



Kitsap County Retirees—Medicare Eligible Benefits Enrollment Guide

Dear Kitsap County Retirees and Families,

Welcome to 2012 Kitsap County Benefits Enrollment Guide for Retirees that are Medicare Eligible. The 2012 renewal year brings upon significant changes for both Group Health and Sterling plan members. Please make sure to read all of the enclosed information carefully. The benefits included in this packet go into effect 1/1/2012-12/31/2012.

The highlights for the 2012 Retiree Open Enrollment:

- **Sterling Medical** coverage has been terminated effective 12/31/2011. A new plan called **Trans-america Affinity Service, Inc.** will be replacing the Sterling plan and will be honoring the previous coverage. If you are currently on the Sterling plan for 2011 you will automatically transfer to the new Transamerica plan unless you submit an enrollment form changing your coverage.
- **Group Health** coverage is changing due to Group Health's policy regarding Medicare Plans. As a result of this change Group Health members will no longer have vision hardware coverage. VSP is now being offered to our Group Health members as an option for coverage. If you are currently on the Group Health plan for 2011 you will automatically transfer to the new Group Health plan unless you submit an enrollment form changing your coverage.
- Retirees must continue to be enrolled in Medicare Part A & B to be eligible for the enclosed coverage. Medicare part D prescription drug coverage is included in our plans and should **NOT** be purchased.
- **Dental:** Dental is only offered to individuals that selected 'retiree' dental at time of retirement or enrolled during the 2010 Enrollment.
- **Vision:** Vision Service Provider (VSP) is offered to all retirees and qualified dependents. Group Health members must complete this new form and select method of payment in order to receive this plans coverage.
- **LEOFF 1 Retirees Only:** Kitsap County will STILL be paying for the vision plan for the LEOFF 1 retiree only. LEOFF 1 retirees previously on Group Health and want to remain on Group Health must complete the new enrollee form for the VSP coverage. Please contact the LEOFF board for specific questions on what they deem as medically necessary. Remember LEOFF I retirees that have their dependents on their plan can now have their spouses premium deducted out of their Department of retirement check. DRS is also offering a Public Safety Tax Savings on Health Insurance Premium paid for dependents. Contact DRS at 800.547.6657 or on the web at www.drs.wa.gov.
- **If you are making a change the Open Enrollment Deadline: December 12, 2011 at 5PM you can send forms by fax at 360.337.7187, or by email to cmackie@co.kitsap.wa.us or regular mail at:** Kitsap County Personnel, Attn: Carol Mackie; 614 Division Street MS#23, Port Orchard, WA 98366
- Good news! Retiree benefits are now online at <http://www.kitsapgov.com/hr/Benefits/EmployeeBenefits2012.htm> if you misplace your information, need additional forms just go to this link and it will be available for you!

Questions? Feel free to contact me at 360.337.7185 ext. 3626.

Sincerely,

A handwritten signature in cursive that reads "Carol Mackie".

Carol Mackie, HR Analyst, Kitsap County Personnel

**IMPORTANT NOTICE FROM KITSAP COUNTY ABOUT YOUR PRESCRIPTION
DRUG COVERAGE AND MEDICARE**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Kitsap County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Kitsap County has determined that the prescription drug coverage offered by the Kitsap County Employee Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. *In addition, if you lose or decide to leave employer/union sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.* You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you do decide to join a Medicare drug plan and drop your Kitsap County prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with Kitsap County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage...

Contact the person listed below for further information or call Human Resource Department at (360) 337-7185 ext. 3516. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Kitsap County changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov, Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help, Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	November 21, 2011
Name of Entity/Sender:	Kitsap County
Contact--Position/Office:	Personnel
Address:	614 Division St, MS # 23, Port Orchard, WA 98366-4676 Phone Number: (360) 337-7185

TRANSAMERICA MEDICAL

Plan Information:

- The Transamerica plan does not restrict your choice of doctors or hospitals and is accepted anywhere Medicare is accepted.
- Benistar/Express Scripts Pharmacy is a part of the benefit and offers pharmacies nationwide including major chains. You will receive a separate pharmacy card.
- This plan has coverage in all 50 states.
- Vision, which includes hardware benefits, is offered through VSP for an additional fee.

