2017 WFCA SELF-FUNDED MEDICAL PLAN—PPO-750 PLAN

PPO-750 Plan	Preferred Provider (In-Network)	Non-Preferred Provider (Out-of-Network)
Network Description—*For a List of Preferred Providers:* In WA, OR & MT: see First Choice Network at www.fchn.com or call (800) 231-6935. For all other states or emergencies: use First Health Network at www.myfirsthealth.com or call (800) 226-5116.	You may choose any licensed health care provider. Most benefits pay at a higher level when using a Preferred Provider.	Non-Network Level applies when services are provided by a Non-Preferred Provider. Exceptions are made for certain situations where use of Non-Network provider is beyond control of patient, such as accidents or travel outside of the provider network.
Deductible	**Per Calendar Year**	
Per Person	$750 per person	
Per Family	$2,250 per family	
Deductible is waived for:	Preventive Care, Prescription Drugs and Vision Benefit	
Deductible Carryover?	Yes	
Common Accident Deductible?	Yes	
Medical Out-of-Pocket Maximum	**Per Calendar Year**	
Per Person	$3,750 per person ($3,000 + $750 Deductible)	
Per Family	$11,250 per family ($9,000 + $2,250 Deductible)	
Includes the Deductible?	Yes	
Includes Medical Copays?	Yes (but not Rx Copays)	
Includes services from both Preferred and Non-Preferred Providers?	Yes	
Expenses excluded from Medical Out-of-Pocket Maximum?	Prescription drug copays and Vision coinsurance for participants age 19 and older	
Prescription Drug Out-of-Pocket Maximum— *There is a separate Out-of-Pocket Maximum for only Prescription Drugs.*	**Per Calendar Year**	
Per Person	$1,000 per person (Deductible waived)	
Per Family	$2,000 per family (Deductible waived)	
OTHER BENEFITS		
Include Wellness Web Portal?	Yes	
Life/AD&D paid by WFCA for Employees & Commissioners covered under this WFCA plan	$2,000 Life/AD&D	
ELIGIBILITY		
Active Commissioners - Eligible for Coverage?	Yes.	
Former Commissioners - Eligible for Coverage?	If *not eligible for Medicare*, may continue on this plan at active rates. If eligible for Medicare, *must* enroll in Retiree Plan.	
LEOFF II / PERS Retirees - Eligible for Coverage?	If *not eligible for Medicare*, may continue on this plan at active rates. If eligible for Medicare, *must* enroll in Retiree Plan.	
LEOFF I Actives & Retirees Eligible?	No. Eligibility limited to Traditional Plan.	
Dependents of Active LEOFF I's Eligible?	Yes, this plan and other medical plans are available in combination with Traditional Plan.	
Dependents of Retired LEOFF I's Eligible?	If *not eligible for Medicare*, may continue on this plan at active rates. If eligible for Medicare, *must* enroll in Retiree or Traditional Plan.	
How long are Children Eligible?	To Age 26	
Are Domestic Partners Eligible?	State-registered domestic partners are eligible for coverage. Participating Districts may also choose to offer coverage to domestic partners who meet specific criteria and sign the WFCA Affidavit of Domestic partnership.	

2017 WFCA SELF-FUNDED MEDICAL PLAN—PPO-750 PLAN (continued)

WHEN COVERAGE BEGINS		
Are new employees covered as of date of hire?	Yes	
Covered for on-the-job illness and injury?	No, only LEOFF I Actives & Retirees covered under Traditional Plan.	
How long before Pre-existing Conditions are covered?	There is no waiting period for coverage of pre-existing conditions.	
TPSC ADMINISTRATION[1]		
Is consolidated billing provided for all coverage?	Yes, for all benefits offered by WFCA (medical, dental, life) one billing is prepared for the District.	
Is COBRA administration included in services?	Yes, for all districts participating in the WFCA benefit program.	
MONTHLY RATES		
	For: Active LEOFF II, PERS & Dependents of Active LEOFF I	
Rates Valid For:	1/1/2017 through 12/31/2017	
Who is Enrolled?	**Monthly Premium**	**Total Cost**
Employee only	$439.03	
Spouse	$966.86	
1 Child	$303.24	
2 or more Children	$540.99	
	For: Active Commissioners	
Rates Valid For:	1/1/2017 through 12/31/2017	
Who is Enrolled?	**Monthly Premium**	**Total Cost**
Commissioner only	$668.37	
Spouse	$1,300.65	
1 Child	$348.16	
2 or more Children	$620.59	
	* Does not include individuals with Medicare Primary.	

[1] All WFCA Self-funded Medical Plans are administered by Trusteed Plans Service Corp. (253) 564-5611 or (800) 426-9786.

