Washington Counties Insurance Fund

2018 Benefit Plan Comparison

- **Medical Plans**
- **Dental Plans**
- **Vision Plans**
- **Basic Life / Accidental Death & Dismemberment Plans**
- **Voluntary Term Life (VTL) & Voluntary Accidental Death & Dismemberment (VAD&D) Plans**
- **Voluntary Long Term (VLTD) & Short Term Disability (VSTD) Plans**
- **Employee Assistance Program (EAP)**
- **Consumer Driven Health Plans (CDHP)**

For additional information including plan summaries and lists of participating providers, visit www.wcif.net. Information about billing, eligibility, and other plan administration is available under the Employer portion of the website.

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PREMERA BLUE CROSS PPO MEDICAL PLANS

Brief Summary of In-Network Benefits (Refer to 2018 Benefit Summary for plan description of Out-of-Network Benefits)

	WCIF 500	WCIF 750	WCIF 1250	WCIF 2000	WCIF 3000	WCIF 5000	WCIF HSA
Medical Cost Share Options							
Deductible (Ded) **Individual** **Family**	$500 $1,000	$750 $1,500	$1,250 $2,500	$2,000 $4,000	$3,000 $6,000	$5,000 $10,000	$1,500 Aggregate Family: $3,000
Coinsurance (Coins)	20%	20%	20%	20%	20%	0%	20%
Out-of-pocket max (includes copay and deductible) **Individual** **Family**	$2,750 $5,500	$5,750 $11,500	$6,350 $12,700	$6,350 $12,700	$6,350 $12,700	$5,000 $10,000	$3,400 Aggregate Family: $6,800
Office Visit	$30 Copay	$30 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	Ded / Coins
Preventive Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
TeleDoc (Virtual Care)	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	Ded / Coins
Manipulations (spinal) 20 visits Per Calendar Year	$30 Copay	$30 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	Ded / Coins
Diagnostic Lab and X-ray Services Some services may require pre-authorization	Ded / Coins	Ded / Coins	Ded / Coins	Ded / Coins	Ded / Coins	Deductible	Ded / Coins
Inpatient Hospital	Ded / Coins	Ded / Coins	Ded / Coins	Ded / Coins	Ded / Coins	Deductible	Ded / Coins
Outpatient Surgery Facility	$75 Copay; Ded / Coins	$75 Copay; Ded / Coins	$75 Copay; Ded / Coins	$75 Copay; Ded / Coins	$75 Copay; Ded / Coins	$75 Copay; Deductible	Ded / Coins
Emergency Care Copay (copay waived if admitted)	$150 Copay; Ded / Coins	$150 Copay; Ded / Coins	$200 Copay; Ded / Coins	$200 Copay; Ded / Coins	$200 Copay; Ded / Coins	$200 Copay; Deductible	Ded / Coins
Pharmacy 30 day supply							
Generic – Tier 1	$5 Copay	$5 Copay	$5 Copay	$5 Copay	$5 Copay	$5 Copay	Ded / Coins
Brand Name – Tier 2	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	Ded / Coins
Non-Preferred – Tier 3	$70 Copay	$70 Copay	$70 Copay	$70 Copay	$70 Copay	$70 Copay	Ded / Coins

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KAISER PERMANENTE ACCESS PPO MEDICAL PLANS

Brief Summary of In-Network Benefits (Refer to 2018 Benefit Summary for plan description of Out-of-Network Benefits)