Contact Information:

- Transamerica plan: 1-800-236-4782
- Benistar/Express Scripts: 1.800.236.4782 or www.express-scripts.com
- The Administrator for the plan is: BSI Administrators 1.855.623.6334 or Washington Counties Insurance Fund at 1.800.344.8570

Forms Required to enroll:

- If you are currently on the Sterling plan for 2011 you will automatically transfer to the new Transamerica plan unless you submit an enrollment form changing your coverage.
- Washington Counties Insurance Fund Enrollment Form (This form is also used to enroll in the Vision Service Plan and Retiree Dental Plan)
- Transamerica Enrollment Form

Transamerica Medical Rates:

Transamerica If outside of WA please contact Personnel for rates.	Retiree	Retiree & Spouse/Registered Domestic Partner (Medicare Eligible)
Regular and LEOFF 1 Retiree Over age 65 Medicare Enrolled (All enrollees must be enrolled in Medicare Part A&B ONLY)	\$359.65	\$719.30

Letter to Sterling Members from Washington Counties Insurance Company

Re: Change in Medicare Supplemental Carriers

Dear Retiree,

The Washington Counties Insurance Fund (WCIF) is pleased to announce that the Board of Directors has approved moving the WCIF sponsored Medicare Supplemental Plan from Sterling Life Insurance Company to Transamerica Affinity Services, Inc. This change will not require you, as a covered retiree, to do anything other than utilizing the new insurance card starting January 1, 2012. Benefit Solutions Inc., the third party administrator for WCIF, will continue to collect premiums from retirees who pay based upon a coupon as well as making all necessary arrangements with the Department of Retirement Systems for deductions from State retirement checks. The coverage under the plan remains unchanged, and the continued use of your current providers is not impaired in any way. The total premium for your plan through Transamerica for 2012 including the Part D coverage is \$359.65.

There are a multitude of reasons for the change. First the renewal rates through Transamerica were \$10.00 per month less than Sterling and we received a guarantee that the maximum increase in the second year of coverage will be no greater than 7.5%. Second, under Transamerica, the retirees insured through WCIF will become a part of a larger pool of retirees and future claims costs will be spread over a larger group resulting in more favorable renewal rates. Third, under Sterling the retiree supplemental plan was limited to retirees living in Washington, Oregon, and Idaho while the Transamerica plan will allow WCIF to offer the supplemental plans to retirees living in any of the fifty states.

An issue has arisen that affects some retirees that is unrelated to the change in carriers. The Part D coverage, which pays for your prescription drugs, is provided by the pharmacy benefit manager Express Scripts. Express Scripts has been unable to reach agreement with Walgreens which many people use as a retail outlet for purchasing their prescriptions. If these issues are not resolved before year end, retirees using Walgreens will have to use a different retail outlet.

Sincerely,

Mike Shelton, Executive Director

Washington Counties Insurance Fund

Medicare Part A Services

Provided by Transamerica Affinity Services, Inc.

Benefit Period: January 1, 2012 through December 31, 2012

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,156	\$1,156 (Part A Deductible)	\$0
61st thru 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but \$578 a day	\$578 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$144.50 a day	Up to \$144.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Washington Counties Insurance Fund

Medicare Part B Services

Provided by Transamerica Affinity Services, Inc.

Benefit Period: January 1, 2012 through December 31, 2012

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES - In or Out of the Hospital and Outpatient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: Medicare Part B Deductible (2012 – \$140) First \$140 of Medicare Approved Amounts Remainder of Medicare Approved Amounts—Plan pays 20% of the Medicare Eligible Part B expenses Part B Excess Charges (Above Medicare Approved Amounts)	 \$0 generally 80% \$0	 Part B Deductible generally 20% 100%	 \$0 \$0 \$0
BLOOD First 3 pints Next \$140 of Medicare Approved Amounts Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs Part B Deductible 20%	 \$0 \$0 \$0
CLINICAL LABORATORY SERVICES Blood tests for Diagnostic Services	 100%	 \$0	 \$0

MEDICARE PARTS A & B

HOME HEALTH CARE Medicare Approved Services: Medically necessary skilled care services and medical supplies Durable medical equipment: First \$140 of Medicare Approved Amounts Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 Part B Deductible 20%	 \$0 \$0 \$0
--	----------------------------	-------------------------------------	-----------------------

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA: First \$250 each calendar year Remainder of charges	 \$0 \$0	 \$0 80% to a lifetime maximum of \$50,000	 \$250 20% and amounts over the \$50,000 lifetime max
---	----------------	--	---

