PORT OF BELLINGHAM
Washington State

Benefit Summary - Effective January 1, 2015

Medical Benefits
Healthcare Management Administrators (HMA) / Regence Blue Shield Network

Covered Services	Preferred Providers	Participating Providers	Non-Contracted Providers
Calendar Year Deductible (Applies to all services unless otherwise noted)	$200 per individual $600 per family		
Maximum Out-of-Pocket per Calendar Year (Includes deductible, copays, and coinsurance)	$2,500 per individual $7,500 per family		
Preventive Care			
Routine well-baby care, routine physical examinations, routine immunizations and routine health screenings	100% (DW*)	100% (DW)	70%
Professional Care			
Office Visits	100% after $20 copay (DW)	70% after $35 copay (DW)	70%
Diagnostic X-Ray and Lab – First $400	100% (DW)	100% (DW)	100% (DW)
Diagnostic X-Ray and Lab – $401+	100%	70%	70%
Hospital Services			
Inpatient Care	100%	70%	70%
Outpatient Surgery	100%	70%	70%
Emergency Care			
Outpatient Emergency Care (Copay waived if admitted directly to a hospital)	100% after a $75 copay	100% after a $75 copay	100% after a $75 copay
Urgent Care	100% after $20 copay (DW)	100% after $35 copay (dw)	100% after $35 copay (dw)
Ambulance Transportation	100%	100%	100%
Mental Health Care / Chemical Dependency			
Inpatient Services	100%	100%	70%
Outpatient	$20 copay (DW)	$20 copay (DW)	70%
Rehabilitation Services			
Inpatient Services (30-day maximum per calendar year)	100%	70%	70%
Outpatient Services (25-visit maximum per calendar year)	100%	70%	70%
Vision			
Eye Exam (1 exam per calendar year)	100% (DW)	100% (DW)	100% (DW)
Lifetime Maximum	**Unlimited Annual Limit on All Essential Benefits** **Unlimited Lifetime Maximum**		

**DW = deductible waived*

For Preferred and Participating Providers you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services; For Non-Contracted Providers you may be billed for balances beyond any deductible, copayment, and/or coinsurance (balance billing).

Please keep in mind that the benefits listed on this handout are merely an outline of the plan. If there is a discrepancy between what has been stated here and the actual contract, the contract will prevail.

Prescription Benefits - EnvisionRx

Outpatient Prescription Drugs	Member Cost Share
Retail Pharmacy – *Up to a 90 day supply*	
Tier 1: Generic	$10 Copay
Tier 2: Preferred Brand (Regence Preferred Drug List)	$20 Copay
Tier 3: Non-Preferred (Prescriptions not on the Preferred Drug List)	$40 Copay
Mail Order Service - *90 day supply*	3x Copay

To find out what tier applies to a specific medication, see the Preferred Drug List at www.envisionrx.com.

Dental & Vision Benefits – Trusteed Plans Service Corporation (TPSC)

Benefits	Dental & Vision Reimbursement Account
Annual Benefit Maximum	$1,765 per member per year
Expenses are reimbursed per member at the following levels:	
First $350 of Expenses	Reimbursed at 90%
Next $750 of Expenses	Reimbursed at 80%
Next $1,700 of Expenses	Reimbursed at 50%
Vision Benefit (included in annual benefit maximum)	$300 per member per year
Orthodontia Benefit	50% of the first $3,000
Orthodontia Lifetime Maximum	$1,500 per member per lifetime

The TPSC direct reimbursement plan allows you to use the provider of your choice. You pay for services up front then submit a claim to TPSC.

Life and AD&D / Long Term Disability Benefits – Lincoln Financial

	Life and AD&D Benefit Amounts
Employee Life Insurance Amount	1x salary to a maximum of $150,000 ($50,000 minimum)
Accidental Death & Dismemberment	In the event of an accidental death or dismemberment, a benefit is provided up to a scheduled amount corresponding to the loss. Life and AD&D benefits will begin to reduce at age 65.
	Long Term Disability Benefits
Benefits Begin (Self-insured after 90 days through day 180)	180 days elimination (waiting) period of continuous disability from the day your disabling condition occurs
Monthly Benefit	66.67% of your covered pre-disability monthly earnings
Maximum Benefit	$7,500 per month

Your Benefits Contacts

Carrier	Plan	Website	Phone Number
Healthcare Management Administrators, Inc. (HMA)	Medical	www.accesshma.com	(800) 869-7093
Trusteed Plans Service Corporation (TPSC)	Dental & Vision / FSA	www.trusteedplans.com	(800) 426-9786 x210
Lincoln Financial	Life and Disability plans	www.lfg.com	(800) 423-2765
Health Promotion Northwest	Employee Assistance Program	www.peacehealth.org/whatcom/eap	(360) 788-6565
Kibble & Prentice	Benefit Resource Center	www.kpcom.com	(866) 468-7272

Premium Worksheet

	Monthly Medical Premium			Monthly Dental / Vision Premium		
	Total Premium	The Port Pays	You Pay	Total Premium	The Port Pays	You Pay
Employee	$595.51	$559.78	$35.73	$47.56	$47.56	$0.00
Employee + Spouse	$1,336.39	$1,251.53	$84.86	$93.23	$93.23	$0.00
Employee + Spouse + Child(ren)	$1,834.76	$1,718.25	$116.51	$135.68	$135.68	$0.00
Employee + Child(ren)	$1,093.88	$1,024.42	$69.46	$90.00	$90.00	$0.00

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