	Access PPO 200	Access PPO 500	Access PPO 1000	Access PPO 2000	Access PPO 3000	Access PPO 5000	Access PPO HSA
Medical Cost Share Options							
Deductible (Ded) **Individual** **Family**	$200 $400	$500 $1,000	$1,000 $2,000	$2,000 $4,000	$3,000 $6,000	$5,000 $10,000	$1,500 Aggregate Family: $3,000
Coinsurance (Coins)	20%	20%	20%	20%	20%	20%	20% (10% enhanced benefit)
Out-of-pocket max (Includes copay and deductible) **Individual** **Family**	$2,000 $4,000	$2,500 $5,000	$3,000 $6,000	$4,000 $8,000	$5,000 $10,000	$5,000 $10,000	$3,500 Aggregate Family: $7,000
Office Visit	$20 Copay ($10 Copay enhanced benefit); Ded / Coins	$30 Copay ($20 Copay enhanced benefit); Ded / Coins	$30 Copay ($20 Copay enhanced benefit); Ded / Coins	$30 Copay ($20 Copay enhanced benefit); Ded / Coins	$30 Copay ($20 Copay enhanced benefit); Ded / Coins	$30 Copay ($20 Copay enhanced benefit); Ded / Coins	Ded / Coins
Preventive Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
CareNow (Virtual Care)	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Welcome Rider	First 4 office visits are copay only (deductible and coinsurance waived). After the 4th visit, services are subject to the deductible and coinsurance (copay waived). 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.						N/A
Manipulations (spinal) 20 Visits Per Calendar Year	$20 Copay; Ded / Coins	$30 Copay; Ded / Coins	$30 Copay; Ded / Coins	$30 Copay; Ded / Coins	$30 Copay; Ded / Coins	$30 Copay; Ded / Coins	Ded / Coins
Diagnostic Laboratory and X-ray Services Some services may require pre-authorization	Inpatient: Covered under Hospital Services Outpatient: Ded / Coins	Inpatient: Covered under Hospital Services Outpatient: Ded / Coins	Inpatient: Covered under Hospital Services Outpatient: Ded / Coins	Inpatient: Covered under Hospital Services Outpatient: Ded / Coins	Inpatient: Covered under Hospital Services Outpatient: Ded / Coins	Inpatient: Covered under Hospital Services Outpatient: Ded / Coins	Inpatient: Covered under Hospital Services Outpatient: Ded / Coins
Inpatient Facility	$100 Copay per day for up to 5 days per admit; Ded / Coins	$100 Copay per day for up to 5 days per admit; Ded / Coins	$100 Copay per day for up to 5 days per admit; Ded / Coins	$100 Copay per day for up to 5 days per admit; Ded / Coins	$100 Copay per day for up to 5 days per admit; Ded / Coins	$100 Copay per day for up to 5 days per admit; Ded / Coins	Ded / Coins
Outpatient Surgery Facility	Ded / Coins	Ded / Coins	Ded / Coins	Ded / Coins	Ded / Coins	Ded / Coins	Ded / Coins
Emergency Care (copay waived if admitted)	$100 Copay; Ded / Coins	$100 Copay; Ded / Coins	$100 Copay; Ded / Coins	$100 Copay; Ded / Coins	$100 Copay; Ded / Coins	$100 Copay; Ded / Coins	Ded / Coins
Pharmacy 30 day supply							
Preferred Generic – Tier 1	$5 Copay	$5 Copay	$5 Copay	$5 Copay	$5 Copay	$5 Copay	Ded then $10 Copay
Preferred Brand Name – Tier 2	$35 Copay ($30 Copay enhanced benefit)	$35 Copay ($30 Copay enhanced benefit)	$35 Copay ($30 Copay enhanced benefit)	$35 Copay ($30 Copay enhanced benefit)	$35 Copay ($30 Copay enhanced benefit)	$35 Copay ($30 Copay enhanced benefit)	Ded then $35 Copay ($30 Copay enhanced benefit)
Non-Preferred – Tier 3	$70 Copay ($60 Copay enhaced benefit)	$70 Copay ($60 Copay enhaced benefit)	$70 Copay ($60 Copay enhaced benefit)	$70 Copay ($60 Copay enhaced benefit)	$70 Copay ($60 Copay enhaced benefit)	$70 Copay ($60 Copay enhaced benefit)	Ded then $70 Copay ($65 Copay enhanced benefit

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KAISER PERMANENTE CORE (HMO) MEDICAL PLANS

Brief Summary of In-Network Benefits (Refer to 2018 Benefit Summary for plan description of Out-of-Network Benefits)

