



Washington Counties Insurance Fund / Pool

2012 Benefit Plan Comparison

WASHINGTON COUNTIES INSURANCE FUND
WASHINGTON COUNTIES INSURANCE POOL


For additional information including plan summaries and lists of participating providers visit us at www.wcif.net. Information about billing, eligibility, and other plan administration is available to administrators under the Admin Access portion of our website.

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2012 Medical Plan Rates

PREMERA BLUE CROSS MEDICAL PLANS

	Four-Tiered Rates				Composite Rates
	Employee	Employee & Spouse*	Employee & Child(ren)	Employee, Spouse*, & Child(ren)	Employee, Spouse*, & Child(ren)
WCIF HDHP (High Deductible Health Plan)	\$468.88	\$1,042.67	\$851.17	\$1,424.97	\$785.93
WCIF 750	\$548.63	\$1,202.35	\$984.38	\$1,638.09	\$993.06
WCIF 500	\$637.56	\$1,393.34	\$1,141.41	\$1,897.18	\$1,190.42
WCIF 200	\$888.65	\$1,915.84	\$1,568.90	\$2,596.08	\$1,767.27
Active LEOFF I WCIF 200	\$888.65	\$1,915.84	\$1,568.90	\$2,596.08	\$1,767.27

GROUP HEALTH MEDICAL PLANS

	Four-Tiered Rates				Composite Rates
	Employee	Employee & Spouse*	Employee & Child(ren)	Employee, Spouse*, & Child(ren)	Employee, Spouse*, & Child(ren)
Select 750	\$606.71	\$1,091.51	\$1,044.74	\$1,621.35	\$1,460.66
Active LEOFF I Select 750	\$753.29	\$1,238.09	\$1,191.32	\$1,767.94	n/a
Options 200	\$746.58	\$1,297.87	\$1,242.21	\$1,928.59	\$1,774.90
Active LEOFF I Options 200	\$893.17	\$1,444.45	\$1,388.79	\$2,075.18	n/a
Options A	\$814.98	\$1,449.88	\$1,387.65	\$2,154.90	\$1,955.90
Active LEOFF I Options A	\$961.57	\$1,596.46	\$1,534.24	\$2,301.49	n/a

* Or Qualified Domestic Partner



PREMERA BLUE CROSS PPO MEDICAL PLANS

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

	WCIF 200	WCIF 500	WCIF 750	WCIF HDHP
MEDICAL COST SHARE OPTIONS				
Deductible Per Calendar Year (PCY)	Individual: \$200 Family: \$600	Individual: \$500 Family: \$1,500	Individual: \$750 Family: \$2,250	Individual: \$1,250 Aggregate Family: \$2,500 PCY Aggregate Family Deductible replaces Individual Deductible when more than one person in the same family enrolls; Deductible applies to Prescriptions
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	20%	20%	20%
Out-of-pocket (OOP) PCY (Excludes copay, includes Deductible)	Individual: \$2,200 Family: \$4,400	Individual: \$2,750 Family: \$5,500	Individual: \$5,750 Family: \$11,500	Individual: \$5,000 Aggregate Family: \$10,000 Aggregate Family OOP replaces Individual OOP when more than one in the same family enrolls
Office Visit (General and Family Practitioner)	\$20 copay	\$25 copay, then Coinsurance	First 6 visits \$25 copay; then \$25 copay and Coinsurance	Deductible/Coinsurance
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION - UNLIMITED				
Preventive Office Visit Preventive Professional Diagnostic Imaging and Laboratory Services (Including PAP/PSA) Immunizations	Covered in full	Covered in full	Covered in full	Covered in full
Mammography	Covered in full	Covered in full	Covered in full	Covered in full
Well Child Visit	Covered in full	Covered in full	Covered in full	Covered in full
Nicotine Dependency Programs (ND)	Covered in full	Covered in full	Covered in full	Covered in full
Diabetes Health Education (DE)	Covered in full	Covered in full	Covered in full	Covered in full
PROFESSIONAL CARE				
Urgent Care	\$20 copay	\$25 copay, then Coinsurance	See Office Visit	Deductible/Coinsurance
Inpatient Professional Services	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance

