



2016 Enrollment Guide for: Island County

Your employer offers the following benefits through WCIF:

- Medical
- Dental
- Voluntary Vision
- Employee Assistance Program (EAP)
- Life and Accidental Death & Dismemberment (AD&D) Coverage
- Voluntary Term Life (VTL)
- Base Long Term Disability (BLTD)
- Voluntary Accidental Death & Dismemberment (VAD&D)
- Voluntary Long Term Disability Buy-up (LTD Buy-up)
- Voluntary Short Term Disability (VSTD)

This benefit comparison is intended to provide a brief description of 2016 coverage and is not a complete explanation of covered services, exclusions, limitation, reductions or the 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 and exclusion, please refer to the applicable summary plan documents posted to www.wcif.net. 2016 documents will be posted as they are approved by respective carriers.

	WCIF 750	WCIF 1250	WCIF HSA
Provider Network			
Medical Cost Share Options			
Deductible PCY			
Individual	\$750	\$1,250	\$1,500
Family	\$1,500	\$2,500	Aggregate Family: \$3,000
Coinsurance	20%	20%	20%
Out-of-pocket max <small>(includes all cost shares for covered services)</small>			
Individual	\$5,750	\$6,350	\$3,400
Family	\$11,500	\$12,700	Aggregate Family: \$6,800
Office Visit	\$25 Copay	\$30 Copay	Ded / Coins
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 Ded / Coins
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	Ded / Coins
Emergency Care Copay <small>(waive copay if admitted)</small>	\$150 Copay Ded / Coins	\$200 Copay Ded / Coins	Ded / Coins
Pharmacy 30 day supply			
Generic – Tier 1	\$5 Copay	\$5 Copay	Ded / Coins
Brand Name – Tier 2	\$20 Copay	\$20 Copay	Ded / Coins
Non-preferred – Tier 3	\$50 Copay	\$50 Copay	Ded / Coins

PCY = Per Calendar Year

Introducing Virtual Care - \$10 Copay Per Visit*

Premera now covers virtual care. Virtual care gives members immediate and convenient access to care whenever and wherever they need it. Premera members can avoid some trips to urgent care or the emergency room by receiving care virtually from their own doctor or from a Teladoc doctor (Teladoc is a Premera contracted service provider for virtual care). Virtual care is not meant to replace a member's relationship with their primary care provider (PCP) or to replace all in-person, face-to-face visits. It is an expansion of service delivery options. In some cases, it can help members avoid a trip to the emergency room for non-emergency care, or save a trip to urgent care for a simple prescription. Teladoc physicians consult, diagnose, and can even prescribe medication, if medically necessary.

How Virtual Care Works – Four Simple Steps:

Register via phone (855) 332-4059 or online at www.teladoc.com/premera

Consult a physician anytime via phone or online video

Pay your \$10 copay* and Teladoc will send the claim to Premera

Teladoc will contact your PCP and coordinate future care

PCPs and Other Local Providers

If a member's doctor offers consultation, diagnosis, treatment advice, and prescriptions by phone, video, or other online media, Premera reimburses for virtual care at the standard copay, coinsurance, and deductible level.

Please note: Active employer group medical coverage can only be waived if you have other group

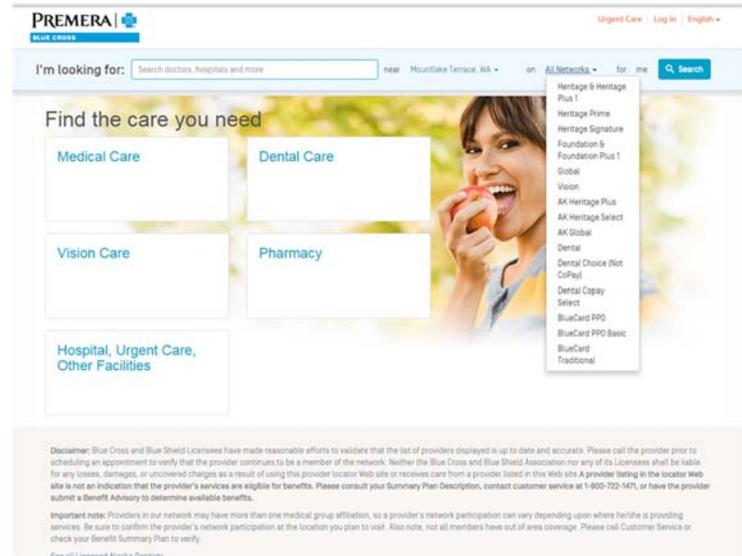
Heritage Prime Network

Provider Search Instructions

To check if your provider will be in Premera's Prime Network please go to:

<https://www.premera.com/wa/visitor/find-a-doctor/>

- 1) You may log in as a member to search for a provider or you may select "Search for providers in our widest networks" under the Visitor box.
- 2) Enter your provider's name and zip code at the top of the screen in the "I'm looking for" search box.
- 3) Select Heritage Prime under network drop down box, then
- 4) Click Search



It is always a good idea to confirm with your provider directly if they are in the Prime network as sometimes the insurance carrier does not have the most up-to-date information on their websites. Provider contracts are regularly negotiated and there is no way to guarantee or predict continued provider participation in any given network. Providers are subject to change without notice to members.

Heritage Prime Network — New ID Cards

New ID cards will be mailed to the address on record in late December / early January. Please be on the lookout for a plain envelope. If you do not receive a new card in the mail, you can log in to Premera.com to order a new card or call customer service at (877) 500-9247, Monday through Friday, 8am to 5pm.



Reminders.....

1. Prescription drug formularies are reviewed on an ongoing basis and are subject to change with limited notice to members.
2. Some services require prior authorization. Members should make sure their provider requests an authorization in advance for certain services. This pre-service, or prospective review, must be completed before the service is rendered. If the member uses an In-network provider, the provider is responsible for the prior authorization. If the member uses an Out-of-network provider, it is the member's responsibility to make sure their doctor requests the Prior Authorization. A penalty up to \$1,500 may apply for non-compliance.

Prior Authorization helps to:

- Verify coverage before a scheduled procedure
- * Save money and avoid extra costs
- * Give an estimate of out-of-pocket costs
- * Avoid inappropriate or unnecessary medical treatment and unnecessary services

Prior Authorization does not apply for: Emergency room services, Dialysis services, and Childbirth



Medical

offered by Group Health

Customer Service: (888) 901-4636

24-Hour Nurseline: (800) 297-6877

www.ghc.org

Medical Cost Share Options		Options 200
Deductible		
Individual		\$200
Family		\$400
Coinsurance		0%
Out-of-pocket max (includes all cost shares for covered services)		
Individual		\$2,200
Family		\$4,400
Office Visit		\$20 Copay Ded applies
Preventive Care		Covered in Full
Manipulations (spinal)		20 Visits PCY \$20 Copay Ded applies
Diagnostic Laboratory and X-ray Services Some services may require pre-authorization		Inpatient: Covered under Hospital Services Outpatient: Ded applies
Inpatient Facility		\$100 Copay per day for up to 5 days per admit; Ded applies
Outpatient Surgery Facility		\$20 Copay Ded applies
Emergency Care (waive copay if admitted)		\$100 Copay Ded applies
Pharmacy 30 day supply		
Preferred Generic – Tier 1		\$5 Copay
Preferred Brand Name – Tier 2		\$25 Copay
Non-preferred – Tier 3		\$50 Copay

PCY = Per Calendar Year



Vision

Offered by Vision Service Plan

Customer Service: (800) 877-7195

VSP Voluntary	
Monthly Rate	
Composite	\$9.54

VOLUNTARY PLAN		
Eye Examination	Exam:	Once every 12 months 100% after \$15 Copay
Diabetic Eyecare Plus:	Exam:	100% after \$20 Copay
Frames and Lenses	Frames:	Once every 24 months 100% after \$15 Copay Frames covered up to \$120.00 \$95 allowance at Costco
	Lenses:	Once every 24 months Single vision, lined bifocal, & lined trifocal lenses; Polycarbonate lenses for dependent children
Contact Lenses	Frequency:	Once every 24 months
	Fitting and evaluation: Lenses:	100% after max \$60 Copay \$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.	

