



Kitsap County Retirees - (Under 65)

Dear Kitsap County Retirees and Families,

Welcome to 2012 Kitsap County Benefits Enrollment Guide for Retirees. The 2012 renewal year brings relatively modest increases to most plans. The benefits included in this packet go into effect 1/1/2012-12/31/2012. Please review all of the enclosed material.

The highlights for the 2012 Retiree Open Enrollment:

- **If you are not making a plan change you do not have to submit a form.** You will automatically stay on the same plan you had for 2011.
- **Medical Options:** Premera & Group Health.
- **Dental:** Dental is only offered to individuals that selected 'retiree' dental at time of retirement or enrolled during the 2010 Enrollment.
- **LEOFF 1 Retirees Only:** 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
- If forms are not received in the Kitsap County Personnel Office by the deadline, you will stay on your current plan and your premiums will reflect the 2012 rates.
- 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,

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
C	Contact--Position/Office:	Personnel
	Address:	614 Division St, MS # 23, Port Orchard, WA 98366-4676 Phone Number: (360) 337-7185

PREMERA

- Premera is available to only retirees and eligible dependents that are not Medicare eligible.
- Premera does not require a referral to see a specialist, but some procedures to require preauthorization.
- Premera has a Vision Benefit attached to the plan design.
- Utilizes the Heritage Network.

Contact Information:

- 1.800.722.1471 or www.premera.com

Forms Required to enroll:

- Premera Blue Cross Enrollment and Change Form

Premera Rates:

Regular Retirees				
Regular Retirees Premera	Retiree	Retiree & Spouse/Registered Do- mestic Partner	Retiree & Child(ren)	Retiree, Spouse/ Do- mestic Partner & child(ren)
Regular Retiree - Under age 65	\$1133.18	\$2322.99	\$1597.87	\$2787.69
LEOFF 1 Retirees				
LEOFF 1 Retirees Premera	LEOFF 1 Retiree (Premium Paid by County)	Spouse/Registered Domestic Partner ONLY	Child (ren) ONLY	Spouse/ Domestic Partner & child(ren ONLY
LEOFF 1 - Under age 65	\$1390.00	\$1189.81	\$464.67	\$1654.48

Highlights of your Health Care Coverage

Kitsap County

Group Number: 1037245

Effective Date: 01/01/2012

*Premera Blue Cross believes this plan is a "grandfathered health plan" under the Affordable Care Act. For more information, please refer to your Benefit Booklet.

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

MEDICAL PLAN GRANDFATHERED	HERITAGE YOUR CHOICE - Retirees	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family Deductible 3x Individual)	\$250 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	40%
Individual Out of Pocket Maximum PCY, Excludes Copay (Family OOP Max 2x Individual)	\$2,000 PCY (Coinsurance Max)	\$3,000 PCY (Coinsurance Max)
Office Visit Cost Share	\$20 Copay	\$20 Copay, then 40% Coinsurance
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	\$20 Copay	Copay, then 40% Coinsurance
Immunizations (Unlimited)	Covered in Full	Waive Deductible, Subject to Coinsurance
Health Education (HE) (Not Covered)	Not Covered	Not Covered
Nicotine Dependency Programs (ND) (Not Covered)	Not Covered	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	\$20 Copay	\$20 Copay, then 40% Coinsurance
Inpatient Professional Services	Deductible, then 10%	Deductible, then 40%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Waive Deductible, Subject to Coinsurance
Other Professional Diagnostic Imaging and Laboratory Services	Deductible, then 10% Coinsurance	Deductible, then 40%
Diagnostic Mammography	Covered in Full	Waive Deductible, Subject to Coinsurance
FACILITY CARE OPTIONS		
Inpatient Facility	Deductible, then 10%	Deductible, then 40%
Outpatient Surgery Facility	Deductible, then 10%	Deductible, then 40%
Skilled Nursing Facility (60 days PCY)	Deductible, then 10%	Deductible, then 40%
EMERGENCY CARE OPTIONS		
Emergency Care (Waive copay if admitted to inpatient facility)	Waive \$125 copay if admitted, always subject to deductible and coinsurance	Waive \$125 copay if admitted, always subject to deductible and coinsurance
Air Ambulance (Unlimited)	Deductible, then 20%	Deductible, then 20%
Ambulance Transportation (Unlimited)	Deductible, then 20%	Deductible, then 20%
ALTERNATIVE CARE		
Manipulations (Spinal and other) (20 visits PCY)	\$20 Copay	\$20 Copay, then 40% Coinsurance
Acupuncture (12 visits PCY)	\$20 Copay	\$20 Copay, then 40% Coinsurance
Nutritional Therapy (4 visits PCY)	\$20 Copay	\$20 Copay, then 40% Coinsurance

Highlights of your Health Care Coverage

Kitsap County

Group Number: 1037245

Effective Date: 01/01/2012

*Premera Blue Cross believes this plan is a "grandfathered health plan" under the Affordable Care Act. For more information, please refer to your Benefit Booklet.