PREMERA BLUE CROSS PPO MEDICAL PLANS

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

	WCIF 200	WCIF 500	WCIF 750	WCIF HDHP
DIAGNOSTIC SERVICE OPTIONS				
Other Professional Diagnostic Imaging and Laboratory Services	Inpatient: Deductible/Coinsurance Outpatient: Deductible/0% Coinsurance	Deductible/Coinsurance	First \$500 PCY: Covered in full After first \$500: Deductible/Coinsurance	Deductible/Coinsurance
FACILITY CARE OPTIONS				
Inpatient Facility	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Surgery Facility	\$75 copay, Deductible/Coinsurance	\$75 copay, Deductible/Coinsurance	\$75 copay, Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (90 days PCY)	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
EMERGENCY CARE OPTIONS				
Emergency Care (Waive copay if admitted, always subject to Deductible and Coinsurance.)	\$150 copay, Deductible/Coinsurance	\$150 copay, Deductible/Coinsurance	\$150 copay, Deductible/Coinsurance	Deductible/Coinsurance
Ambulance Transportation	\$50 copay, Deductible/Coinsurance	\$50 copay, Deductible/Coinsurance	\$50 copay, Deductible/Coinsurance	Deductible/Coinsurance
Air Ambulance (Unlimited)	\$50 copay, Deductible/Coinsurance	\$50 copay, Deductible/Coinsurance	\$50 copay, Deductible/Coinsurance	Deductible/Coinsurance
OTHER SERVICES				
Acupuncture (12 visits PCY)	\$20 copay	\$25 copay, then Coinsurance	\$25 copay	Deductible/Coinsurance
Chemical Dependency (Unlimited)	Inpatient: Deductible/0% Coinsurance	Inpatient: Deductible/Coinsurance	Inpatient: Deductible/Coinsurance	Inpatient: Deductible/Coinsurance
	Outpatient: \$20 copay	Outpatient: \$25 copay, then Coinsurance	Outpatient: \$25 copay	Outpatient: Deductible/Coinsurance
Home Health Care (130 visits PCY)	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Hospice (Inpatient: 14 days; 6 month limit per lifetime)	Inpatient: \$100 copay	Inpatient: \$100 copay	Inpatient: \$100 copay	Deductible/0% Coinsurance
	Outpatient: Deductible/0% Coinsurance	Outpatient: Deductible/0% Coinsurance	Outpatient: Deductible/0% Coinsurance	
Manipulations (Spinal and other)	15 visits PCY	15 visits PCY	20 visits PCY	15 visits PCY
	\$20 copay	\$25 copay, then Coinsurance	\$25 copay	Deductible/Coinsurance



PREMERA BLUE CROSS PPO MEDICAL PLANS

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

	WCIF 200		WCIF 500		WCIF 750		WCIF HDHP	
OTHER SERVICES (continued)								
Medical Supplies (MS) Equipment (ME), Prosthetics (Pro) and Orthotics (Orth) (MS: Unlimited; ME: Unlimited; Pro: Unlimited; Orth: \$300 PCY)	Deductible/Coinsurance (Pro): Deductible/0% Coinsurance		Deductible/Coinsurance		Deductible/Coinsurance		Deductible/Coinsurance	
Mental Health Inpatient Facility Care (Unlimited)	Inpatient: Deductible/0% Coinsurance		Inpatient: Deductible/Coinsurance		Inpatient: Deductible/Coinsurance		Inpatient: Deductible/Coinsurance	
	Outpatient: \$20 copay		Outpatient: \$25 copay, then Coinsurance		Outpatient: \$25 copay		Outpatient: Deductible/Coinsurance	
Rehab Inpatient Facility (30 days PCY) Outpatient Care, Including Physical, Occupational, Speech Therapy (45 visits PCY)	Inpatient: Deductible/Coinsurance		Inpatient: Deductible/Coinsurance		Inpatient: Deductible/Coinsurance		Inpatient: Deductible/Coinsurance	
	Outpatient: \$20 copay		Outpatient: \$25 copay, then Coinsurance		Outpatient: \$25 copay, then Coinsurance		Outpatient: Deductible/Coinsurance	
Massage Therapy (12 visits PCY)	\$20 copay		\$25 copay, then Coinsurance		\$25 copay		Deductible/Coinsurance	
TMJ Disorders (\$1,000 PCY/\$5,000 per Lifetime, Combined Inpatient & Outpatient)	Inpatient: Deductible/Coinsurance		Inpatient: Deductible/Coinsurance		Inpatient: Deductible/Coinsurance		Inpatient: Deductible/Coinsurance	
	Outpatient: \$20 copay		Outpatient: \$25 copay, then Coinsurance		Outpatient: \$25 copay, then Coinsurance		Outpatient: Deductible/Coinsurance	
Transplants (Unlimited)	Deductible/Coinsurance		Deductible/Coinsurance		Deductible/Coinsurance		Deductible/Coinsurance	
SUPPLEMENTAL BENEFITS								
Routine Vision Exam (1 PCY) <i>Hardware not covered</i>	\$20 copay		\$25 copay, then Coinsurance		\$25 copay, then Coinsurance		Deductible/Coinsurance	
PHARMACY PLAN								
	Participating	Mail Order	Participating	Mail Order	Participating	Mail Order	Participating	Mail Order
Maximum day supply	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days
TIER 1 Generic	\$5 copay	\$15 copay	\$5 copay	\$15 copay	\$5 copay	\$15 copay	Deductible/Coinsurance	
TIER 2 Brand Name	\$20 copay	\$45 copay	\$20 copay	\$45 copay	\$20 copay	\$45 copay	Deductible/Coinsurance	
TIER 3 Non-formulary	50%	50%	50%	50%	50%	50%	Deductible/Coinsurance	



