WSWHE COUNTIES Health Insurance Trust

2018 - 2019

WSWHE Consortium	Alternate PPO		HRA		Gold Plan PPO	
Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**In-Network**	**Member Pays**
Deductible	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
			*Deductible is combined In and Out of Network. **For 2-person and family contracts, one individual can satisfy the full $3,000 Family deductible.			
Coinsurance	**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	$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	$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
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)

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	Alternate PPO		HRA		Gold Plan PPO	
HOSPITAL BENEFITS	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Inpatient[1] **(Except Mental Health) Unlimited days, semi-private room and board**	$0 (Covered in full)	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Inpatient Physical Therapy, Physical Medicine, or Rehabilitation[1]	$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[1 2 3]	$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[1 2 3]	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance Unlimited days PCY	Deductible/ Coinsurance Unlimited days PCY
alcohol/substance rehab[1 2 3]	$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[1], pre-surgical testing, chemotherapy, radiation therapy, mammography, and cervical cancer screening	$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	$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	$50 copay	$50 copay	Deductible/ Coinsurance	Deductible/ Coinsurance	$40 copay	$40 copay

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	Alternate PPO		HRA		Gold Plan PPO	
OTHER FACILITY BENEFITS	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Alcohol/Substance Abuse[1] [2 3]	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
Home Health Care	$0 200 visits PCY	20% Coins only. No Deductible 200 visits PCY	Coinsurance 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
Home Infusion Therapy	$0	Not covered	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Not covered
Outpatient Kidney Dialysis	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Hospice	$0 210 days per lifetime	Not covered	Deductible/ Coinsurance 210 days per lifetime	Deductible/ Coinsurance 210 days per lifetime	Deductible/ Coinsurance	Not covered
Skilled Nursing Facility[1]	$0 120 days PCY	Not covered	Deductible/ Coinsurance 120 days PCY	Deductible/ Coinsurance 120 days PCY	Deductible/ Coinsurance 90 days PCY	Not covered
MEDICAL BENEFITS	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Home/Office Visits	$30/$50 co-pay	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	$25/$40 co-pay	Deductible/ Coinsurance
Annual Physical Exam	$0	Not covered	$0 (Covered in full)	Deductible/ Coinsurance	$0	Not covered
Well Child Care (Including necessary immunizations)	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance	$0	Deductible/ Coinsurance

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

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	Alternate PPO		HRA		Gold Plan PPO	
MEDICAL BENEFITS cont'd	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Cost Sharing	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Anesthesiology	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Lab, X-ray	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
MRI[1]	$0	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Mental Health[2 3]	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	$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	$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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2018 - 2019

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

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2018 - 2019

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

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.

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

Last update 3/17/2017