GROUP HEALTH

Plan Information:

- **Group Health** coverage is changing due to Group Health's policy regarding Medicare Plans. As a result of this change Group Health members will no longer have vision hardware coverage. VSP is now being offered to our Group Health members as an option for coverage. If you are currently on the Group Health plan for 2011 you will automatically transfer to the new Group Health plan unless you submit an enrollment form changing your coverage.
- Group Health is available to all retirees both over age of 65 and their eligible dependents.
- Group Health is a HMO Plan and requires you to see a Group Health doctor.
- To see a contracted specialist outside of the Group Health network you must get a referral from your Primary Care Physician.
- Vision, which includes hardware benefits, is offered through VSP for an additional fee.

Contact Information:

- 1.800.901.4636 or www.ghc.org

Forms Required to enroll:

- Group Health Enrollment and Change Form
- Washington Counties Insurance Fund Enrollment Form (This form is used to enroll in the Vision Service Plan and Retiree Dental Plan)

Group Health Rates:

Group Health	Retiree	Retiree & Spouse/Registered Domestic Partner	Retiree & Child(ren)	Retiree, Spouse/ Domestic Partner & child(ren)
Regular Retiree - Over Age 65 Medicare Enrolled (Medicare eligible: Must also be enrolled in Medicare Part A & B ONLY)	\$226.25	\$452.50 (Both Medicare Eligible) \$1012.61 (Only 1 Medicare Eligible)	\$548.68 (Retiree Medicare Eligible)	\$774.94 (Both Retiree & Spouse Medicare Eligible) \$1335.05 (Only 1 Medicare Eligible)

Medicare Advantage Prescription Drug HMO benefit summary for retired employees

This is a brief summary of benefits. **This is not a contract or evidence of coverage.** All benefit descriptions, including alternative care, are for medically necessary services. For full coverage provisions, including limitations, please refer to your evidence of coverage.

BENEFIT CATEGORY	2012 PLAN 4 BENEFITS
Type of Medicare Health Plan	Medicare Advantage HMO
Out-of-Pocket Max	\$2,500
Hospital Inpatient	\$100 copay/admit
Office Visits	\$15 copay
Chiropractic	\$15 copay
Outpatient Surgery	\$50 copay
Emergency Room	\$65 copay
Outpatient Rehabilitation Services	\$15 copay
Diagnostic, Lab, and X-ray	\$0 copay
Retail Prescription Drugs 30-day supply	Generic \$10 copay/Brand \$40 copay Nonformulary, 50% coinsurance
Mail Order Prescriptions 90-day supply	Generic \$20 copay/Brand \$80 copay Nonformulary, 50% coinsurance
Hearing Exam	\$15 copay
Hearing Hardware	Not covered
Vision Exam	\$15 copay
Vision Hardware	Not covered
Alternative Therapy Acupuncture / Chiropractic / Massage Therapy / Naturopath	Acupuncture—8 visits Chiropractic—10 visits Massage—Medically necessary. Prior approval required. Naturopath—3 visits
Preventive Care	\$0 copay
Urgent Care	\$15 copay
Ambulance	\$150 copay
Skilled Nursing Facility	\$0 copay Limited to 100 days per benefit period
Wellness	Silver Sneakers®, EnhanceFitness®

(LETTER SENT TO GROUP HEALTH MEMBERS FROM GROUP HEALTH)



GroupHealth®

Your Medicare Health Benefits and Services

as a Member of Your

Group Health Cooperative Clear Care

Employer Group (HMO)

Dear Member,

This is the time of year when we thank you for your continued membership with Group Health, and let you know of changes in your Employer-Group Retiree Medicare Advantage plan.

As you may know, when you became eligible for Medicare, in addition to your Employer-Group Retiree plan, you were also enrolled in the **Group Health Cooperative Clear Care Employer Group (HMO)**.

Historically, your retiree group benefits and your Medicare Advantage benefits were reviewed and, based on Group Health's determination; you received the better of the two benefits.

We're making the move to a more standard benefit package that better aligns with Medicare. Starting January 1, 2012 as groups renew, your retiree group will determine your Medicare Advantage plan benefits.