GROUP HEALTH HMO MEDICAL PLANS

Summary of In-Network Benefits (Refer to plan summary for Out-of-Network Benefits for Options A and Options 200 plans.)

	OPTIONS A	OPTIONS 200	SELECT 750 (No Out-of-Network Benefits)
MEDICAL COST SHARE OPTIONS			
Deductible Per Calendar Year (PCY)	No Annual Deductible	Individual: \$200 Family: \$600	Individual: \$750 Family: \$2,250
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	No Plan Coinsurance	No Plan Coinsurance	Plan pays 80%, you pay 20%
Out-of-pocket limit (OOP) PCY	Individual: \$1,000 Family: \$2,000	Individual: \$2,000 Family: \$6,000	Individual: \$2,000 Family: \$6,000
	OOP expenses for the following covered services are included in the OOP limit: Inpatient Services, Outpatient Services, Emergency Services at a Managed Health Care Network (MHCN) facility and Ambulance Services.	OOP expenses for the following covered services are included in the OOP limit: Outpatient Services, Emergency Services at a Managed Health Care Network (MHCN) facility and Ambulance Services.	OOP expenses for the following covered services are included in the OOP limit: Plan Coinsurance, Emergency Services at a Managed Health Care Network (MHCN) facility and Ambulance Services.
Outpatient Services (Office Visits)	\$15 copay	\$15 copay, Deductible applies	\$20 copay, Deductible and Coinsurance apply
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Care (Well-care physicals, immunizations, Pap smear exams, mammograms)	Covered in full	Covered in full	Covered in full
Tobacco cessation counseling	Free & Clear Program - covered in full	Free & Clear Program - covered in full	Free & Clear Program - covered in full
PROFESSIONAL CARE			
Inpatient/Outpatient	See Facility Care Options	See Facility Care Options	See Facility Care Options
DIAGNOSTIC SERVICE OPTIONS			
Diagnostic lab and X-ray services (High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency or Inpatient Services.)	Covered in full	Inpatient: Covered under Hospital Services	Inpatient: Covered under Hospital Services
		Outpatient: Deductible applies	Outpatient: Deductible and Coinsurance apply



GROUP HEALTH HMO MEDICAL PLANS

Summary of In-Network Benefits (Refer to plan summary for Out-of-Network Benefits for Options A and Options 200 plans.)

