

**SUMMARY OF THE WILSON COUNTY BOARD OF EDUCATION BENEFIT PLAN  
School Year 2010 - 2011**

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**MEDICAL BENEFITS**

**MAJOR MEDICAL DEDUCTIBLE – CALENDAR YEAR (JANUARY 1 TO DECEMBER 31)**

Deductibles must be satisfied each calendar year.	Deductible per individual Deductible per family	In-Network - \$500.00 In-Network - \$1,000.00	Out of Network - \$1,000.00 Out of Network - \$2,000.00
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**MAJOR MEDICAL – PERCENTAGE PAID AFTER DEDUCTIBLE HAS BEEN SATISFIED**

The individual is responsible for payment of all other expenses for any other non-covered medical expenses such as co-pays, amounts over usual & customary charges and any other non-covered medical expense for an Out-of-Network provider or facility.	In-Network Plan pays 90% - Employee pays 10% - Out-of-Network Plan pays 60% - Employee pays 40% -
Treatment at University Medical Center (except doctor's fees)	Plan pays 95% - Employee pays 5%

**OUT-OF-POCKET EXPENSE (O-O-P)**

The O-O-P expense <u>excludes</u> deductibles, prescriptions and any other non-covered medical expenses such as co-pays, amounts over usual & customary charges and, any other non-covered medical expense. After the O-O-P has been reached for the calendar year, the Plan will pay 100% of all subsequent claims for the remainder of the calendar year providing there is no secondary coverage.	In-Network Per Individual - \$1,000.00 - Per Family - \$ 2,000.00 Out-of-Network - Per Individual - \$2,000.00 - Per Family - \$ 4,000.00
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**EMERGENCY ROOM TREATMENT**

Emergency Room co-pay for a <u>non-medical</u> emergency per visit. The patient may also be charged an additional call back fee for the physician. The ER physician determines a medical vs. non-medical emergency. The co-pay is waived if the patient is admitted as an in-patient within 23 hours of the ER visit or the ER doctor determines the visit was a medical emergency. Payments are made under the major medical portion of the plan and subject to deductibles; NO ER treatment is paid at 100%.	In-network Co-pay - \$100.00 In-Network hospital Plan pays 90% UMC Plan pays 95% Out-of-Network Co-Pay - \$100.00 Out-of-Network Hospital Plan pay 60%
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**PRE-CERTIFICATION**

**In-Network Pre-certification is required** for in-patient hospital stays and certain outpatient procedures. **Pre-certification is the responsibility of the in-network provider. All contracted providers are educated and familiar with the CIGNA pre-certification policy.**

**The patient is responsible** for pre-certification for all hospital admissions, and these admissions are subject to continued stay review for **out-of-network providers and facilities**. If no pre-certification is obtained prior to the treatment or service, a penalty applies to the admission. The penalty or cost of denied benefits does not apply to the deductible or out-of-pocket maximum.

**RETAIL PRESCRIPTIONS  
MUST USE A PARTICIPATING PHARMACY**

<p align="center"><b>Retail Pharmacy Co-pays - 30-day supply</b></p> <p align="center">\$10.00 Co-pay for all Generic Drugs \$20.00 Co-pay for all Formulary Drugs \$40.00 Co-pay for all Non-Formulary Drugs (Or the actual cost of the medication if it is less than the co-pay) A participating pharmacy must be used. Any expenses paid out of pocket will require approval from the Central Office for reimbursement.</p>	<p align="center"><b>CIGNA Tel-Drug Pharmacy Co-pays - 90-day supply</b></p> <p align="center">\$20.00 Co-pay for all Generic Drugs \$40.00 Co-pay for all Formulary Drugs \$80.00 Co-pay for all Non-Formulary Drugs</p>
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**WELLNESS BENEFITS - NOT APPLIED to DEDUCTIBLES or O-O-P**

Annual Routine Wellness Physical Exam (patients four years and over)	Plan pays 100% up to a \$200.00 maximum.
Annual Women's Wellness OB/GYN Exam (office visit, pap smear & mammogram)	Plan pays 100% per calendar year.
Routine Mammography (Diagnostic mammography covered under major medical and subject to deductible)	In-Network provider - Plan pays 90% Out-of-Network - Plan pays 60%

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Post-mastectomy prosthesis (unlimited) Mastectomy bras (no limit)	Subject to major medical deductible In-Network provider - Plan pays 90% Out-of-Network – Plan pays 60%	
Routine Prostate Specific Antigen (PSA) no age limit	Plan pays 100% per calendar year	
Routine Colo-Rectal Screenings. Colonoscopy is a covered expense under the major medical	In-Network provider - Plan pays 100% In-Network provider - Plan pays 90% Subject to the deductible	Out-of-Network – Plan pays 60% Out-of-Network – Plan pays 60% Subject to the deductible
Corrective Shoes & Shoe Orthotics 4 corrective shoes and 4 inserts per calendar year	Subject to major medical deductible - In-Network provider - Plan pays 90% Out-of-Network – Plan pays 60%	
Childhood immunizations <u>required by the health department to attend school</u> . (Children only)	In-Network Provider Plan pays 100%	
Routine Well Child Care exams & immunizations ages 0 through age 3	Plan pay 100%	