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

MEDICAL PLAN	GRANDFATHERED	HERITAGE YOUR CHOICE - Retirees	
		HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
OTHER SERVICES			
Mental Health Inpatient Facility Care (Unlimited)		Deductible, then 10%	Deductible, then 40%
Mental Health Outpatient Professional Care (Unlimited)		\$20 Copay	\$20 Copay, then 40% Coinsurance
Chemical Dependency Inpatient Facility Care (Unlimited)		Deductible, then 10%	Deductible, then 40%
Chemical Dependency Outpatient Professional Care (Unlimited)		\$20 Copay	\$20 Copay, then 40% Coinsurance
Rehab Inpatient Facility (60 Days PCY)		Deductible, then 10%	Deductible, then 40%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (35 visits PCY)		\$20 Copay	\$20 Copay, then 40% Coinsurance
Medical Supplies, Equipment, Prosthetics and Orthotics (MS: Unlimited; ME: Unlimited; Pro: Unlimited; Orth: Unlimited)		Deductible, then 10%	Deductible, then 40%
Home Health Visits (130 visits PCY)		Deductible, then 10%	Deductible, then 40%
Hospice Care (Inpatient: 7 days; Respite: Unlimited; 6 month limit)		Deductible, then 10%	Deductible, then 40%
TMJ (Temporomandibular Joint Disorders) (\$1,000 PCY/\$5,000 per Lifetime)		Covered as Any Other Service	Covered as Any Other Service
Transplants (Unlimited up to the member annual maximum; \$75,000 donor and \$7,500 travel and lodging limits)		Covered as Any Other Service	Not Covered
SUPPLEMENTAL BENEFITS			
Routine Vision Exam (Exam: 1 PCY)		\$20 Copay	\$20 Copay
Vision Hardware (\$250 PCY)		Covered In Full	Covered In Full
ANNUAL PLAN MAXIMUM			
Annual Plan Maximum		Unlimited Lifetime Max; \$2,000,000 Aggregate Annual Max	Shared with in-network

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

Highlights of your Health Care Coverage

Kitsap County

Group Number: 1037245

Pharmacy Benefits

Tier 1 = Generic
 Tier 2 = Preferred Brand Name
 Tier 3 = Non Preferred Brand Name

Below is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the Preferred Drug List for your plan when using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To find out what tier applies to a specific medication, see our Preferred Drug List in your pharmacy packet or at www.premera.com.

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

Effective Date: 01/01/2012

PHARMACY PLAN		RX CONFIGURE PLANS -RETIRES<65 RETAIL \$10/\$30/\$50 MAIL ORDER \$20/\$60/\$100
		Cost Share Category Tier1/Tier2/Tier3
PRESCRIPTION DRUGS		
Retail Cost Shares		\$10/\$30/\$50
Mail Cost Shares		\$20/\$60/\$100
Day Supply		Retail: 30 Days; Mail: 90 Days; Specialty:30 Days
Individual Deductible PCY		\$0
Out of Network (Non-participating retail pharmacies)		Cost Share, then 40% (to allowable)
Out of Pocket Maximum		Unlimited
Annual Benefit Maximum		Unlimited

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highligh is not a contract For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

GROUP HEALTH

- Group Health is a HMO Plan and requires you 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.
- Group Health has a vision benefit attached to the plan design.

Contact Information:

- 1.800.901.4636 or www.ghc.org

Forms Required to enroll:

- Group Health Enrollment and Change Form

Group Health Rates:

Regular Retirees				
Regular Retirees Group Health	Retiree	Retiree & Spouse/Registered Do- mestic Partner	Retiree & Child(ren)	Retiree, Spouse/ Do- mestic Partner & child(ren)
Regular Retiree - Under age 65	\$804.25	\$1590.61	\$1126.68	\$1913.04
LEOFF 1 Retirees				
LEOFF 1 Retirees Group Health	LEOFF 1 Retiree (Premium Paid by County)	Spouse/Registered Domestic Partner ONLY	Child (ren) ONLY	Spouse/ Domestic Partner & child(ren) ONLY
LEOFF 1 - Under age 65	\$943.29	\$786.36	\$322.43	\$1108.71

Benefit Summary

Kitsap County Retirees Plan II

Group Number: 1225300 (Under 65/Not Medicare Eligible)



Effective Date 1/1/2012	Health Plan Group Health	Ref RQ-43909
--------------------------------	---------------------------------	---------------------

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Group Health believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010. Questions regarding this status may be directed to Customer Service (888) 901-4636. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or <http://www.dol.gov/ebsa/healthreform>.