	OPTIONS A	OPTIONS 200	SELECT 750 (No Out-of-Network Benefits)
FACILITY CARE OPTIONS			
Hospital Services (Inpatient Services)	Covered in full	\$100 copay, per day for up to 5 days per admit Deductible applies	Deductible and Coinsurance apply
Outpatient Surgery	\$15 copay	\$15 copay, Deductible applies	\$20 copay, Deductible and Coinsurance apply
Skilled Nursing Facility (Up to 100 days PCY)	Covered in full	Deductible applies	Deductible and Coinsurance apply
EMERGENCY CARE OPTIONS			
Emergency Services (Copay waived if admitted)	\$100 copay	\$100 copay, Deductible applies	\$100 copay, Deductible and Coinsurance apply
Ambulance Services	Plan pays 80%, you pay 20%	Deductible and Coinsurance	Plan pays 80%, you pay 20%
OTHER SERVICES			
Acupuncture (Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by the plan)	\$15 copay	\$15 copay, Deductible applies	\$20 copay, Deductible and Coinsurance apply
Chemical Dependency (Unlimited)	Inpatient: Covered in full	Inpatient: \$100 copay, per day for up to 5 days per admit, Deductible applies	Inpatient: Deductible and Coinsurance apply
	Outpatient: \$15 copay	Outpatient: \$15 copay, Deductible applies	Outpatient: \$20 copay, Deductible and Coinsurance apply
Home Health Services (No visit limit)	Covered in full	Covered in full	Covered in full
Hospice Services	Covered in full	Covered in full	Covered in full
Manipulative Therapy (Self-referred up to 20 visits PCY)	\$15 copay	\$15 copay, Deductible applies	\$20 copay, Deductible and Coinsurance apply
Devices, equipment and supplies (Durable medical equipment, orthopedic appliances, post-mastectomy bras limited to two (2) every six (6) months, ostomy supplies, prosthetic devices)	Covered in full	Covered at 80%	Covered at 80%



GROUP HEALTH HMO MEDICAL PLANS

Summary of In-Network Benefits (Refer to plan summary for Out-of-Network Benefits for Options A and Options 200 plans.)

	OPTIONS A	OPTIONS 200	SELECT 750 (No Out-of-Network Benefits)			
OTHER SERVICES (continued)						
Mental Health (Unlimited)	Inpatient: Covered in full	Inpatient: \$100 copay, per day for up to 5 days per admit Deductible applies	Inpatient: Deductible and Coinsurance apply			
	Outpatient: \$15 copay	Outpatient: \$15 copay, Deductible applies	Outpatient: \$20 copay, Deductible and Coinsurance apply			
Rehabilitation Services (Occupational, speech, physical including services for neurodevelopmentally disabled children age six and under) Rehabilitation visits are a total of combined therapy visits PCY (Inpatient: 60 days PCY, Outpatient: 60 visits PCY)	Inpatient: Covered in full	Inpatient: \$100 copay, per day for up to 5 days per admit Deductible applies	Inpatient: Deductible and Coinsurance apply			
	Outpatient: \$15 copay	Outpatient: \$15 copay, Deductible applies	Outpatient: \$20 copay, Deductible and Coinsurance apply			
Massage Services	See Rehabilitation Services	See Rehabilitation Services	See Rehabilitation Services			
Temporomandibular Joint (TMJ) Services (\$1,000 PCY/\$5,000 lifetime max)	Inpatient: Covered in full	Inpatient: \$100 copay, per day for up to 5 days per admit Deductible applies	Inpatient: Deductible and Coinsurance apply			
	Outpatient: \$15 copay	Outpatient: \$15 copay, Deductible applies	Outpatient: \$20 copay, Deductible and Coinsurance apply			
Organ Transplants (Unlimited, No waiting period)	Inpatient: Covered in full	Inpatient: \$100 copay, per day for up to 5 days per admit Deductible applies	Inpatient: Deductible and Coinsurance apply			
	Outpatient: \$15 copay	Outpatient: \$15 copay, Deductible applies	Outpatient: \$20 copay, Deductible and Coinsurance apply			
SUPPLEMENTAL BENEFITS						
Routine Vision Care (1 visit every 12 months) <i>Hardware not covered</i>	\$15 copay	\$15 copay, Deductible waived	\$20 copay, Deductible and Coinsurance waived			
PHARMACY PLAN (some injectable drugs may be covered under Outpatient Services)						
	GH Facility	Mail Order	GH Facility	Mail Order	GH Facility	Mail Order
Maximum day supply	30 days	90 days	30 days	90 days	30 days	90 days
Formulary generic	\$5 copay	2x prescription cost share	\$5 copay	2x prescription cost share	\$5 copay	2x prescription cost share
Formulary brand	\$30 copay	2x prescription cost share	\$30 copay	2x prescription cost share	\$30 copay	2x prescription cost share
Non-formulary	50%	2x prescription cost share	50%	2x prescription cost share	50%	2x prescription cost share



The Standard[®] THE STANDARD LIFE PLANS

BASIC LIFE & ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) | NOTE: Basic Life is a mandatory employer-paid benefit. All eligible employees must be enrolled.