For 2012, you will receive an Evidence of Coverage (EOC) for your retiree group Medicare Advantage plan once your group selects a benefit plan. This EOC booklet tells you how to get your Medicare medical care and if applicable, your prescription drugs through our plan, a Medicare Advantage Plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

Group Health Medicare Customer Service

For help or information, please call Customer Service or go to our web site at www.ghc.org/customerservice.
Phone numbers:

Seattle area: 206-901-4600 **Toll-free:** 1-888-901-4600

TTY/TDD for the hearing- or speech-impaired:

WA Relay 711 or toll-free 1-800-833-6388.

Normal hours of operation:

Monday through Friday, 8 a.m. – 8 p.m.

Special hours of operation:

From Oct. 15, 2012, to Feb. 14, 2012: 7 days a week,
8 a.m. – 8 p.m.

VISION SERVICE PLAN

Plan Information:

- The Vision Service Plan (VSP) is available at an additional charge.
- If you see a VSP Doctor you have a richer benefit.

Contact Information:

- Vision Service Provider (VSP): 1.800.368.1135 or vsp.com
- The Administrator for the plan is: BSI Administrators 1.855.623.6334 or Washington Counties Insurance Fund at 1.800.344.8570

Forms Required to enroll:

- Washington Counties Insurance Fund Enrollment Form

VSP Rates:

Retiree Vision	Retiree	Retiree & Spouse/Registered Domestic Partner
Vision Service Plan (VSP)	\$8.49	\$19.08

Your eyecare benefit is brought to you by Washington Counties Insurance Fund and VSP.



Your VSP Vision Benefits Summary

Welcome to VSP® Vision Care. Your VSP vision benefit offers you the best in eyecare and eyewear.

Personalized Care. A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Eyewear. Choose the eyewear that's right for you and your budget. From classic styles to the latest designer frames, you'll find the eyewear that's right for you and your family.

Choice of Providers. With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider.

Using your VSP benefit is easy.

- **Find the right eyecare provider for you.** To find a VSP doctor, visit vsp.com or call 800.877.7195.
- **Review your benefit information.** Visit vsp.com to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card required.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor.

For your complete benefit description, visit vsp.com or call 800.877.7195.

Your Copays

Exam	\$10.00
Prescription Glasses	\$25.00
Elective Contact Lenses	No copay applies

Your Coverage from a VSP Doctor

Exam covered in full	every 12 months
Prescription Glasses	
Lenses covered in full	every 12 months
• Single vision, lined bifocal, lined trifocal lenses, ultra violet protection, scratch-resistant coating, anti-reflective coating, and rimless mounting.	
• Polycarbonate lenses for dependent children	
Frame	every 24 months
• Frame of your choice covered up to \$ 130.00.	
• Plus, 20% off any out-of-pocket costs.	
	~OR~
Elective Contact Lenses	every 12 months
<i>\$120 allowance for contacts and the contact lens exam (fitting and evaluation). There may be additional fees charged to the member above the allowance. Ask your provider for a pre-determination of benefits for a detailed estimate.</i>	

Extra Discounts and Savings

- Glasses and Sunglasses**
- Average 35 - 40% savings on all non-covered lens options
 - 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam
- Contacts**
- 15% off cost of contact lens exam (fitting and evaluation)
- Laser Vision Correction**
- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
 - After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, copays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP network, call us first at 800-877-7195.

Out-of-Network Reimbursement Amounts:

Exam	Up to \$50.00
Lenses:	
Single Vision	Up to \$50.00
Lined Bifocal	Up to \$75.00
Lined Trifocal	Up to \$100.00
Frame	Up to \$70.00
Tints	Up to \$5.00
Contacts	Up to \$105.00

VSP guarantees service from VSP network doctors only.

In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

WASHINGTON DENTAL SERVICE RETIREE DENTAL PLAN

- Retirees were only eligible to enroll into the dental plan when first retired or during 2010 Open Enrollment. If you did not select dental during those times, you are not eligible for this plan coverage.
- Retirees with current coverage can choose to make changes such as add or drop dependents, or terminate coverage.
- Retirees who terminate coverage will not be eligible to re-enroll into the plan.