Benefits	Inside Network
Plan deductible	No annual deductible
Individual deductible carryover	Not applicable
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	Individual out-of-pocket limit: \$1,000 Family out-of-pocket limit: \$2,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Inpatient services, outpatient services, emergency services at a GHC or non-GHC facility, ambulance services.
Pre-existing condition (PEC) waiting period	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	\$15 copay
Hospital services	Inpatient services: \$100 copay, per admit Outpatient surgery: \$15 copay
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand \$15/\$30 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$15 copay
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	Inpatient: \$100 copay, per admit Outpatient: \$15 copay

<p>Devices, equipment and supplies</p> <ul style="list-style-type: none"> • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices 	<p>Covered at 80%</p> <p>Covered at 80%</p>
<p>Diabetic supplies</p>	<p>Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.</p>
<p>Diagnostic lab and X-ray services</p>	<p>Inpatient: Covered under Hospital services Outpatient: Covered in full</p> <p>High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.</p>
<p>Emergency services (copay waived if admitted)</p>	<p>\$50 copay at a designated facility \$50 copay at a non designated facility</p>
<p>Hearing exams (routine)</p>	<p>\$15 copay</p>
<p>Hearing hardware</p>	<p>Not covered</p>
<p>Home health services</p>	<p>Covered in full. No visit limit.</p>
<p>Hospice services</p>	<p>Covered in full</p>
<p>Infertility services</p>	<p>Not covered</p>
<p>Manipulative therapy</p>	<p>Covered up to 20 visits per calendar year without prior authorization \$15 copay</p>
<p>Massage services</p>	<p>See Rehabilitation services</p>
<p>Maternity services</p>	<p>Inpatient: \$100 copay, per admit</p> <p>Outpatient: \$15 copay. Routine care not subject to outpatient services copay</p>
<p>Mental Health</p>	<p>Inpatient: \$100 copay, per admit</p> <p>Outpatient: \$15 copay</p>
<p>Naturopathy</p>	<p>Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by plan \$15 copay</p>
<p>Newborn Services</p>	<p>Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.</p>
<p>Obesity-related surgery (bariatric)</p>	<p>Not covered</p>
<p>Organ transplants Donor search & harvest applies to lifetime max</p>	<p>Unlimited, no waiting period</p> <p>Inpatient: \$100 copay, per admit</p> <p>Outpatient: \$15 copay</p>
<p>Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms</p>	<p>Covered in full</p>
<p>Rehabilitation services (Occupational, speech, physical including services for neurodevelopmentally disabled children age six and under) Rehabilitation visits are a total of combined therapy visits per calendar year</p>	<p>Inpatient: 60 days per calendar year \$100 copay, per admit</p> <p>Outpatient:60 visits per calendar year \$15 copay</p>

Skilled nursing facility	Covered in full up to 60 days per calendar year
Sterilization (vasectomy, tubal ligation)	Inpatient: \$100 copay, per admit
	Outpatient: \$15 copay
Temporomandibular Joint (TMJ) services	\$1,000 per calendar year; \$5,000 lifetime max
	Inpatient: \$100 copay, per admit
	Outpatient: \$15 copay
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	\$15 copay
Optical hardware Lenses, including contact lenses and frames	\$250 per 12 months

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 selected this dental plan in 2010.	Retiree	Retiree & Spouse/Registered Domestic 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

WDS Dental Plan:

Retirees that have 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 & Premera Coverage:

Retirees that select Group Health or Premera 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:

- Premera Enrollment Form
- Group Health Enrollment Form
- Washington Counties Insurance Fund Enrollment Form (This form is used to enroll in the 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 WDS (Dental) only.



BLUE CROSS

P.O. Box 91059
Seattle, WA 98111-9159
www.premera.com

MEMBER ENROLLMENT AND CHANGE APPLICATION

1. GROUP INFORMATION (to be completed by the group)

Group ID 1037245, Group name Kitsap County - Retiree Plan, Reason OPEN ENROLLMENT, Date of event 1/1/2012, Employee class, Employee job title, Employee date of hire, Date employee entered eligible class, Effective date 1/1/2012, If COBRA, indicate number of months eligible for coverage, If State Continuation (COC), eligible period of coverage cannot exceed 3 months.

2. EMPLOYEE INFORMATION (employee to complete sections 2 through 4)

Employee name (Last, First, MI), Home phone, Work phone, Home address, City, State, ZIP, Mailing address (if different than home address), City, State, ZIP

3. ENROLLMENT INFORMATION

Plan choice 1037245, Kitsap County - Retiree Plan, NOTE: In order for dependents to qualify for a benefit selection, the employee must select the same benefit. Please indicate each member's name as you would like it to appear on the ID card. ID card names are limited to 26 characters and spaces.