Please note: Active employer group medical coverage can only be waived if you have other group



Delta Dental of Washington

Dental

offered by Delta Dental of Washington

Customer Service: (800) 554-1907 www.deltadentalwa.com

	Island County DeltaPremier
	Base Plan
Deductible	\$50 / \$150
Annual Maximum	\$1,000
Class I - Diagnostic & Preventive (Sealants covered up to age 15)	60% Premier dentists 60% Nonparticipating 60% Out-of-State dentists*
Class II - Restorative Restorations, Endodontics, Periodontics, Oral Surgery	60% Premier dentists 60% Nonparticipating 60% Out-of-State dentists*
Class III - Major Crowns, Dentures, Partials, Bridges, and Implants	40% Premier dentists 40% Nonparticipating 40% Out-of-State dentists*
Orthodontia (Adults and Children)	Not Covered
* 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.	

	ENHANCED PPO PLANS Member Providers
	Buy-Up Plan
Deductible	No Deductible
Annual Maximum	\$2,000
Class I - Diagnostic & Preventive (Sealants covered up to age 15)	100% PPO dentists 100% Premier dentists 100% Nonparticipating dentists*
Class II - Restorative Restorations, Endodontics, Periodontics, Oral Surgery	90% PPO dentists 80% Premier dentists 80% Nonparticipating dentists*
Class III - Major Crowns, Dentures, Partials, Bridges, and Implants	50% PPO dentists 50% Premier dentists 50% Nonparticipating dentists*
Orthodontia (Adults and Children)	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.	



Dental

offered by Willamette Dental of Washington

Customer Service: (800) 359-6019

www.willamettedental.com

	MANAGED CARE DENTAL PLAN
Deductible	No Deductible
Annual Maximum	No Annual Maximum
General Office Visit	\$10 copay per visit
Diagnostic and Preventive Services, Restorative Dentistry, Prosthetics, Oral Surgery, Endodontic and Preiodontics	Covered at 100%
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.

Our benefit program includes an Employee Assistance Program (EAP) which provides confidential consultation for you, everyone living in your household, and dependent children up to age 26 living away from home. This program is free of cost to you and provides confidential assistance for a wide variety of life's challenging personal circumstances.

Magellan Health Services EAP provides up to 6 in-person counseling sessions, per issue, per year for any problem, issue, stressor, or concern. **No problem is too big or too small!**

Phone and In-Person Services include:

- ⇒ Access to services 24/7 via the toll-free number or online with licensed mental health professionals
- ⇒ Referrals to EAP counselors, as needed, for in-person counseling up to 6 visits per issue per year
- ⇒ Referrals to community resources
- ⇒ Professional Legal Consultations — *free initial consultation, ongoing services at 25% discount*
- ⇒ Financial Services — *free telephonic consultations*

Online Services Include:

- ⇒ *Live Chat with a live online specialist to obtain answers to benefit plan questions during normal business hours*
- ⇒ Interactive website with information on a variety of personal, family, and work-related concerns
- ⇒ Legal and Financial forms library
- ⇒ Interactive wellness tools
- ⇒ Online library and resources such as a discount center and medical information center

Employee Assistance Program

Instructions for Accessing Free Online Will Preparation

www.magellanassist.com or www.magellanhealth.com/member

If Not Already Registered, Select New or Unregistered User

Enter 800-523-5668

Enter: Employer Name

Magellan now requires you to register as they save the documents to your account.

Under Benefits (middle of the page) select (click) the last tab: Legal & Financial

Select: Legal & Financial Resources and click on the "Visit Site" button

Select: Legal Forms, then Personal Documents

From there you will be prompted to enter your state and then select the type of document you want to create. Search for Washington from the drop down list. *Please note, online will preparation will be found under the Wills, Powers of Attorney and Estate Planning category.*



Long Term Disability Coverage

offered by Standard Insurance Company

www.standard.com

*Base Plan provided to employees enrolled in medical
Buy-Up Plan available to employees in Base Plan*

Base Long Term Disability (LTD)

Have you ever thought about how you would protect yourself, your lifestyle, and those who count on you from an unexpected loss of income? Would you be able to meet your financial obligations if you became disabled and unable to work? If you depend on your regular paycheck to pay your bills, what would happen if you became sick and couldn't work?

Your employer provides eligible employees with Base LTD coverage to help protect a certain level of income.