	Core 250	Core 500	Core 750	Core 2000
Medical Cost Share Options				
Deductible (Ded) **Individual** **Family**	$250 $500	$500 $1,000	$750 $1,500	$2,000 $4,000
Coinsurance (Coins)	0%	10%	20%	20%
Out-of-pocket max (Includes copay and deductible) **Individual** **Family**	$1,000 $2,000	$2,000 $4,000	$2,700 $5,400	$4,000 $8,000
Office Visit	$20 Copay; Ded applies	$20 Copay; Ded / Coins	$20 Copay; Ded / Coins	$20 Copay; Ded / Coins
Preventive Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full
CareNow (Virtual Care)	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Manipulations (spinal) 20 Visits Per Calendar Year	$20 Copay; Ded applies	$20 Copay; Ded / Coins	$20 Copay; Ded / Coins	$20 Copay; Ded / Coins
Diagnostic Laboratory and X-ray Services Some services may require pre-authorization	Inpatient: Covered under Hospital Services	Inpatient: Covered under Hospital Services	Inpatient: Covered under Hospital Services	Inpatient: Covered under Hospital Services
	Outpatient: Ded applies	Outpatient: Ded / Coins	Outpatient: Ded / Coins	Outpatient: Ded / Coins
Inpatient Facility	Ded applies	Ded / Coins	Ded / Coins	Ded / Coins
Outpatient Surgery Facility	$20 Copay; Ded applies	$20 Copay; Ded / Coins	$20 Copay; Ded / Coins	$20 Copay; Ded / Coins
Emergency Care (copay waived if admitted)	$100 Copay; Ded applies	$100 Copay; Ded / Coins	$100 Copay; Ded / Coins	$100 Copay; Ded / Coins
Pharmacy 30 day supply				
Preferred Generic – Tier 1	$5 Copay	$5 Copay	$5 Copay	$5 Copay
Preferred Brand Name – Tier 2	$25 Copay	$25 Copay	$25 Copay	$25 Copay
Non-Preferred – Tier 3	$50 Copay	$50 Copay	$50 Copay	$50 Copay

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DENTAL PLANS

DELTA DENTAL OF WASHINGTON PPO PLANS & WILLAMETTE DENTAL GROUP PLAN

DELTA DENTAL

Delta Dental of Washington

	Delta Dental of Washington				
	PPO PLANS		ENHANCED PPO PLANS		INCENTIVE PPO PLAN
	Plan A	Plan B	Plan C	Plan D	Incentive Plan
Deductible	No Deductible		No Deductible		No Deductible
Annual Maximum	$1,000	$2,000	$1,000	$2,000	$2,000
Class I - Diagnostic & Preventive (Sealants covered up to age 15)	100% PPO dentists 80% Premier dentists 80% Nonparticipating dentists*		100% PPO dentists 100% Premier dentists 100% Nonparticipating dentists*		70%-100% PPO dentists 70%-100% Premier dentists 70%-100% Out-of-State dentists*
Class II - Restorative Restorations, Endodontics, Periodontics, Oral Surgery	80% PPO dentists 70% Premier dentists 70% Nonparticipating dentists*		90% PPO dentists 80% Premier dentists 80% Nonparticipating dentists*		70%-100% PPO dentists 70%-100% Premier dentists 70%-100% Out-of-State dentists*
Class III - Major Crowns, Dentures, Partials, Bridges, and Implants	50% PPO dentists 40% Premier dentists 40% Nonparticipating dentists*		50% PPO dentists 50% Premier dentists 50% Nonparticipating dentists*		50% PPO dentists 50% Premier dentists 50% Out-of-State dentists*
Orthodontia (Adults and Children)	50% payable to a $2,000 lifetime maximum		50% payable to a $2,000 lifetime maximum		50% payable to a $2,000 lifetime 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 procedures.*

Willamette Dental Group

	WILLAMETTE DENTAL
	PROACTIVE DENTAL CARE PLAN
Deductible	No Deductible
Annual Maximum	No Annual Maximum
General Office Visit	$10 Copay per visit
Diagnostic and Preventive Services, Restorative Dentistry, Prosthodontics Oral Surgery, Endodontic and Periodontics	Covered at 100% after Office Visit Copay
Specialty Office Visit	$30 Copay per visit
Orthodontia	$1,800 Copay
	$150 Copay for Pre-Orthodontic Service; fee is credited towards orthodontic copay if patient accepts treatment plan.