OVERVIEW			RATES		ADEA Benefit Reduction Schedule	
Basic Life	AD&D	Maximum			Employee & Spouse*	
\$12,000	\$12,000	see Basic Life	Employee Basic Life and AD&D	\$0.15 per \$1,000	At age 70	Rate and benefit reduced to 65% of original
\$15,000	\$15,000	see Basic Life	Dependent Basic Life (1 or more)	\$0.65 for \$1,000 benefit	At age 75	Rate and benefit reduced to 45% of original
\$20,000	\$20,000	see Basic Life			At age 80	Rate and benefit reduced to 30% of original
\$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				
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						

VOLUNTARY TERM LIFE (VTL) INSURANCE

OVERVIEW			RATES			ADEA Benefit Reduction Schedule																																																				
<ol style="list-style-type: none"> VTL is a portable benefit and can be maintained upon termination, as long as termination is not due to retirement or disability. High limits for: <ul style="list-style-type: none"> 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 (Not to exceed 100% of employee's VTL amount) Employees must have coverage in order to cover spouse and children. 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) Low rates per \$10,000 coverage (see Rate Table) Complies with Voluntary Life ADEA (see Benefit Reduction Schedule) Accelerated benefit available to employee, spouses*, and children if at least \$10,000 of coverage is in force. 			Rate per unit (unit = \$10,000) Age as of December 31 <table border="1"> <thead> <tr> <th>Employee</th> <th>Spouse*</th> </tr> </thead> <tbody> <tr><td>Under 20</td><td>\$0.56</td><td>\$0.60</td></tr> <tr><td>20-24</td><td>\$0.66</td><td>\$0.70</td></tr> <tr><td>25-29</td><td>\$0.71</td><td>\$0.75</td></tr> <tr><td>30-34</td><td>\$0.82</td><td>\$0.90</td></tr> <tr><td>35-39</td><td>\$0.98</td><td>\$1.05</td></tr> <tr><td>40-44</td><td>\$1.45</td><td>\$1.55</td></tr> <tr><td>45-49</td><td>\$2.35</td><td>\$2.45</td></tr> <tr><td>50-54</td><td>\$3.91</td><td>\$4.09</td></tr> <tr><td>55-59</td><td>\$5.81</td><td>\$5.87</td></tr> <tr><td>60-64</td><td>\$8.74</td><td>\$9.57</td></tr> <tr><td>65-69</td><td>\$12.53</td><td>\$13.53</td></tr> <tr><td>70 & Over</td><td>\$12.53</td><td>n/a</td></tr> </tbody> </table> Children - \$0.44 per \$2,000			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	Spouse* voluntary term life insurance terminates on the date the spouse* becomes 70 years of age. <table border="1"> <thead> <tr> <th></th> <th>Employee</th> <th>Spouse*</th> </tr> </thead> <tbody> <tr> <td>At age 70</td> <td>Rate and benefit reduced to 65% of original</td> <td>No coverage</td> </tr> <tr> <td>At age 75</td> <td>Rate and benefit reduced to 45% of original</td> <td>No coverage</td> </tr> <tr> <td>At age 80</td> <td>Rate and benefit reduced to 30% of original</td> <td>No coverage</td> </tr> </tbody> </table>				Employee	Spouse*	At age 70	Rate and benefit reduced to 65% of original	No coverage	At age 75	Rate and benefit reduced to 45% of original	No coverage	At age 80	Rate and benefit reduced to 30% of original	No coverage
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VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (VAD&D) INSURANCE