Contact Information:

- Washington Dental Service 1.800.554.1907 or www.deltadental.wa.com
- The Administrator for the plan is: BSI Administrators 1.855.623.6334 or Washington Counties Insurance Fund at 1.800.344.8570

Forms Required to enroll:

- Washington Counties Insurance Fund Enrollment Form

Washington Dental Service Rates:

Retiree Dental Only available to Retirees who enrolled at retirement or se- lected this dental plan in 2010.	Retiree	Retiree & Spouse/Registered Do- mestic Partner	Retiree & Child(ren)	Retiree, Spouse/ Domestic Partner & child(ren)
Washington Dental Service (WDS)	\$62.23	\$124.38	\$123.53	\$185.68



WASHINGTON COUNTIES INSURANCE FUND
WASHINGTON COUNTIES INSURANCE POOL



Washington Dental Service is a member of the Delta Dental Plans Association

WCIF – Retiree Option

Plan #00499

Delta Dental Premier[®]

Effective Date: January 1, 2012

Plan Summary	Payment Levels		
	Delta Dental Premier Dentist	Nonparticipating Dentist in Washington State	Dentist Outside of Washington State
Class I – Diagnostic & Preventive Exams, Prophys, X-rays, Fluoride Sealants are covered up to age 15	80%	80%	80%
Class II – Restorative Restorations, Endodontics, Periodontics, Oral Surgery	80%	80%	80%
Class III – Major Crowns, Dentures, Partials, Bridges and Implants	50%	50%	50%
Annual Maximum Per Person Benefit Period: (January 1 – December 31)	\$2,000	\$2,000	\$2,000
Deductible (Waived on Class I) Per person/per benefit period Annual family maximum	\$50 \$150	\$50 \$150	\$50 \$150

MySmile[®] personal benefits center, available on Washington Dental Service's Web site at **DeltaDentalWA.com**, is customized to your individual needs and provides you with answers to your most pressing questions about your dental coverage.

*Please Note: This is a brief summary of benefits only and does not constitute a contract. You will have access benefits booklets that completely detail your Delta Dental Premier dental benefits. Please feel free to call our customer service department if you have any questions or visit our Web site at **DeltaDentalWA.com**.*

Washington Dental Service

PO Box 75983

Seattle, WA 98175-0983

Customer Service toll-free (800) 554-1907, Monday – Friday 8 a.m. to 5 p.m., Pacific Time

ACCESSING CARE

How to use your Delta Dental Premier® plan

The dental plan offered to your group is Delta Dental Premier, a traditional fee-for-service plan. You may select any licensed dentist under this plan; however, if you choose a participating Washington Dental Service dentist, your benefits may be paid at a higher level and your out-of-pocket expenses may be lower.

Washington Dental Service will handle all customer service and claims processing for your plan. Tell your dentist you are covered by Washington Dental Service and give him or her your member identification number, the plan name and plan number.

Delta Dental Premier dentists

If your dentist is a Washington Dental Service participating dentist, he or she will submit your claims directly to Washington Dental Service. Payment will be based on the approved fees your dentist has on file with us. You are responsible only for your stated deductibles, coinsurance and/or amounts in excess of the plan maximums.

Finding a dentist

You can find a participating dentist in your area by visiting the Washington Dental Service Web site at DeltaDentalWA.com. Click on the *Patients* tab and then on the *Find A Dentist* tab to begin your search. **Be sure to select the Delta Dental Premier plan and follow the prompts.**

Nonparticipating dentists in Washington state

If you choose a nonparticipating dentist, you will be responsible for having the dentist complete and sign claim forms. It will also be up to you to ensure that the claims are sent to Washington Dental Service. Claim payments will be based on actual charges or Washington Dental Service's maximum allowable fees for nonparticipating dentists, whichever is less. You will be responsible for any balance remaining. Please be aware that Washington Dental Service has no control over nonparticipating dentists' charges or billing procedures.

Outside of Washington state

If you receive dental treatment from a dentist outside Washington state, you will be responsible for having the dentist complete and sign claim forms. It will also be up to you to ensure that the claims are sent to Washington Dental Service. Claim payments will be based on actual charges or on Washington Dental Service's maximum allowable fees for participating dentists, whichever is less.

Predetermination (estimate) of benefits

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, sometimes called a "predetermination of benefits." This will allow you to know in advance what procedures may be covered, the amount Washington Dental Service may pay and your expected financial responsibility. A predetermination of benefits is not a guarantee of payment.

PAYMENT OPTIONS

Transamerica, VSP or WDS Plan:

Retirees that elect the Sterling, VSP or the Dental plan will can either select to have their deductions through your retirement check from the Department of Retirement Systems OR be billed from the new vendor Benefit Solutions, INC.