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VISION SERVICE PLAN (VSP) VISION PLANS

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.

	EXTENDED PLAN		STANDARD PLAN		BUDGET PLAN	
Eye Examination	Exam:	100% once every 12 months	Exam:	100% once every 12 months	Exam:	100% once every 24 months
Diabetic Eyecare Plus	Exam:	100% after $20 Copay	Exam:	100% after $20 Copay	Exam:	100% after $20 Copay
Frames and Lenses	Frames:	Once every 24 months 100% after $15 Copay Frames covered up to $150.00	Frames:	Once every 24 months 100% after $15 Copay Frames covered up to $150.00	Frames:	Once every 24 months 100% after $15 Copay Frames covered up to $150.00
	Lenses:	Once every 12 months Single vision, lined bifocal, lined trifocal lenses, ultra violet protection, scratch-resistant coating and anti-reflective coating; Polycarbonate lenses for dependent children	Lenses:	Once every 12 months Single vision, lined bifocal, lined trifocal lenses, ultra violet protection, scratch-resistant coating and anti-reflective coating; Polycarbonate lenses for dependent children	Lenses:	Once every 24 months Single vision, lined bifocal, & lined trifocal lenses; Polycarbonate lenses for dependent children
	Second Pair Benefit:	Frames: Once every 24 months 100% after $20 Copay Frames covered up to $150.00 Lenses: Once every 12 months				
Contact Lenses	Frequency:	Once every 12 months	Frequency:	Once every 12 months	Frequency:	Once every 24 months
	Fitting & Evaluation:	100% after max $60 Copay	Fitting & Evaluation:	100% after max $60 Copay	Fitting & Evaluation:	100% after max $60 Copay
	Lenses:	$120 allowance for contacts	Lenses:	$120 allowance for contacts	Lenses:	$120 allowance for contacts
Benefit Limitations	**Members may choose between the benefit of glasses or contact lenses, but not both, during any benefit plan period.** (Second Pair Benefit on the Extended Plan still applies.)					

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THE STANDARD LIFE and AD&D PLANS

BASIC LIFE and ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

NOTE: Basic Life is a mandatory employer-paid benefit. All eligible employees must be enrolled.

OVERVIEW

Basic Life	AD&D	Maximum
$12,000	$12,000	*see Basic Life*
$15,000	$15,000	*see Basic Life*
$20,000	$20,000	*see Basic Life*
$24,000	$24,000	*see Basic Life*
$36,000	$36,000	*see Basic Life*
$40,000	$40,000	*see Basic Life*
$48,000	$48,000	*see Basic Life*
$50,000	$50,000	*see Basic Life*
1X Annual Salary	1X Annual Salary	$50,000
1X Annual Salary	1X Annual Salary	$100,000
1X Annual Salary	1X Annual Salary	$150,000

Spouse* Coverage - $1,000 Basic Life Insurance
Child(ren) Coverage - $1,000 Basic Life Insurance

RATES

Employee Basic Life and AD&D	$0.15 per $1,000
Dependent Basic Life *(one or more)*	$0.40 for $1,000 benefit

If Basic dependent life coverage is elected it requires 100% employee participation and is employer paid.

ADEA Benefit Reduction Schedule

	Employee & Spouse*
At age 70	Benefit reduced to 65% of original
At age 75	Benefit reduced to 45% of original
At age 80	Benefit reduced to 30% of original

VOLUNTARY TERM LIFE (VTL) INSURANCE

OVERVIEW

1) VTL offers continuation of coverage through portability/conversion and can be maintained upon termination. Additional information and applications available at www.wcif.net.
2) Coverage limits for:
   - Employees in $10,000 increments to $500,000 or 6 x annual earnings, whichever is less.
   - Spouses* in $10,000 increments to $250,000
   - Children in $2,000 increments to $10,000

   (Dependent benefit not to exceed 100% of employee's VTL amount)
3) Employees must have coverage in order to cover spouse and children.
4) Guarantee Issue Coverage at $50,000 for employees, $20,000 for spouses*, and $10,000 for children
   (Must enroll within 31 days of eligibility to qualify)
5) Accelerated benefit available to employee, spouses*, and children if at least $10,000 of coverage is in force.

