



Washington Counties Insurance Fund 2018 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 PPO MEDICAL PLANS for under age 65

	WCIF 750	WCIF 3000	LEOFF 1 Only WCIF 200
Provider Network	For Out-of-Network benefits, please see full plan summary		
Deductible (Ded) PCY			
Individual	\$750	\$3,000	\$200
Family	\$1,500	\$6,000	\$400
Coinsurance (Coins)	20%	20%	20%
Out-of-pocket max <small>(includes deductible, coinsurance, and copays)</small>			
Individual	\$5,750	\$6,350	\$2,200
Family	\$11,500	\$12,700	\$4,400
Office Visit Cost Share	\$30 Copay	\$35 Copay	\$25 Copay
Preventive Care	Covered in Full	Covered in Full	Covered in Full
Manipulations (spinal)	20 visits PCY \$30 Copay	20 visits PCY \$35 Copay	20 visits PCY \$25 Copay
Diagnostic Lab and X-ray Services <small>Some services may require pre-authorization</small>	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 <small>(waive copay if admitted)</small>	\$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	\$35 Copay	\$35 Copay	\$35 Copay
Non-formulary – Tier 3	\$70 Copay	\$70 Copay	\$70 Copay
Rates	Retirees	Retirees	LEOFF 1 Retirees
Retiree	\$1,183.88	\$757.03	\$1,545.55
Retiree/Spouse*	\$2,614.66	\$1,639.51	\$3,347.17
Retiree/Children	\$2,137.54	\$1,341.44	\$2,738.68
Retiree/Spouse*/Children	\$3,568.32	\$2,223.93	\$4,540.28

*or qualified domestic partner



KAISER PERMANENTE MEDICAL PLAN under age 65

	Core 750		Core 5000	ACCESS PPO 5000
Provider Network	HMO In-Network Only		HMO In-Network Only	For Out-of-Network benefits, see full plan summary
Deductible (Ded)				
Individual	\$750		\$5,000	\$5,000
Family	\$1,500		\$10,000	\$10,000
Coinsurance (Coins)	20%		20%	20%
Out-of-pocket max (Includes deductible, coinsurance, and copays)				
Individual	\$2,700		\$5,000	\$5,000
Family	\$5,400		\$10,000	\$10,000
Office Visit Cost Share	\$20 Copay Ded / Coins		\$20 Copay; Ded / Coins	Welcome Rider: First 4 office visits are not subject to deductible and/or coinsurance, \$30 Copay (\$20 Copay at enhanced provider) only. After the 4th visit, services are subject to the deductible and then coinsurance (copay waived).
Preventive Care	Covered in Full		Covered in Full	Covered in Full
Manipulations (spinal) 20 visits PCY	\$20 Copay; Ded / Coins		\$20 Copay; Ded / Coins	\$30 Copay; Ded / Coins
Outpatient Diagnostic Laboratory and X-ray Services Some services may require pre-authorization	Ded / Coins		Ded / Coins	Welcome Rider: 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.
Inpatient Facility	Ded / Coins		Ded / Coins	\$100 Copay, per day for up to 5 days per admit Ded / Coins
Outpatient Surgery Facility	\$20 Copay; Ded / Coins		\$20 Copay; Ded / Coins	Ded / Coins
Emergency Care (waive copay if admitted)	\$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
Preferred Brand Name – Tier 2	\$25 Copay		\$25 Copay	\$35 Copay (\$30 Copay enhanced benefit)
Non-preferred – Tier 3	\$50 Copay		\$50 Copay	\$70 Copay (\$60 Copay enhanced benefit)
Rates	Retirees	LEOFF 1 Retirees	Retirees	Retirees
Retiree	\$1,521.67	\$1,669.54	\$973.49	\$1,541.92
Retiree/Spouse*	\$2,465.81	\$2,613.69	\$1,577.51	\$2,498.63
Retiree/Children	\$2,359.44	\$2,507.31	\$1,509.46	\$2,390.83
Retiree/Spouse*/Children	\$3,671.09	\$3,818.96	\$2,348.59	\$3,719.94

*or qualified domestic partner

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

	Plan F	High Deductible Plan F
Overall Deductible	No Deductible	\$2,240
Part A Deductible	Covered in Full	Deductible; then Covered in Full
Hospitalization	Covered in Full	Deductible; then Covered in Full
Skilled Nursing Coinsurance	Covered in Full	Deductible; then Covered in Full
Part B Deductible	Covered in Full	Deductible; then Covered in Full
Part B Coinsurance	Covered in Full	Deductible; then Covered in Full
Foreign Travel	\$250 Deductible 20% to \$50,000 lifetime maximum	\$250 Deductible 20% to \$50,000 lifetime maximum
Maximum out of pocket expenses (Rx excluded)	\$0; Medicare Eligible Expenses Only	\$2,240; Medicare Eligible Expenses Only

Prescription Drug Coverage - same for both options

	Plan F		High Deductible Plan F	
	No Deductible		No Deductible	
Prescription Deductible	No Deductible		No Deductible	
Generics	\$5 Copay	Mail Order: \$10 Copay	\$5 Copay	Mail Order: \$10 Copay
Preferred Brands	\$40 Copay	Mail Order: \$80 Copay	\$40 Copay	Mail Order: \$80 Copay
Non-Preferred Brands	\$75 Copay	Mail Order: \$180 Copay	\$75 Copay	Mail Order: \$180 Copay
Specialty Drugs	33% Coinsurance	Mail Order: 33% Coinsurance	33% Coinsurance	Mail Order: 33% Coinsurance
Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Rates				
Per participant	\$393.00		\$230.00	

*or qualified domestic partner

RETIREE DENTAL and VISION PLANS

 Delta Dental of Washington		DELTA DENTAL	 WILLAMETTE DENTAL		 VISION SERVICE PLAN (VSP)	
Deductible (Waived on Class I)		\$50 per person \$150 per family	Deductible		No Deductible	
Annual Maximum		\$2,000	Annual Maximum		No Annual Maximum	
Class I Diagnostic & Preventive (Sealants covered to age 15)		80% PPO dentists 80% Premier dentists 80% Nonparticipating	General Office Visit		\$15 copay per visit	
Class II - Restorative Restorations, Endodontics, Periodontics, Oral Surgery		80% PPO dentists 80% Premier dentists 80% Nonparticipating	Diagnostic and Preventive Services		Covered at 100%	
Class III - Major Crowns, Dentures, Partials, Bridges, and Implants		50% PPO dentists 50% Premier dentists 50% Nonparticipating	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	
Orthodontia		Not covered	Specialty Office Visit		\$30 copay per visit	
Rates	Retiree	\$62.05	Orthodontia		\$2,800 Copay	
	Retiree/Spouse*	\$124.03			\$150 copay for Pre-Orthodontic Service; fee is credited towards orthodontic copay if patient accepts treatment plan.	
	Retiree/Child(ren)	\$123.18	Rates	Retiree		\$53.40
	Retiree/Spouse*/Child(ren)	\$185.15		Retiree/Spouse*		\$106.70
		Retiree/Child(ren)			\$106.03	
		Retiree/Spouse*/Child(ren)			\$159.38	
			Frames and Lenses		Lenses: once every 12 months Frames: once every 24 months 100%* after \$25 copay <i>*frame of your choice covered up to \$150.00</i>	
			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.