OVERVIEW			RATES		ADEA Benefit Reduction Schedule																			
<ol style="list-style-type: none"> Coverage sold in units of \$25,000, from \$25,000 up to \$500,000 maximum Maximum benefit of \$500,000 - any amount in excess of \$250,000 may not exceed ten times your annual earnings Spouse* may select 50% or 100% of Employee's Benefit (Not to exceed 100% of employee's VAD&D amount) Children may be covered up to 10% of employee benefit not to exceed \$30,000 (Not to exceed 100% of employee's VAD&D amount) Other VAD&D Features: <ul style="list-style-type: none"> Higher Education Benefit Career Adjustment Benefit Paralysis Benefit Common Disaster Benefit Expanded AD&D Package Complies with VAD&D ADEA (see Benefit Reduction Schedule) 			Rate per unit (unit = \$1,000) <table border="1"> <tbody> <tr> <td>Employee</td> <td>\$0.025</td> </tr> <tr> <td>Spouse*</td> <td>\$0.025</td> </tr> <tr> <td>Child(ren)</td> <td>\$0.030</td> </tr> </tbody> </table>		Employee	\$0.025	Spouse*	\$0.025	Child(ren)	\$0.030	Employee & Spouse* <table border="1"> <tbody> <tr> <td>At age 70</td> <td>Rate and benefit reduced to 65% of original</td> </tr> <tr> <td>At age 75</td> <td>Rate and benefit reduced to 45% of original</td> </tr> <tr> <td>At age 80</td> <td>Rate and benefit reduced to 30% of original</td> </tr> <tr> <td>At age 85</td> <td>Rate and benefit reduced to 20% of original</td> </tr> <tr> <td>At age 90</td> <td>Rate and benefit reduced to 15% of original</td> </tr> <tr> <td>95 or over</td> <td>Rate and benefit reduced to 10% of original</td> </tr> </tbody> </table>		At age 70	Rate and benefit reduced to 65% of original	At age 75	Rate and benefit reduced to 45% of original	At age 80	Rate and benefit reduced to 30% of original	At age 85	Rate and benefit reduced to 20% of original	At age 90	Rate and benefit reduced to 15% of original	95 or over	Rate and benefit reduced to 10% of original
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* or qualified domestic partner

This benefit comparison is intended to provide a brief description of 2012 coverage and is not a complete explanation of covered services, exclusions, limitations, reductions, or the terms under which the program may be continued in force. This summary is not a contract. For full coverage provisions, including a description of waiting periods, limitations, and exclusions please refer to the applicable summary plan documents posted to www.wcif.net. 2012 documents will be posted as they are approved by respective carriers. Members seeking guidance concerning legislative topics may contact their employment law advisor or refer to the appropriate federal and/or state agency.



The Standard[®] 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 <i>Employer Paid</i>	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 <i>Employee Paid</i>	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	Stand Alone (no WCIF medical)
\$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 - \$10,000	\$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 <i>Employee Paid</i>	60% weekly benefit up to \$1,000 per week with a 30 day waiting period
Maximum Benefit Period	Option 1: 180 days (coincides with Base LTD enrollment) Option 2: 90 days (coincides with Buy-Up LTD enrollment)

Rates

Monthly Salary Range	Monthly Premium Due	
	180-DAY COVERAGE	90-DAY COVERAGE
\$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 +	\$37.30	\$24.80



MAGELLAN HEALTH SERVICES EMPLOYEE ASSISTANCE PROGRAM (EAP)

NOTE: This plan is bundled with all WCIF medical plans, or available as a 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 6 one-hour counseling sessions per problem per year					
Services Provided	<p>For Management: Program orientation and training for supervisors. Telephone consultation service to assist them in approach and support for troubled employees. Guidelines for working with drug-free workplace policies. Service includes promotion and orientation for all employees through brochures, posters and videos.</p> <p>For Employees: Assessment and referral. 24-hour toll free phone lines for immediate help in crisis or urgent situations. Access to local professional counselors at no cost to the employee for up to six counseling sessions per problem per year. EAP sessions last one hour. For treatment beyond EAP services, refer to counselors within the community or covered by employee's insurance plan, if appropriate.</p>					
Problems Addressed	Personal Concerns	Home Life & Family Concerns	Legal Services	Financial Services	Management Services	Web Resources www.magellanhealth.com/member
	<ul style="list-style-type: none"> - Ambivalence - Antisocial Behavior - Depression/Suicidal Thoughts - Literacy Program Information - Sleep Problems - Sexual Concerns - Anxiety Reactions - Withdrawal - Self Confidence / Self Worth - Guilt - Insecurity - Loss - Harassment <p><i>Also addresses occupational adjustments, occupational stress, behavioral concerns, and chemical dependency</i></p>	<ul style="list-style-type: none"> - Family Violence - Single Parenting - Step Parenting - Adolescent Adjustment - Parent/Child Relationships - Value Conflicts - Separation/ Divorce Adjustment - Communication Problems - Sexual Concerns - Role Conflicts 	<ul style="list-style-type: none"> - Free one-hour initial consultation per subject matter per year with attorney - If legal matter requires ongoing service, 25% discount on fees is offered - Via website, wide range of legal information is available including an interactive will preparation program 	<ul style="list-style-type: none"> - Free one-hour initial consultation per subject matter per year with financial professional - Unlimited free telephone consultation for financial matters with financial counselor - Via website, wide range of financial information - Financial Problem Referrals 	<ul style="list-style-type: none"> - Supervisor Consultations - Critical Incident/Trauma Debriefing - Assistance with Drug/Substance Abuse <p>*Please note that there may be additional fees associated with some services such as, Critical Incident/Trauma Debriefing</p>	<ul style="list-style-type: none"> - Library of Resources and Articles - EAP Provider Self Referral - Child and Elder Care Databases for Self Search - Fitness Tools and Calculators - Legal and Financial Tools and Calculators - Self-Assessments and Personal Development Plans - Online Trainings and more - NEW Healthy Roads™ online wellness program - NEW Online Discount Center
Rates	<p>\$1.94 Per Employee Per Month <i>covers employee and all individuals in employee's household</i></p>					