For DRS Deductions: Complete the enclosed WCIF Deduction Form

To be billed: Submit a check payable to Washington Counties Insurance Fund with your enrollment forms and you will receive a bill for the following months and will send your premiums directly to: Washington Counties Insurance Fund c/o: **Benefit Solutions INC (BSI)**, PO BOX 6, Mukilteo, WA 98275.

Group Health Coverage:

Retirees that select Group Health coverage can authorize deductions through their retirement check from the Department of Retirement Systems OR make monthly payments by personal check made out to and submitted to Kitsap County Auditor-Payroll division.

For DRS Deductions: Complete the enclosed Kitsap County Selection of Payment to Deduct

ONLY if you are changing your current payment method or if you are making a change to your coverage.

Pay By Check: Please submit prior to the first of the month you are paying for and submit it directly to: **Kitsap County Auditor**, ATTN: Payroll, 614 Division ST MS#31, Port Orchard, WA 98366.

FORMS

Forms Required to enroll:

- Transamerica Enrollment Form
- Group Health Enrollment Form
- Washington Counties Insurance Fund Enrollment Form (This form is also used to enroll in the Vision and Dental Service Plan and Retiree Dental Plan)

Forms Required for Department of Retirement Deduction:

- Kitsap County Selection of Payment to Deduct Form –For Group Health and Premera Members only.
- WCIF DRS Deduction Form - For Transamerica, WDS (Dental) and VSP only.

REMEMBER:

- *If you are currently on the Sterling plan for 2011 you will automatically transfer to the new Transamerica plan unless you submit an enrollment form changing your coverage.*
- *If you are currently on the Group Health plan for 2011 you will automatically transfer to the new Group Health plan unless you submit an enrollment form changing your coverage.*
- *Group Health Members!!! Group Health members who want to select the VSP vision coverage; must complete this new form and select method of payment in order to receive this plans coverage.*

Transamerica Affinity Services, Inc. (Benistar) Enrollment Form

ACTION REQUIRED BY YOU FOR ENROLLMENT

BENISTAR CUSTOMER SERVICE PHONE NUMBER: 1-800-236-4782
BENISTAR FAX NUMBER: 1-860-408-7025
ATTN: JANE MOTICKA

Mailing address: BENISTAR
ATTN: Jane Moticka
100 Grist Mill Road
Simsbury, CT 06070

YOUR NAME (EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD):

YOUR ADDRESS:

YOUR MEDICARE CLAIM NUMBER:

YOUR SPOUSE NAME (EXACTLY AS IT APPEARS ON THEIR MEDICARE CARD)

YOUR SPOUSE MEDICARE CLAIM NUMBER:

MEDICARE		HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)			
NAME OF BENEFICIARY			
JANE DOE			
MEDICARE CLAIM NUMBER		SEX	
000-00-0000-A		FEMALE	
IS ENTITLED TO		EFFECTIVE DATE	
HOSPITAL (PART A)		07-01-1986	
MEDICAL (PART B)		07-01-1986	
SIGN HERE → <i>Jane Doe</i>			

EMPLOYER: PLEASE COMPLETE THIS SECTION

Coverage effective date _____
Group name _____
*Group number _____

Choose one: **Group Health Cooperative** **Group Health Options, Inc.**

Original date of hire ____/____/____
Date of rehire ____/____/____
Date transferred from part time (p/t) to full time (f/t) ____/____/____
Hours worked per week _____
If retired, date of retirement ____/____/____

Choose one:
 Open enrollment
 New employee
 Address/name change
 Add dependent(s)
 Remove coverage
 ____ Subscriber ____ Dependent(s)
Date processed ____/____/____ by _____

Transfer to COBRA
Start date _____
 18 months
 36 months

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____ Marital status: Single Married Date married ____/____/____ State-registered domestic partnership
(Last name) (First name) (M.I.)
Resident address _____ Work phone () _____
(Street) (City) (State) (ZIP)
Mailing address (if different) _____ Home phone () _____
Billing address (if different) _____
Employee Medicare claim # _____ Former name of applicant or spouse _____
Health plan choice: *If more than one health plan is offered, please write in your choice, including the group number.*
Health plan _____ *Group number _____

