WCIF
WASHINGTON COUNTIES
INSURANCE FUND

Washington Counties Insurance Fund

2016 Benefit Plan Comparison for Retirees

- **Retiree Medical Plans for Under Age 65 (former WCIF medical enrollees only)**
- **Retiree Medical Plans for Over Age 65 (all eligible retirees)**
- **Retiree Dental Plans (former WCIF dental enrollees only)**
- **Retiree Vision Plan (former WCIF vision enrollees only)**

For additional information including plan summaries and lists of participating providers, visit us at www.wcif.net. For information about billing, eligibility, and other plan administration, please contact the Retiree Administration Desk at Benefit Solutions, Inc.

PREMERA | BLUE CROSS

PREMERA BLUE CROSS PPO MEDICAL PLANS for under age 65

Summary of In-Network Benefits (Refer to Summary Plan Description for Out-of-Network Benefits.)

	WCIF 750	WCIF 3000	LEOFF 1 Only WCIF 200
Medical Cost Share Options			
Deductible PCY **Individual** **Family**	$750 $1,500	$3,000 $6,000	$200 $400
Coinsurance	20%	20%	20%
Out-of-pocket max (includes deductible) **Individual** **Family**	$5,750 $11,500	$6,350 $12,700	$2,200 $4,400
Office Visit Copay	$25	$30	$20
Preventive Care	Covered in Full	Covered in Full	Covered in Full
Manipulations (spinal)	20 visits PCY $25 copay	20 visits PCY $30 copay	15 visits PCY $20 copay
Diagnostic Lab and X-ray Services Some services may require pre-authorization	Ded / Coins	Ded / Coins	Ded / Coins
Inpatient Hospital	Ded / Coins	Ded / Coins	Ded / Coins
Outpatient Surgery Facility	$75 Copay Ded / Coins	$75 Copay Ded / Coins	$75 Copay Ded / Coins
Emergency Care Copay (waive copay if admitted)	$150 copay Ded / Coins	$200 copay Ded / Coins	$150 copay Ded / Coins
Pharmacy 30 day supply			
Generic – Tier 1	$5 Copay	$5 Copay	$5 Copay
Brand Name – Tier 2	$20 Copay	$20 Copay	$20 Copay
Non-formulary – Tier 3	$50 Copay	$50 Copay	$50 Copay
Rates	**Retirees**	**Retirees**	**LEOFF 1 Retirees**
Retiree	$921.26	$589.72	$1,200.68
Retiree/Spouse*	$2,034.65	$1,277.15	$2,600.27
Retiree/Children	$1,663.38	$1,044.96	$2,127.55
Retiree/Spouse*/Children	$2,776.77	$1,732.40	$3,527.14

**or qualified domestic partner*

GroupHealth

GROUP HEALTH MEDICAL PLAN under age 65

Summary of In-Network Benefits

	HMO 750	
Medical Cost Share Options		
Deductible **Individual** **Family**	$750 $1,500	
Coinsurance	20%	
Out-of-pocket max (Includes deductible) **Individual** **Family**	$2,700 $5,400	
Office Visit Copay	$20 Ded / Coins	
Preventive Care	Covered in full	
Manipulations (spinal)	20 visits PCY $20 copay; Ded / Coins	
Diagnostic Laboratory and X-ray Services Some services may require pre-authorization	Inpatient: Covered under Hospital Services	
	Outpatient: Ded / Coins	
Inpatient Facility	Ded / Coins	
Outpatient Surgery Facility	$20 copay Ded / Coins	
Emergency Care (waive copay if admitted)	$100 copay Ded / Coins	
Pharmacy 30 day supply		
Preferred Generic – Tier 1	$5 Copay	
Preferred Brand Name – Tier 2	$25 Copay	
Non-preferred – Tier 3	$50 Copay	
Rates	**Retirees**	**LEOFF 1 Retirees**
Retiree	$1,239.75	$1,387.71
Retiree/Spouse*	$2,008.98	$2,156.94
Retiree/Children	$1,922.32	$2,070.28
Retiree/Spouse*/Children	$2,990.97	$3,138.93

**or qualified domestic partner*

This benefit comparison is intended to provide a brief description of 2016 coverage and is not a complete explanation of covered services, exclusions, limitations, reductions or terms under which a program may be continued in force. This summary is not a contract. For full coverage provisions, including a description of waiting periods, limitations, exclusions, please refer to the applicable summary plan documents posted to www.wcif.net. 2016 documents will be posted as they are approved.