Benefit Amount:	40% of pre-disability earnings (up to \$10,000 monthly salary)
Maximum Benefit:	\$4,000 per month
Waiting Period:	180 days from the date of disability

Voluntary Buy-up Long Term Disability (Buy-up LTD)

Guarantee issue coverage only applies during the initial eligibility period.

Since every employee's needs are different, your employer also provides eligible employees with the opportunity to apply for coverage under a voluntary Buy-up LTD plan from The Standard. The advantages of the Voluntary Buy-up LTD coverage include choice, flexibility, convenience, and peace of mind.

If you are enrolled in the Base LTD plan, your employer offers you an opportunity to purchase Voluntary Buy-up LTD benefits on a discounted basis based on your salary. This is an excellent opportunity to help protect yourself and your lifestyle. Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments. The coverage under the Voluntary Buy-up LTD plan increase the Base LTD plan benefits.

Benefit Amount:	60% of pre-disability earnings (up to \$10,000 monthly salary)
Maximum Benefit:	\$6,000 per month
Waiting Period:	90 days from the date of disability



Life / Accidental Death & Dismemberment and Voluntary Coverages

offered by Standard Insurance Company

Customer Service: (800) 848-5132
www.standard.com

Travel Assistance Program Group #: 9061
Customer Service: (800) 527-0218 or In other countries worldwide,
call +1(410) 453-6330 collect

Basic Life / Accidental Death & Dismemberment (AD&D)

Your employer provides you with a Basic Life/AD&D Plan. As part of this benefit, a Travel Assistance Program through United Healthcare Global is included. This Travel Assistance Program helps you cope with emergencies when you travel more than 100 miles from home or internationally for trips up to 180 days. The program can help you with non-emergencies, such as trip planning as well. The following services are included:

- ⇒ Pre-Trip Assistance
- ⇒ Trip Assistance
- ⇒ Medical Assistance
- ⇒ Legal Assistance
- ⇒ Emergency Transportation Services
- ⇒ Personal Security Services

Please refer to the Travel Assistance Flyer or online brochure for more information.

Voluntary Term Life (VTL)

Guarantee issue coverage **only applies during the initial eligibility period.**

The time you spend with your family is priceless, and you wouldn't trade those special moments together for anything in the world. But what would happen if you suddenly died?

Would your family have the funds to pay bills, your home mortgage, burial and funeral expenses? Would your family be able to live on one income and maintain their current lifestyle? What about medical expenses associated with a terminal illness? Would your family be financially prepared? Your employer offers you an excellent opportunity to help protect your loved ones by sponsoring group Voluntary Term Life (VTL) coverage. Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

How much coverage may I get for myself and my dependents?

- ⇒ You may elect VTL coverage for yourself in units of \$10,000 to a maximum of \$500,000 or 6 times your annual salary when combined with your employer-provided coverage.
- ⇒ You may elect VTL coverage for your spouse in units of \$10,000 to a maximum of \$250,000, but not to exceed 100% of your VTL coverage.
- ⇒ You may elect VTL coverage for your children in units of \$2,000 to a maximum of \$10,000, but not to exceed 100% of your VTL coverage.

If you enroll within 31 days of benefit eligibility and meet the active work requirement, you will automatically qualify for up to a set amount of insurance coverage called the "guarantee issue amount". The set amounts of coverage are as follows:

Employee:	Up to \$50,000
Spouse:	Up to \$20,000
Children:	Up to \$10,000



Voluntary Accidental Death & Dismemberment Coverage (VAD&D)

offered by Standard Insurance Company

www.standard.com

It's a fact of life. Accidents happen, often when you least expect them. Car wreck on the freeway, fall from a ladder at home, mishap with machinery. According to the Centers for Disease Control and Prevention accidents were the 5th leading cause of death in 2010. What if it happened to you?

Would your family have the funds to pay bills, the home mortgage, burial and funeral expenses? Would your family be financially prepared? Your employer offers you an excellent opportunity to help protect your loved ones by sponsoring group Voluntary Accidental Death and Dismemberment (VAD&D) coverage. Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

How much coverage may I get for myself and my dependents?