Consumer Driven Health Plans (CDHP) Health Savings Account (HSA) & Flexible Spending Account (FSA) including Dependent Daycare Assistance Program (DCAP)

Business Solutions Inc. (BSI) administers Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), and Dependent Daycare Assistance Programs (DCAPs) for WCIF members. Employers may only offer HSAs to employees enrolled in the Premera WCIF HDHP plan.

SERVICES	RATES / FEES
HSA/FSA/DCAP Administration	\$5.25 HSA/FSA/DCAP per enrollee per month
Debit Card	<p>\$1 one time fee per card (employer paid)</p> <p>\$10 replacement fee per card (employee paid)</p>

DENTAL PLANS

WASHINGTON DENTAL SERVICE PPO PLANS & WILLAMETTE DENTAL MANAGED CARE PLAN

	WASHINGTON DENTAL SERVICE				
	PPO PLANS Participating Providers		ENHANCED PPO PLANS Member Providers		INCENTIVE PLANS DeltaPremier
	Plan A-1	Plan B-4	Plan C-1 & C-2	Plan D-3 & D-4	Incentive Plan 1
	No Deductible				
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% Premier dentists 70%-100% Nonparticipating 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% Premier dentists 70%-100% Nonparticipating 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% Premier dentists 50% Nonparticipating 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

* Claim payments will be based on actual charges or WDS' maximum allowable fees for nonparticipating dentists in the state in which services are performed, whichever is less. The patient will be responsible for any balance remaining.

RATES				
100% Employer paid	Plan A-1	Plan C-1	Plan D-3	Incentive Plan 1
Employee	\$47.83	\$50.49	\$53.42	\$53.96
Employee & Dependents (1 or more)	\$133.63	\$140.47	\$148.06	\$149.44
Composite	\$92.39	\$97.43	\$106.32	\$107.32
100% Employer paid except dependents	Plan B-4	Plan C-2	Plan D-4	
Employee	\$50.62	\$50.49	\$53.42	
Employee & 1 Dependent	\$90.20	\$89.98	\$94.65	
Employee & Dependents (2 or more)	\$162.20	\$162.37	\$170.68	

	WILLAMETTE DENTAL
	MANAGED CARE DENTAL PLAN
Deductible	No Deductible
Annual Maximum	No Annual Maximum
General Office Visit	\$15 copay per visit
Diagnostic and Preventive Services, Restorative Dentistry, Prosthetics, Oral Surgery, Endodontics and Periodontics	Covered at 100%
Emergency Office Visit	\$50 copay per visit
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.
RATES	
Managed Care Dental Plan	
Employee	\$55.77
EE + 1 Dependent	\$92.81
EE + Dependents (2 or more)	\$148.52
Composite	\$93.62