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RETIREE MEDICAL PLANS over age 65

Available to >65 Medicare eligible retirees and eligible spouses only.*

MEDICARE SUPPLEMENTAL PLANs underwritten by United American Insurance Company		
	Option 1	**Option 2**
Calendar Year Deductible	$0	$147
Hospitalization	$0	$0
Part A Deductible	$0	$0
Skilled Nursing Coinsurance	$0	$0
Part B Deductible	$0	$0
Part B Coinsurance (generally 20%)	$0	20%
Foreign Travel	$250 Deductible 20% to $50,000 lifetime maximum	
Maximum out of pocket expenses	None	$2,000
Prescription Drug Coverage - same for both options		
Prescription Deductible	None	None
Generics	$5	Mail Order: $10
Preferred Brands	$40	Mail Order: $80
Non-Preferred Brands	$75	Mail Order: $180
Specialty Drugs (cost $600 or more)	33%	Mail Order: 33%
Maximum Benefit	Unlimited	Unlimited
Rates		
Per participant	$406.00	$285.00

**or qualified domestic partner*

RETIREE DENTAL and VISION PLANS

Delta Dental of Washington

DELTA DENTAL		
Deductible (Waived on Class I)	$50 per person $150 per family	
Annual Maximum	$2,000	
Class I Diagnostic & Preventive (Sealants covered to age 15)	80% Premier dentists 80% Nonparticipating 80% Out-of-State dentists	
Class II - Restorative Restorations, Endodontics, Periodontics, Oral Surgery	80% Premier dentists 80% Nonparticipating 80% Out-of-State dentists	
Class III - Major Crowns, Dentures, Partials, Bridges, and Implants	50% Premier dentists 50% Nonparticipating 50% Out-of-State dentists	
Orthodontia	Not covered	
Rates	Retiree	$58.61
	Retiree/Spouse*	$117.15
	Retiree/Child(ren)	$116.34
	Retiree/Spouse* /Child(ren)	$174.88

Willamette Dental Group

WILLAMETTE DENTAL		
Deductible	No Deductible	
Annual Maximum	No Annual Maximum	
General Office Visit	$15 copay per visit	
Diagnostic and Preventive Services	Covered at 100%	
Restorative Dentistry, Endodontics, Periodontics, Oral Surgery	Copays vary based on type of service. Examples include: Fillings (Amalgam) Covered at 100% Root Canal Therapy - Molar $200 copay Root Planing (per Quadrant) $75 copay Porcelain-Metal Crown $275 copay Complete Upper or Lower Denture $450 copay	
Specialty Office Visit	$30 copay per visit	
Orthodontia	$2,800 Copay $150 copay for Pre-Orthodontic Service; fee is credited towards orthodontic copay if patient accepts treatment plan.	
Rates	Retiree	$50.15
	Retiree/Spouse*	$100.21
	Retiree/Child(ren)	$99.54
	Retiree/Spouse* /Child(ren)	$149.64

VISION SERVICE PLAN (VSP)		
Eye Examination	Once every 12 months 100% after $10 copay	
Diabetic Eyecare Exam	100% after $20 copay	
Frames and Lenses	Lenses: once every 12 months Frames: once every 24 months 100%* after $25 copay **frame of your choice covered up to* ***$140.00***	
Contact Lenses	Once every 12 months Up to $120 allowance for contacts (copay does not apply) and contact lens exam up to $60 copay (fitting and evaluation)	
Benefit Limitations	Members may choose between the benefit of glasses or contacts, but not both, during any benefit plan period.	
Rates	Retiree	$6.31
	Retiree & dependent(s)	$21.58

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.

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