RATES

Rate per unit (unit = $10,000)

Age as of December 31	**Employee**	**Spouse***
Under 20	$0.56	$0.60
20-24	$0.66	$0.70
25-29	$0.71	$0.75
30-34	$0.82	$0.90
35-39	$0.98	$1.05
40-44	$1.45	$1.55
45-49	$2.35	$2.45
50-54	$3.91	$4.09
55-59	$5.81	$5.87
60-64	$8.74	$9.57
65-69	$12.53	$13.53
70 & Over	$12.53	n/a

Children - $0.44 per $2,000

ADEA Benefit Reduction Schedule

	Employee	Spouse*
At age 70	Benefit reduced to 65% of original	No coverage
At age 75	Benefit reduced to 45% of original	No coverage
At age 80	Benefit reduced to 30% of original	No coverage

Spouse voluntary term life insurance terminates on the date the spouse* becomes 70 years of age.*

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (VAD&D) INSURANCE

OVERVIEW

1) Coverage sold in units of $25,000 up to $500,000 maximum
2) Maximum benefit of $500,000 - any amount in excess of $250,000 may not exceed ten times your annual earnings
3) Spouse* may select 50% or 100% of Employee's Benefit
4) Children may be covered up to 10% of employee benefit not to exceed $30,000
5) Other VAD&D Features:
   - Higher Education Benefit
   - Career Adjustment Benefit
   - Paralysis Benefit
   - Common Disaster Benefit
   - Seat Belt Benefit

RATES

Rate per unit (unit = $1,000)

Employee	$0.025
Spouse*	$0.025
Child(ren)	$0.030

ADEA Benefit Reduction Schedule

	Employee & Spouse*
At age 70	Benefit reduced to 65% of original
At age 75	Benefit reduced to 45% of original
At age 80	Benefit reduced to 30% of original
At age 85	Benefit reduced to 20% of original
At age 90	Benefit reduced to 15% of original
95 or over	Benefit reduced to 10% of original

** or qualified domestic partner*

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THE STANDARD DISABILITY PLANS

BASE LONG TERM DISABILITY (LTD) PLAN

NOTE: *Base LTD is an employer-paid benefit. If an employer elects to offer Base LTD, then all eligible employees must be enrolled.*

Base LTD Plan *Employer Paid*	40% benefit up to $4,000 per month with a 180 day waiting period.	
Rates	**Groups offering WCIF medical**	**Stand Alone** (no WCIF medical)
	$5.36	**$5.86**

VOLUNTARY BUY-UP LONG TERM DISABILITY (LTD) PLAN

NOTE: *Employees must be enrolled in Base LTD to purchase Voluntary Buy-Up LTD. Rates are $0.50 higher if medical plans are not offered through WCIF.*

Voluntary Buy-Up LTD Plan *Employee Paid*	60% benefit up to $6,000 per month with a 90 day waiting period.

Rates

Monthly Salary Range	Monthly Premium Due: Groups offering WCIF medical	Monthly Premium Due: Stand Alone (no WCIF medical)
$999 or under	$3.75	$4.25
$1,000 - $1,499	$6.25	$6.75
$1,500 - $1,999	$8.75	$9.25
$2,000 - $2,499	$11.25	$11.75
$2,500 - $2,999	$13.75	$14.25
$3,000 - $3,499	$16.25	$16.75
$3,500 - $3,999	$18.75	$19.25
$4,000 - $4,499	$21.25	$21.75
$4,500 - $4,999	$23.75	$24.25
$5,000 - $5,499	$26.25	$26.75
$5,500 - $5,999	$28.75	$29.25
$6,000 - $6,499	$31.25	$31.75
$6,500 - $6,999	$33.75	$34.25
$7,000 - $7,499	$36.25	$36.75
$7,500 - $7,999	$38.75	$39.25
$8,000 - $8,499	$41.25	$41.75
$8,500 - $8,999	$43.75	$44.25
$9,000 - $9,499	$46.25	$46.75
$9,500 or Over	$48.75	$49.25

