifocal lenses Up to \$75 reimbursement for Contact lenses.

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Participating Matrix provider accept the schedule of allowances payment as payment in full for those services that indicate "The difference between the charges and the schedule of allowances."

\* PCY = Per Calendar Year

- (1) For PPO and HRA only - you are responsible for obtaining precertification from Empire's Medical Management Program for these services provided in-area and out-of-area, in-network and out-of-network. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
- (2) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the copayment for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers. You are responsible for obtaining precertification from Empire's Medical Management Program for in-area and out-of-area out-of-network services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
- (3) Per the Federal Mental Health Parity Mandate, effective 7/1/2010 the consolidated WSWHE benefit plan will offer existing mental health and substance abuse coverage in parity with medical and surgical benefits. This requires benefit modifications, which may include, but not be limited to changes for coinsurance amounts, copayment amounts, visit maximums, inpatient day limitations, and outpatient stay maximums.

Alternate PPO / Gold Plan PPO: The following practitioners receive the lower (primary) copay for services provided in an office: Patient's PCP, obstetrics, gynecologists, certified nurse midwives, chiropractors, and physical, occupational, speech and vision therapists. The higher (specialist) copay will apply for all other specialists when a copay is required, and for services received in an outpatient facility for physical and other speech, language, occupational, vision and cardiac therapy.

the terms, conditions, limitations, and exclusions set forth in the contract.

Last update 3/17/2017