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

FOR HEALTH PLAN INTERNAL USE ONLY	CHECK ONE		PLEASE PRINT			SOCIAL SECURITY NUMBER	MALE/FEMALE	BIRTHDATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
	ADD	REMOVE	LAST NAME	FIRST NAME	M.I.				
			SELF						
			SPOUSE/DEPENDENT						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Please list names of any **dependents who are Medicare-eligible and their Medicare number:**

NAME (FIRST AND LAST)	MEDICARE NUMBER
SPOUSE	
DEPENDENT	
DEPENDENT	

Additional health benefits information

Other coverage (that is not Group Health Cooperative or Group Health Options, Inc.) _____

Who is the subscriber under this plan? _____

What is their social security or policy number with this plan? _____ Attach any certificate of creditable coverage letters to this form.

Your contract may contain coverage exclusions for Pre-Existing Conditions (PEC). These exclusions could be fully or partially waived based on prior or current coverage. Review this section carefully and complete the information requested for both you and your dependents to assure proper processing of your claims.

NAME (FIRST AND LAST)	CURRENT OR PREVIOUS CARRIER (INCLUDE PHONE NUMBER)	COBRA	DATE COVERAGE BEGAN (MM/DD/YY)	DATE COVERAGE ENDED (MM/DD/YY)
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

(Signature of employee)

(Date signed)

Please retain a copy for your records.

2012 Retiree Enrollment & Change Form

To ensure accurate and timely enrollment, please complete and submit this signed form to the address listed at the end of PAGE 2 at your earliest convenience. Please note: **if this form is not complete it may result in delays in processing and/or delays in claim payment.**

SECTION 1 • MEMBER INFORMATION

Name (Last, First, MI):

Social Security #: Date of Birth: Phone Number:

Physical Address:

Gender: Male Female Disabled (eligible for Medicare by reason of disability)

SECTION 2 • PLAN SELECTION

Medical If selected, choose a plan below.	Dental Washington Dental Service Retiree Plan	Vision Vision Service Plan (VSP) Retiree Plan
<input type="checkbox"/> for myself only	<input type="checkbox"/> for myself only	<input type="checkbox"/> for myself only
<input type="checkbox"/> for myself & my spouse	<input type="checkbox"/> for myself & my spouse	<input type="checkbox"/> for myself & my spouse
<input type="checkbox"/> for myself & my family	<input type="checkbox"/> for myself & my family	<input type="checkbox"/> for myself & my family
<input type="checkbox"/> I decline this coverage.	<input type="checkbox"/> I decline this coverage.	<input type="checkbox"/> I decline this coverage.

Medical Plans | Check **one** if you have selected to enroll in a medical plan as noted above.

- Transamerica Affinity Svcs, Inc. Available to members **OVER AGE 65** only.
Additional forms needed for new enrollees.

SECTION 3 • DEPENDENT COVERAGE

- Spouse / Domestic Partner | Marriage / Establishment Date:
- Unmarried child(ren) (to age 26)

Note: For all WCIF plans eligible dependents include a lawful spouse, domestic partner, and unmarried dependent children (including biological, step, foster and legally adopted) up to age 26. In addition, a child of the participant will be eligible for coverage under the plan when required by court order or qualified medical child support order (QMSCO).

CONTINUED ON PAGE 2 ►

RETIREE NAME (first & last): _____

SECTION 3 • DEPENDENT COVERAGE *continued*

	Last Name	First Name	MI	Sex	Relationship	SSN	Birthdate	Medical	Dental	Vision	Add / Drop
#1								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
#2								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
#3								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
#4								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

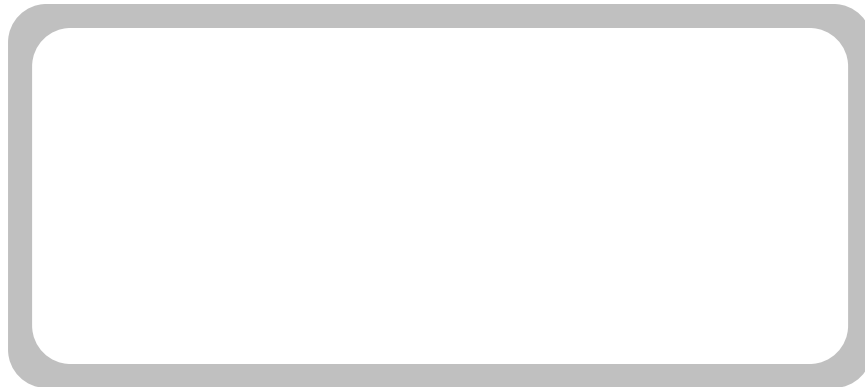
SECTION 4 • SIGNATURE (required)

By signing this form, I declare that the information I have provided is true, complete, and correct. If the information I have provided is false, incorrect, or if I do not update this information within the timelines in WCIF rules, I must repay any claims paid by my health plan(s) or premium paid on my behalf. My family members and I may also lose WCIF benefits as of the last day of the month we qualified. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines and denial of WCIF benefits.