VOLUNTARY SHORT TERM DISABILITY (VSTD) PLAN

NOTE: *Employees may enroll in Voluntary Short Term Disability without being enrolled in a Long Term Disability policy. In this instance they may choose to enroll in either the 90-day or the 180-day VSTD policy.*

VSTD Plan *Employee Paid*	60% weekly benefit up to $1,000 per week with a 30 day waiting period
Maximum Benefit Period	Option 1: 90 days (coincides with Buy-Up LTD enrollment) Option 2: 180 days (coincides with Base LTD enrollment)

Rates

Monthly Salary Range	Monthly Premium Due: 180-DAY COVERAGE *coincides with Base LTD enrollment*	Monthly Premium Due: 90-DAY COVERAGE *coincides with Buy-Up LTD enrollment*
$999 or under	$10.80	$9.30
$1,000 - $1,499	$12.30	$10.30
$1,500 - $1,999	$14.80	$11.30
$2,000 - $2,499	$16.80	$12.80
$2,500 - $2,999	$19.30	$14.30
$3,000 - $3,499	$20.80	$15.30
$3,500 - $3,999	$23.30	$16.30
$4,000 - $4,499	$25.30	$17.80
$4,500 - $4,999	$26.80	$18.80
$5,000 - $5,499	$28.80	$19.80
$5,500 - $5,999	$30.80	$21.30
$6,000 - $6,499	$32.80	$22.30
$6,500 - $6,999	$34.80	$23.80
$7,000 or Over	$37.30	$24.80

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MAGELLAN HEALTH SERVICES EMPLOYEE ASSISTANCE PROGRAM (EAP)

NOTE: *This plan is bundled with all WCIF medical plans, or available as stand-alone coverage.*
EAP is an employer-paid benefit. If an employer elects to offer EAP, then all eligible employees must be covered.

Frequency	Up to six, one-hour in-person counseling sessions* per problem per year; Unlimited telephonic counseling
Eligibility	The employee, everyone living in their household, and dependent children up to age 26 living away from home.
Services Provided for Management: Employers have access to a wide variety of services	• Program orientation and training for supervisors • Telephone consultation services to assist them in approach and support for troubled employees • Mandatory referral • Guidelines for working with drug-free workplace policies • Quarterly webinars on various management topics • Critical Incident & Stress Management (CISM) work place training seminars
Services Provided for Employees: Employees have access to a wide variety of services	• 24-hour toll free phone lines for immediate help in crisis or urgent situations • Telephonic Coaching for over-the-phone consultations with a professional coach (sessions last 40 minutes) • Legal Consultation (50 minute consultation per issue) & online legal library • Access to local professional counselors* • Telephonic Financial Consultation (sessions last 50 minutes), as well as access to the online library and tools • Web-based Confidential Care - online programs for: Depression, Substance Use, Anxiety, Insomnia, and Obsessive Compulsive Disorder • LifeMart Discount Center • Monthly personal development webinars including topics like Personal Finance and Holiday Stress • Momentum monthly newsletters

* For treatment beyond the scope of EAP services, counselors may refer to providers within the community or to providers covered by the employee's medical plan

CONSUMER DRIVEN HEALTH PLANS (CDHP)

NOTE: For more information about CDHPs, please contact WCIF or BSI's CDHP department

SERVICES	
HSA	Business Solutions Inc. (BSI) administers Health Savings Account (HSA) for WCIF members. Employers may only offer HSAs to employees enrolled in Qualified High Deductible Health Plans (HDHP). For 2018, annual contribution limits are up to the IRS maximum of $3,450 for single coverage and $6,900 for family coverage.
FSA/DCAP	Business Solutions Inc. (BSI) administers Flexible Spending Arrangements (FSA) and Dependent Daycare Assistance Program (DCAP) for WCIF members. For 2018, annual contribution limits are up to the IRS maximum of $2,600 for FSA and $5,000 for DCAP.
HRA	Business Solutions Inc. (BSI) administers Health Reimbursement Accounts (HRA) for WCIF members. HRA funds are disbursed only after eligible expenses have been incurred and the employee has requested reimbursement.

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