Table with columns: Add, Drop, Relationship to Employee, Last Name, First Name, MI, Social Security No., Date of Birth, Gender (Male, Female), Benefit Selection (Medical). Rows for Self and Spouse.

Does a dependent have a different mailing address? No Yes, complete the following: Dependent's Name (Last, First, MI), Dependent's mailing address, City, State, ZIP

Is any child over the dependent age limit applying for coverage due to disability? No Yes, complete and attach the Request for Certification of Disabled Dependent form.

Has any applicant had health insurance coverage at any time during the past 3 months before your enrollment date on this plan? (If prior coverage information is not provided, the full waiting period will apply.) No Yes, if yes, who was covered? Employee Spouse Dependent Children, Date coverage began, Date coverage ended

Will any applicant have other current health coverage including Medicare or Premera, which will remain in effect when your Premera coverage begins? No Yes, please complete and attach the Other Coverage Questionnaire form.

4. EMPLOYEE SIGNATURE

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions as stated on the reverse side. The changes on this form supersede all previous forms submitted.

Employee signature, Date signed

Please note: 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.

PREMERA PRIVACY POLICY AND NOTIFICATION PRACTICES

We may collect, use, or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, health-care providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other health-care plans; conducting care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us.

To view or print copies of our detailed Privacy Notice and other forms, please visit our web site at www.premera.com. To have forms mailed to you, please call the number below.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan at a future date, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

LATE ENROLLEES

A "Late Enrollee" is an individual or family dependent who did not enroll when first eligible for coverage under this plan and does not qualify as a Special Enrollee. If you or your dependents are Late Enrollees, you or your dependents may enroll during the next occurring Annual Group Enrollment Period.

PRE-EXISTING CONDITION WAITING PERIOD

Your plan includes a waiting period for pre-existing conditions. A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received in a period of time that ends on your "enrollment date." This "look-back" period is 6 months if your employer has 50 or fewer employees or 3 months if your employer has more than 50 employees. The "enrollment date" is the employee's date of hire for an employee and eligible dependents who enroll when the employee is first eligible. If an employee is transferring from an ineligible class of employees, the enrollment date is the date the employee entered the eligible class. For everyone else, the enrollment date is the date coverage starts. Your waiting period for pre-existing conditions will be 9 months from your enrollment date if your employer has 50 or fewer employees or 3 months if your employer has more than 50 employees.

Please check with your employer if you have a question regarding the total number of employees in your company.

Benefits won't be provided for pre-existing conditions until after your coverage becomes effective and your waiting period for pre-existing conditions has been met. The length of your waiting period for pre-existing conditions may be reduced by periods of "creditable" coverage (see below) you've accrued under other health care plans prior to your enrollment date for this plan. You'll receive credit for prior creditable coverage that occurred without a break in coverage of more than 3 months. Any coverage you had before a break in coverage which exceeds 3 months isn't credited toward your waiting period for pre-existing conditions.

Please complete the prior coverage information in section 3 of the enrollment form **or** attach a copy of the Certificate of Creditable Coverage you received from your prior insurance carrier to this application. If you do not have a Certificate of Creditable Coverage, or have misplaced it, you have the right to request one from a prior employer or health carrier within 24 months of the date your coverage under that plan terminated. If you need help to obtain creditable coverage information from your prior plan or prior insurance carrier, please call us at the number listed below and we will help you. If prior coverage information is not provided, the full waiting period will apply.

CREDITABLE COVERAGE

"Creditable Coverage" means prior or ongoing health care coverage including any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage (including student health plans), Medicare, Medicaid, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, state Children's Health Insurance Programs (SCHIP), a public health plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

If you have any questions about the information included in this notice, please call us at 1-800-722-1471.

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):	<input type="text"/>				
Social Security #:	<input type="text"/>	Date of Birth:	<input type="text"/>	Phone Number:	<input type="text"/>
Physical Address:	<input type="text"/>				
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Disabled (eligible for Medicare by reason of disability)		

SECTION 2 • PLAN SELECTION

Dental Washington Dental Service Retiree Plan
<input type="checkbox"/> for myself only
<input type="checkbox"/> for myself & my spouse
<input type="checkbox"/> for myself & my family
<input type="checkbox"/> I decline this coverage.

SECTION 3 • DEPENDENT COVERAGE

<input type="checkbox"/> Spouse / Domestic Partner Marriage / Establishment Date:	<input type="text"/>
<input type="checkbox"/> 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		Dental	Add / Drop
#1									<input type="checkbox"/>	
#2									<input type="checkbox"/>	
#3									<input type="checkbox"/>	
#4									<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: _____