The WCIF/WCIP Program may verify eligibility for myself and my family members. If I or my eligible dependents choose to waive coverage, I understand that I/we can re-enroll during the annual open enrollment period or within the time allowed under special enrollment provisions as defined in WAC 182-12-262. If I waive medical for myself, I also waive medical for my eligible dependents.

This form replaces all previous forms and submissions I have made for WCIF benefits.

Member's signature: _____ Date: _____





Selection of Payment and Deduction Authorization Form

Kitsap County, 614 Division ST. MS#23

Port Orchard, WA 98366

(360) 337-7185

RETIREE INFORMATION

Retiree Name: _____ Sex: Male Female

Address: _____
Street, City, State and Zip

Social Security #: _____

Last Date of Coverage Under Active Employer Plan: _____

PAYMENT SELECTION

I request to pay my retiree medical premiums by:

Check made payable to Kitsap County required prior to the first of every month. (This option is only available on **Premera or Group Health** Plans. Failing to pay the premium prior to the first of the month could result in loss in coverage.)

By selecting this option I, _____, authorize the Department of Retirement Systems to deduct from my pension any premiums I am required to pay for medical insurance.

AUTHORIZATION

I, _____, do hereby declare that to the best of my knowledge; the information that I have provided is true and I am eligible for the coverage requested. I also understand that I am responsible for notifying the Kitsap County Personnel Department before Medicare eligibility at age 65, or in the event of covered spouses death, change of address or other change in status.

Signature: _____ Date: _____

KITSAP COUNTY PERSONNEL USE ONLY

DRS VENDOR NUMBER: _____

EFFECTIVE DATE OF COVERAGE: _____

BEGIN DEDUCTIONS ON: _____

TOTAL MONTHLY PREMIUM: _____

Kitsap County Authorized Signature: _____ Date: _____



WASHINGTON COUNTIES INSURANCE FUND
WASHINGTON COUNTIES INSURANCE POOL

Washington Counties Insurance Fund
Administered By Benefit Solutions, Inc.
PO Box 6
Mukilteo WA 98275-0006
(206) 859-2600



2012 DRS Retirement Deduction Authorization Form

Name (Last)		(First)	(Middle Initial)	Social Security #
Address (Street)				Date of Birth
City		State	Zip	Phone Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Former Employer			Date Active Coverage Ended

Select plan(s) to be deducted from your monthly DRS check:

Medical	Dental	Vision
<input type="checkbox"/> Myself <input type="checkbox"/> Myself & Eligible Dependents <input type="checkbox"/> Decline	<input type="checkbox"/> Myself <input type="checkbox"/> Myself & Eligible Dependents <input type="checkbox"/> Decline	<input type="checkbox"/> Myself <input type="checkbox"/> Myself & Eligible Dependents <input type="checkbox"/> Decline
<input type="checkbox"/> Transamerica Affinity Services (3181)	<input type="checkbox"/> Washington Dental Service (3074)	<input type="checkbox"/> Vision Service Plan (VSP 3081)

Please note:

You are responsible for notifying WCIF when you or your spouse reach age 65, or in the event of either's death, change of address, and other changes in status. Please allow us 45 days to process.

Please complete information below for your DRS Retirement Check Deduction. Return form to Benefit Solutions, Inc.

This form is an authorization for payroll deductions for health insurance only. I do hereby declare that to the best of my knowledge, I am eligible for the coverage requested. I authorize the Department of Retirement Systems to deduct from my pension any premium I am requested to pay. This form supercedes all previous forms I have submitted for coverage.

Name:	
Applicant Signature:	
Date Signed:	

FOR BSI USE ONLY	Plan Code Medical:		Premium:	
Effective Date:	Plan Code Dental:		Premium:	
Signature:	Plan Code Vision:		Premium:	