You may elect VAD&D coverage for yourself in units of \$25,000 to a maximum of \$500,000. Amounts in excess of \$250,000 may not exceed 10 times your annual earnings.

If you elect coverage for yourself, you may also elect coverage for your spouse and dependent children. The amount for each dependent is as follows:

Spouse: Your choice of 50% or 100% of your coverage

Children: 10% of your coverage for each child, not to exceed \$30,000



Voluntary Short Term Disability Coverage (VSTD)

offered by Standard Insurance Company

www.standard.com

Guarantee issue coverage only applies during the initial eligibility period.

Can you go a month without a paycheck? How about three months? Or six months? The risk of disability is greater than you think. Recent statistics show that every 90 seconds someone files for bankruptcy in the wake of serious illness. Also, almost 3 in 10 of today's 20-year-olds will become disabled before reaching age 67. If you depend on your regular paycheck to pay your bills, what would happen if you became sick and couldn't work?

Voluntary Short Term Disability (VSTD) insurance is designed to pay a weekly benefit to you in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, thus helping you meet your financial commitments when you need it most.

Your employer offers you an opportunity to purchase VSTD benefits on a discounted basis based on your salary. This is an excellent opportunity to help protect yourself and your lifestyle. Premiums are deducted directly from your paycheck so you don't have to worry about mailing monthly payments.

Benefit Amount: 60% of pre-disability earnings (up to \$1,666 weekly pay)

Maximum Benefit: \$1,000 per week

Waiting Period: 30 days for Accidental Injury; 30 Days for Physical Disease, Pregnancy, or Mental Disorder



Affordable Care Act (aka Health Care Reform) — What to expect at tax time.....

All employee enrolled in medical plans (regardless of employer size) will be sent an IRS Form 1095-B by the carrier for the 2015 calendar year.

If you have elected medical coverage through Premera or Group Health under WCIF, you will receive an IRS Form 1095-B in the mail by the end of January 2016 / early February 2016. This document will include enrollment information for you and any of your dependents covered under a WCIF medical plan through your employer.

If you do not receive this Form 1095-B in the mail, verify your current mailing address with your employer, then contact Premera or Group Health customer service directly for another copy. Your employer DOES NOT have access to the forms.

PLEASE hold onto the Form 1095-B as it is your proof of coverage to avoid tax penalties under the Individual Mandate requirement of the Affordable Care Act.

If you work for an employer with more than 50 full-time or full-time equivalent employees and you work 30 hours or more per week, you will receive an IRS Form 1095-C for the 2015 calendar year.

If you work 30 hours per week or more for a large employer, you will receive an IRS Form 1095-C from your employer. You will receive this form in the mail by the end of January 2016 / early February 2016. In many cases, it may be in the same envelope as the W-2 statement you receive from your employer.

If you do not receive this form, you must contact your employer for another copy.

PLEASE hold onto this document. The IRS will use this information to determine if your employer meets the requirements under the Affordable Care Act for coverage and affordability.



Health Insurance Marketplace Coverage Options and Your Health Coverage

The Health Insurance Marketplace opened 4th quarter 2013. This notice provides some basic information about the Marketplace.

The Marketplace is designed to help you find and compare private health insurance options.

If the cost of our medical plan to cover yourself (and not any other members of your family) is more than 9.5 percent of your household income for the year, or our coverage does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan covers, on average, at least 60 percent of the cost of all benefits.) **ALL WCIF medical plans currently meet the "minimum value standard".**

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, you lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

If you are not eligible for our Plan, you may want to look at the Health Insurance Marketplace as an option. In some cases you may qualify for a subsidy if you meet certain requirements. You will need to consult with an Insurance Navigator at the Health Insurance Marketplace to better understand your plan options as well as any subsidies which may apply to you.

How Can I Get More Information? Please visit www.wahealthplanfinder.org or www.HealthCare.gov for more information.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their health premiums. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDSNOW (1 (877) 543-7669)** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

To see if any more States have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa

1 (866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1 (877) 267-2323, Menu Option 4, Ext. 61565

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan. Please call your Plan Administrator for more information.

HIPAA / GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Questions?

For additional plan information including Retiree Plans, Consumer Driven Health Plans, and a copy of our privacy policy please contact your Human Resources Department or visit WCIF's website at www.wcif.net.