MEDICAL SUMMARY OF BENEFITS—PPO-750 Plan

BENEFIT PERIOD	Calendar Year	
BENEFIT LIMITATION	Services from Non-Preferred Providers are limited to a Usual & Customary and/or Reasonable (UCR) allowance.	
PRE-CERTIFICATION	Pre-certification is required for certain Inpatient admissions. Refer to the section PRE-CERTIFICATION OF INPATIENT ADMISSIONS for details.	
LIFETIME MAXIMUM BENEFIT	Unlimited	
	PREFERRED PROVIDER	**NON-PREFERRED PROVIDER**
DEDUCTIBLE— *Applies to all services unless noted as "Waived."*	**$750** per Person **$2,250** per Family	
MEDICAL OUT-OF-POCKET MAXIMUM— *Benefits are increased to 100% payment if Out-of-Pocket expenses reach these amounts. Outpatient prescription drugs, coinsurance for vision benefits for participants over age 19, and non-covered services do not apply to the Out-of-Pocket Maximum.*	**$3,750** per Person **$11,250** per Family	
OUTPATIENT PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM—*Benefits are increased to 100% payment if Out-of-Pocket expenses reach these amounts. Deductible does not apply to the Out-of-Pocket Maximum.*	**$1,000** per Person **$2,000** per Family	
PRIMARY BENEFITS		
I. PHYSICIAN SERVICES		
Inpatient		
Hospital Visit	Paid at 80%	Paid at 60%
Surgery	Paid at 80%	Paid at 60%
Outpatient		
Primary Care Office Visit/Urgent Care	**$25** Copay, then Paid at 80%	**$25** Copay, then Paid at 60%
Specialist Office Visit	**$50** Copay, then Paid at 80%	**$50** Copay, then Paid at 60%
Primary Care Office Surgery	**$25** Copay, then Paid at 80%	**$25** Copay, then Paid at 60%
Specialist Office Surgery	**$50** Copay, then Paid at 80%	**$50** Copay, then Paid at 60%
Outpatient Surgery at Other Facility	Paid at 80%	Paid at 60%
II. PREVENTIVE CARE SERVICES— *For a list of Preventive Care Services, see www.trusteedplans.com/preventive-care-services*	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 60%
III. HOSPITAL SERVICES		
Inpatient		
Room and Board	Paid at 80%	Paid at 60%
Intensive Care & Coronary Care Units	Paid at 80%	Paid at 60%
Hospital Miscellaneous Expenses	Paid at 80%	Paid at 60%
Outpatient		
Outpatient Department/Ambulatory Surgical Center/Birthing Center	Paid at 80%	Paid at 60%
Emergency Room	**$125 Copay*** then:	**$125 Copay*** then:
Services and Supplies	Paid at 80%	Paid at 80%
X-ray and Lab	Paid at 80%	Paid at 80%
* Emergency Room Copay is waived if patient is admitted as an Inpatient.		
IV. DIAGNOSTIC SERVICES—*Including interpretations; non-routine/non-preventive scans, imaging and labs; non-routine cancer screenings.*		
Physician Services	Paid at 80%	Paid at 60%
Inpatient Facility Services	Paid at 80%	Paid at 60%
Outpatient Facility Services	Paid at 80%	Paid at 60%
V. MATERNITY & NEWBORN CARE *Limited to Employee and Spouse only (maternity).*	Paid same as any other condition.	

MEDICAL SUMMARY OF BENEFITS—PPO-750 Plan (continued)