**OTHER PLAN PROVISIONS**

Chiropractic Care - \$1,000.00 maximum per calendar year	In-Network provider - Plan pays 90% Subject to deductible	Out-of-Network provider – Plan pays 60% Subject to deductible
Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	60 combined visits per calendar year. In-Network provider - Plan pays 90% Subject to deductible	60 combined visits per calendar year Out-of-Network provider – Plan pays 60% Subject to deductible
Allergy testing and allergen immunotherapy including, injections of allergenic extracts and purchase of syringes.	In-Network provider - Plan pays 90% Subject to deductible	Out-of-Network provider – Plan pays 60% Subject to deductible
TMJ – Surgical and Non-Surgical Treatment is provided on a limited case by case basis, subject to medical necessity and pre-certification. Appliances and orthodontic treatment for TMJ is not covered under the major medical.		Plan pays 90% after deductible has been met. <b>In net-work providers only – no out-of network coverage</b>

**DENTAL BENEFITS**

**DENTAL DEDUCTIBLE – CALENDAR YEAR (JANUARY 1 TO DECEMBER 31)**

\$50.00 Individual deductible  
\$150.00 Family deductible

\$1,200 per calendar year maximum applies to Class I, Class II and Class III treatments per covered individual. You will not be balanced billed when using a contracted in-network dentist for any discounts. It is strongly recommended that you read the dental section of your Plan Booklet to understand what is and what is not covered before committing to a major procedure and expense. Routine exams do not have to be scheduled six months apart.

**Type I-Preventative Care – Deductible Waived**

2 cleanings & scaling - 2 bitewing x-rays	Plan pays 100% Per calendar year
1 full mouth x-ray per series	Plan pays 100% every 3 years
Fluoride treatment for children who have not reached their 14 <sup>th</sup> birthday (must be a covered dependent) Space Maintainer and their fitting	Plan pays 100% Per calendar year
Emergency treatment for dental pain when no other treatment but x-rays is given	Plan pays 100% Per calendar year

**Type II – Basic**

Diagnostic lab tests; extractions oral surgery; fillings- amalgam or synthetic process; Anesthetics/Nitrous Oxide only; Therapeutic injections; Root canals; Alveolectomy.	Plan pays 80% after deductible is met
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<p align="center"><b>Type III – Major Services</b></p> <p>Crowns; Inlays; Onlays; Prosthetics including dentures and bridges; Read the dental restrictions of your Plan Booklet if you have any specific questions.</p>	<p>Plan pays 50% (Deductibles apply if not applied for prior dental work in the same year.)</p>
<p align="center"><b>Type IV – Orthodontia Expense</b></p> <p>Coverage for eligible children and adults Read your Plan Booklet for exclusions and covered expenses</p>	<p>Plan pays 50% - no deductible \$1,000.00 per covered individual per lifetime</p>
<p align="center"><b>Type V - TMJ Services</b></p> <p>Coverage available for eligible children and adults Read your Plan Booklet for exclusions and covered expenses</p>	<p>Plan pays 50% - no deductible \$1,000.00 per covered individual per lifetime No out of network coverage</p>
<p align="center"><b>VI - Periodontal Expense</b></p> <p>Coverage available for eligible children and adults Read your Plan Booklet for exclusions and covered expenses.</p>	<p>Plan pays 80% after deductible \$1,000.00 per covered individual per lifetime.</p>

**Pre-Treatment Review / Determination**

When having major dental work done above \$200.00 make sure your dentist requests a pre-determination from CIGNA. A pre-determination will tell you exactly which procedure will or will not be covered as well as the cost of each procedure. The pre-determination gives you the opportunity to be selective in your treatment enabling the work to be scheduled at intervals, if necessary and according to your financial requirements.

**THE WILSON COUNTY BOARD OF EDUCATION’S MEDICAL AND DENTAL PLAN IS SELF-INSURED. WE USE THE CIGNA DISCOUNT NETWORK AND CIGNA PROVIDERS ONLY. WE ARE NOT INSURED BY CIGNA.**

**MEDICAL AND DENTAL BENEFITS APPLY TO EACH ENROLLED EMPLOYEE AND EACH ENROLLED DEPENDENT**

**Use of the CareHere Clinic is limited to enrolled employees/retirees and their enrolled dependents of the Wilson County Board of Education Group Medical Plan.**

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**CAREHERE (Free Clinic) PROGRAM**

Employees and dependents that are enrolled in our healthcare program are eligible for access to FREE medical services through the CareHere clinic network! Local physicians and/or physician’s assistants will provide primary care treatment, generic non-narcotic prescriptions and annual routine exams, lab work and screenings. The employee will have access to the CareHere website to schedule his or her own appointment time and to review his or her own exam results (HIPAA Rules are observed). As an incentive to using this valuable service, employees who go to the clinic during work hours do NOT have to clock out! Clinics are located in Lebanon and Mt. Juliet, and the hours are flexible. See information enclosed in your packet or visit [www.carehere.com](http://www.carehere.com) or call 877-423-1330 for more information.