

COMPARISON OF BENEFIT OPTIONS



The chart on the following pages is designed to compare Uniform Benefits, the Standard Plan and the Medicare Plus Plan.

This outline is not intended to be a complete description of coverage. The Uniform Benefits package is described in detail in your *It's Your Choice: Reference Guide*. Details for the other plans are found in the *Standard Plan* (ET-2131), and the *Medicare Plus* (ET-4113) benefit booklets.

Differences might exist among the health plans in the administration of the Uniform Benefits packages. Slight differences may also exist in benefits such as dental or wellness programs, and treatment may vary depending on patient needs, the physicians' preferred practices, and the managed care policies and procedures of the health plan.

Note: Footnotes below refer to the chart on the following pages.

¹ Deductible applies to all Uniform Benefits medical services when employer selects deductible option. Deductible applies to Standard Plan services. Deductible does not apply to certain preventive services and prescription drugs.

² PPOs have out-of-network deductibles. See PPO Plan Descriptions (WEA Trust PPOs and WPS Metro Choice) for details.

³ Coinsurance out-of-pocket limit (OOPL) does not include deductible.

⁴ PPOs have out-of-network coinsurance. See *Health Plan Descriptions* for details.

⁵ This is separate from other out-of-pocket limit (OOPL), such as the medical.

⁶ Level 3 copays do not apply to the OOPL.

⁷ Medicare Plus supplements Medicare's payment up to 100% coverage. If Medicare denies, this plan also denies except as stated.

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BENEFIT	UNIFORM BENEFITS	STANDARD PLAN (If under Medicare Age)		MEDICARE Plus (and Medicare Part A, B and D ⁷)
		Preferred Provider	Non-Preferred Provider	
Annual Deductible ¹	No deductible ²	\$100 individual/ \$200 family	\$500 individual/ \$1,000 family	No deductible
Annual Coinsurance & OOP ³	As described below ⁴	None	80%/20% Annual OOP (includes deductible): \$2,000 individual/\$4,000 family	100%
Routine Preventive	One per year	100% ⁵	Deductible and coinsurance	100% covered by Medicare only
Hospital Days	As medically necessary, plan providers only. No day limit	Deductible, as medically necessary, no day limit	Deductible and coinsurance, as medically necessary, no day limit	100% 120 days; semi-private room
Emergency Room	\$60 copay per visit	\$75 copay per visit, deductible thereafter.	\$75 copay per visit, preferred provider deductible and coinsurance thereafter	100%, no copay
Ambulance	100%	Deductible	Deductible and coinsurance	100%
Transplants (May cover these and others listed)	<i>Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung</i>	Deductible <i>bone marrow, musculoskeletal, corneal, and kidney</i>	Deductible and coinsurance <i>bone marrow, musculoskeletal, corneal, and kidney</i>	100% for Medicare approved heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a Medicare-certified facility
Mental Health/ Alcohol & Drug Abuse	Inpatient, outpatient, and transitional, 100%	Deductible	Deductible and coinsurance	Inpatient 100%, up to 120 days. Outpatient & transitional 100%
Hearing Exam	100%	Benefit for illness or disease to deductible	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease 100%

Footnotes are explained on the preceding page.

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BENEFIT	UNIFORM BENEFITS	STANDARD PLAN (If under Medicare Age)		MEDICARE Plus (and Medicare Part A, B and D ⁷)
		Preferred Provider	Non-Preferred Provider	
Hearing Aid (per ear)	Every 3 years: Adults, 80%/20%, up to \$1,000; dependents younger than 18 years, 100%, maximum does not apply	For dependents younger than 18 years only, every 3 years—deductible	For dependents younger than 18 years only, every 3 years—deductible and coinsurance	For dependents younger than 18 years only, every 3 years—100%
Cochlear Implants	Adults, 80%/20% for device, surgery, follow-up sessions; 100% hospital charge for surgery. Dependents under 18, 100%	Dependents under 18, deductible for device, surgery, follow-up sessions	Dependents under 18, deductible and coinsurance for device, surgery, follow-up sessions	Dependents under 18, 100% for device, surgery, follow-up sessions
Routine Vision Exam	One per year	100% for children under age 5 ⁶ ; illness or disease only, deductible	No benefit for routine; illness or disease only, deductible and coinsurance	No benefit for routine; illness or disease only, 100%
Skilled Nursing Facility (non custodial care)	120 days per benefit period	Deductible, as medically necessary, 120 days per benefit period	Deductible and coinsurance, as medically necessary, 120 days per benefit period	100% 120 days/ benefit period at Medicare-approved facility. At non-Medicare-approved facility, if transferred within 24 hours of hospital release, benefits payable up to 30 days/confinement
Home Health (non custodial)	50 visits per year; plan may approve an additional 50	Deductible, 50 visits per plan year; plan may approve an additional 50	Deductible and coinsurance, 50 visits per plan year; plan may approve an additional 50	100%
Physical/ Speech/ Occupational Therapy	50 visits per year; plan may approve an additional 50	Deductible, 50 visits per plan year; plan may approve an additional 50	Deductible, 50 visits per plan year; plan may approve an additional 50	100%
Durable Medical Equipment	80%/20% coinsurance, \$500 OOPL	Deductible	Deductible and coinsurance	100%

Footnotes are explained on Page 22.

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		Preferred Provider	Non-Preferred Provider	
Hospital Pre-Certification	Varies by plan	WPS Medical Management for inpatient stays	WPS Medical Management for inpatient stays	None required
Referrals	In-network varies by plan; out-of-network required.	None required	Not required	Not required
Treatment for Morbid Obesity	Excluded	Deductible at Center of Excellence in-network provider	Non-preferred provider deductible and coinsurance outside Center of Excellence provider	100% for Medicare-covered service
Oral Surgery	11 procedures	23 procedures—deductible	23 procedures—deductible and coinsurance	100%
Dental Care	Varies by plan	No benefit	No benefit	No benefit
Drug Copays and OOPL ⁶ (non-specialty)	Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$410 individual/\$820 family	Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$1,000 individual/\$2,000 family	Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$1,000 individual/\$2,000 family	Level 1=\$5; 2=\$15; 3=\$35 ⁶ OOPL \$410 individual/\$820 family
Specialty Drug Copays and OOPL ⁶ Preferred Pharmacy	Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL	Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL	Not applicable	Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL
Specialty Drug Copays and OOPL ⁶ Non-Preferred Pharmacy	Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL	Not applicable	Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL	Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family; Non-formulary drugs \$50, no OOPL

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