PRIMARY BENEFITS (continued)	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
VI. CHEMICAL DEPENDENCY & MENTAL HEALTH TREATMENT		
Inpatient Facility/Physician Services	Paid at 80%	Paid at 60%
Outpatient Facility Services	Paid at 80%	Paid at 60%
Outpatient Physician Services	**$25** Copay, then paid at 80%	**$25** Copay, then paid at 60%
VII. HOME HEALTH CARE *Limited to 130 visits per Calendar Year.*	Paid at 80%	Paid at 60%
VIII. HOSPICE *Limited to six (6) months of care per Calendar Year.*	Paid at 80%	
IX. OUTPATIENT PRESCRIPTION DRUGS ***Deductible Waived**		
	MaxorPlus Pharmacies	**Non-Member Pharmacies***
Retail—*Limited to a 34-day supply.*		
Generic Drug	**$15** Copay	Paid at 50%
Formulary Brand Name Drug	**$30** Copay	Paid at 50%
Non-Formulary Brand Name Drug	**$30** Copay	Paid at 50%
Mail-Order—*Limited to a 90-day supply.*		
Generic Drug	**$30** Copay	Not Covered
Formulary Brand Name Drug	**$60** Copay	Not Covered
Non-Formulary Brand Name Drug	**$60** Copay	Not Covered
Specialty Medications—*Limited to a 34-day supply; only first fill at pharmacy, then mail-order through MaxorPlus*		
Generic Drug	**$15** Copay	
Formulary Brand Name Drug	**$30** Copay	Not Covered
Non-Formulary Brand Name Drug	**$30** Copay	
	**Limited to Maxor's Maximum Allowable Charge. Must pay 100% of cost at purchase, then submit claim directly to Maxor for reimbursement.*	
X. SKILLED NURSING FACILITY *Limited to 90 days per Calendar Year.*	Paid at 80%	Paid at 60%
XI. TRANSPLANTS—*Subject to the Limitations described at XI. Transplant Benefit.*	Paid the same as any other condition for certain transplants.	
Travel, lodging & meals—*Limited to $2,500 per transplant.*	Paid at 100%	
XII. OTHER BENEFITS		
Acupuncture Services— *Limited to sixteen (16) visits per Calendar Year.*	**$25** Copay, then paid at 80%	**$25** Copay, then paid at 60%
Ambulance	Paid at 80%	Paid at 80%
Blood	Paid at 80%	Paid at 80%
Diabetes Care Training	**$25** Copay, then paid at 80%	**$25** Copay, then paid at 60%
Durable Medical Equipment (DME), Prosthetic & Orthopedic Appliances	Paid at 80%	Paid at 60%
Habilitative Services—*Includes Neurodevelopmental, Occupational, Physical, & Speech Therapies.* *Limited to forty (40) visits per Calendar Year all modalities combined. No visit limits for children through age 6.*	Paid at 80%	Paid at 60%
Hearing—		
Exam—*Limited to one (1) exam per 24 months.*	Paid at 100%	
Hearing Aids—*Limited to $700 per 24 months.*	Paid at 100%	
Home Infusion Therapy	Paid at 80%	Paid at 60%
Inpatient Rehabilitation— *Limited to fifteen (15) days each for habilitation or rehabilitation services per Calendar Year.*	Paid at 80%	Paid at 60%
Manipulations & Related Modalities— *Limited to thirty (30) visits per Calendar Year.*	**$25** Copay, then paid at 80%	**$25** Copay, then paid at 60%

MEDICAL SUMMARY OF BENEFITS—PPO-750 Plan (continued)

XII. OTHER BENEFITS (continued)	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Massage Therapy— *Limited to sixteen (16) visits per Calendar Year.*	**$25** Copay, then paid at 80%	**$25** Copay, then paid at 60%
Mastectomy & Breast Reconstruction	Covered the same as any other condition.	
Medical Supplies	Paid at 80%	
Nutritional Counseling (*other than Diabetes Care Training)—Limited to four (4) visits per Calendar Year.*	**$25** Copay, then paid at 80%	**$25** Copay, then paid at 60%
Outpatient Dialysis Treatment— *Subject to the requirements of the Outpatient Dialysis Program (as defined).*	Paid at 80%	Paid at 60%
PKU	Paid at 80%	Paid at 60%
Outpatient Rehabilitation—*Includes Cardiac, Occupational, Physical, Pulmonary & Speech Therapies* *Limited to forty (40) visits per Calendar Year all modalities combined.*	Paid at 80%	Paid at 60%
Temporomandibular Joint Dysfunction (TMJ) *Limited to $1,000 per Calendar Year and $5,000 per Lifetime.*	Paid at 80%	Paid at 60%
Eligible Non-Listed Services	Paid at 80%	Paid at 60%

This summary is offered as a highlight of the benefits available to eligible Employees. Please refer to the Plan Document and Summary Plan Description for details and any applicable Limitations and Exclusions.

VISION SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year
BENEFIT LIMITATION	All services are limited to a Usual & Customary and/or Reasonable (UCR) allowance.
LIFETIME MAXIMUM BENEFIT	Unlimited
DEDUCTIBLE	None
BENEFITS	
VISION EXAM *Limited to one (1) per Calendar Year.*	Paid at 100%
HARDWARE For Dependent Children under Age 19— Lenses—*Limited to one (1) pair per two (2) Calendar Years.* Frames—*Limited to one (1) pair per two (2) Calendar Years.* *or* Contact lenses equivalent *(in lieu of eyeglasses)*— *Limited to equivalent per two (2) Calendar Years.* For All Others— Lenses and Frames or Contact Lenses— *Limited to $200 per two (2) Calendar Years.*	 Paid at 80% Paid at 80% Paid at 80% Paid at 80%