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
Frames and Lenses	Frames:	100%* after \$15 copay Once every 24 months <i>*frame of your choice covered up to \$130.00</i>	Frames:	100%* after \$15 copay Once every 24 months <i>*frame of your choice covered up to \$130.00</i>	Frames:	100%* after \$15 copay Once every 24 months <i>*frame of your choice covered up to \$130.00</i>
	Lenses:	Once every 12 months Single vision, lined bifocal, lined trifocal lenses, ultra violet protection, scratch-resistant coating, anti-reflective coating, and rimless mounting covered; Polycarbonate lenses for dependent children	Lenses:	Once every 12 months Single vision, lined bifocal, lined trifocal lenses, ultra violet protection, scratch-resistant coating, anti-reflective coating, and rimless mounting covered; 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:	100%* after \$20 copay - applies once per 12 month benefit period; single vision, lined bifocal, & lined trifocal lenses; Polycarbonate lenses for dependent children <i>*frame of your choice covered up to \$130.00</i>				
Contact Lenses	Contacts:	Once every 12 months <i>(Same benefit applies to First and Second Pair)</i> \$120 allowance for contacts and contact lens exam (fitting and evaluation)	Contacts:	Once every 12 months \$120 allowance for contacts and contact lens exam (fitting and evaluation)	Contacts:	Once every 24 months \$120 allowance for contacts and contact lens exam (fitting and evaluation)
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 Coverage plan still applies.)					

RATES

		EXTENDED PLAN	STANDARD PLAN	BUDGET PLAN
Four-Tiered	Employee	\$12.54	\$8.93	\$6.29
	Employee & Spouse*	\$23.82	\$16.95	\$11.95
	Employee & Child(ren)	\$21.93	\$15.61	\$11.01
	Employee, Spouse*& Child(ren)	\$33.22	\$23.64	\$16.67
Composite	Employee, Spouse*& Child(ren)	\$23.48	\$17.38	\$12.37

* or qualified domestic partner

RETIREE PLANS

RETIREE MEDICAL PLANS *under age 65***

PREMERA BLUE CROSS PPO PLAN			
REGULAR RETIREES		LEOFF I RETIREES	
FOR BENEFITS SEE WCIF 750 PLAN (Pages 1 - 3)		FOR BENEFITS SEE WCIF 200 PLAN (Pages 1 - 3)	
Retiree	\$676.13	Retiree	\$881.20
Retiree/Spouse*	\$1,493.27	Retiree/Spouse*	\$1,908.39
Retiree/Child(ren)	\$1,220.79	Retiree/Child(ren)	\$1,561.45
Retiree/Spouse* /Child(ren)	\$2,037.92	Retiree/Spouse* /Child(ren)	\$2,588.63
GROUP HEALTH HMO PLAN			
REGULAR RETIREES		LEOFF I RETIREES	
FOR BENEFITS SEE SELECT 750 PLAN (Pages 4 - 6)			
Retiree	\$804.19	Retiree	\$950.78
Retiree/Spouse*	\$1,303.17	Retiree/Spouse*	\$1,449.75
Retiree/Child(ren)	\$1,246.94	Retiree/Child(ren)	\$1,393.53
Retiree/Spouse* /Child(ren)	\$1,940.13	Retiree/Spouse* /Child(ren)	\$2,086.73

RETIREE MEDICAL PLAN *over age 65***

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

MONUMENTAL LIFE MEDICARE SUPPLEMENTAL PLAN	
MEDICAL COVERAGE	
Medicare Coverage	Coinsurance
Hospitalization	\$0
Part A Deductible (\$1,068)	\$0
Skilled Nursing Coinsurance	\$0
Part B Deductible (\$135)	\$0
Part B Coinsurance (generally 20%)	\$0
Part B Excess	Charges Covered
Foreign Travel	\$250 Deductible 20% Max \$50,000
Maximum out of pocket expenses	None
PRESCRIPTION DRUG COVERAGE	
Copay	
Deductible	None
Generics	\$0
Preferred Brands	\$30
Non Preferred Brands	\$60
Specialty Drugs (cost \$600 or more)	33%
Mail Order	2 copayments
Maximum Benefit	Unlimited
RATE	
Retiree/Spouse*	\$359.65
SEE WWW.WCIF.NET FOR ADDITIONAL INFORMATION	

**or qualified domestic partner*

** Bundled benefits are not available to retirees.*

RETIREE DENTAL PLAN

WASHINGTON DENTAL SERVICE (WDS)	
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 \$62.23
	Spouse* \$62.15
	Child(ren) \$61.30

RETIREE VISION PLAN

VISION SERVICE PLAN (VSP)	
Eye Examination	Once every 12 months 100% after \$10 copay
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 \$130.00</i>
Contact Lenses	Once every 12 months Up to \$120 allowance for contacts and contact lens exam (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 \$8.49
	Retiree & dependent(s) \$19.80

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.