2017 WFCA SELF-FUNDED MEDICAL PLAN—RETIREE PLAN

Name Of 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	$350 per person	
Per Family	$1,050 per family	
Deductible is waived for:	Preventive Care and Prescription Drugs	
Deductible Carryover?	Yes	
Common Accident Deductible?	Yes	
Medical Out-of-Pocket Maximum	**Per Calendar Year**	
Per Person	$1,850 per person ($1,500 + $350 Deductible)	There is no limit on how much you may pay during a coverage period for services from Non-Preferred Providers.
Per Family	$3,300 per family ($3,000 + $300 Deductible)	
Includes the Deductible?	Yes	
Includes Medical Copays?	Yes (but not Rx Copays)	
Includes services from Preferred Providers *only*?	Yes	
Expenses excluded from Medical Out-of-Pocket Maximum?	Prescription drug copays, services from Non-Preferred Providers, and Non-designated transplant facilities	
Prescription Drug Out-of-Pocket Maximum— *There is a separate Out-of-Pocket Maximum for only Prescription Drugs.*	**Per Calendar Year**	
Per Person *(Deductible waived)*	$2,000 per person	There is no coverage for Prescription Drugs purchased from Non-Preferred Providers.
Per Family *(Deductible waived)*	$4,000 per family	
Includes services from Preferred Providers *only*?	Yes	
OTHER BENEFITS		
Include Wellness Web Portal?	Yes	
Life/AD&D paid by WFCA for *active* Employees & Commissioners only	No	
ELIGIBILITY		
Active Commissioners - Eligible for Coverage?	No	
Former Commissioners - Eligible for Coverage?	If *eligible for Medicare* and served as a Commissioner for at least six (6) years and have been covered under a WFCA Health Plan for at least one (1) year.	
LEOFF II / PERS Retirees - Eligible for Coverage?	If *eligible for Medicare* and meet WA state retirement criteria for LEOFF II, PERS, or Disability Retirement.	
LEOFF I Retirees Eligible?	No. Eligibility limited to Traditional Plan.	
Dependents of Active LEOFF I's Eligible?	No	
Dependents of Retired LEOFF I's Eligible?	Yes, even if *eligible for Medicare* or if they may enroll in the Traditional Plan.	

2017 WFCA SELF-FUNDED MEDICAL PLAN—RETIREE PLAN (continued)

ELIGIBILITY (continued)		
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.	
WHEN COVERAGE BEGINS		
When are retirees covered?	The first day of the month following the effective date of retirement	
Covered for on-the-job illness and injury?	N/A	
How long before Pre-existing Conditions are covered?	There is no waiting period for coverage of pre-existing conditions.	
TPSC ADMINISTRATION[1]		
How are Retirees billed?	Premium billing for Retirees may be sent directly to the Retiree or through the District Billing Statement.	
Is COBRA administration included in services?	Yes, for all districts participating in the WFCA benefit program.	
MONTHLY RATES		
	For: LEOFF II & PERS Retirees, Former Commissioners, & Dependents of LEOFF I Retirees	
Rates Valid for Medical Only from	1/1/2017 through 12/31/2017	
Who is Enrolled?	**Monthly Premium**	**Total Cost**
Not Medicare eligible		
Retiree under age 55	$535.33	
Retiree age 55-59	$567.82	
Retiree age 60-64	$652.97	
Spouse under age 55	$535.33	
Spouse age 55-59	$567.82	
Spouse age 60-64	$652.97	
Medicare eligible		
Retiree age 65 or older	$403.00	
Retiree ANY AGE	$403.00	
Spouse age 65 or older	$403.00	
Spouse ANY AGE	$403.00	
All Dependent Children		
1 Child	$148.60	
2 or more Children	$371.50	

[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—RETIREE 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."*	**$350** per Person **$1,050** 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.*	**$1,850** per Person **$5,550** per Family	**Unlimited** *Only services received from Preferred providers apply to the Out-of-Pocket Maximum.*
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.*	**$2,000** per Person **$4,000** per Family	
NOTE: *Medicare-eligible Retirees and Dependents are not eligible for Outpatient Prescription Drug coverage under this Plan.*		
PRIMARY BENEFITS		
I. PHYSICIAN SERVICES		
Inpatient		
Hospital Visit	**$15** Copay, then paid at 80%	**$30** Copay, then paid at 60%
Surgery	**$15** Copay, then paid at 80%	**$30** Copay, then paid at 60%
Outpatient		
Office Visit/Urgent Care	**$15** Copay, then paid at 80%	**$30** Copay, then paid at 60%
Outpatient/Office Surgery	**$15** Copay, then paid at 80%	**$30** Copay, then 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%	Not covered
III. HOSPITAL SERVICES		
Inpatient	**$100** Copay/day,***** then	**$100** Copay/day,***** then
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	**$100** Copay/visit,***** then paid at 80%	**$100** Copay/visit,***** then paid at 60%
Emergency Room	**$100** Copay/visit,** then	**$100** Copay/visit,** then
Services and Supplies	Paid at 80%	Paid at 80%
X-ray and Lab	Paid at 80%	Paid at 80%
*Inpatient and Outpatient Copays are limited to a combined $300 per Calendar Year. **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	**$15** Copay, then Paid at 80%	**$30** Copay, then 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 the same as any other condition.	

MEDICAL SUMMARY OF BENEFITS—RETIREE PLAN (continued)

PRIMARY BENEFITS (continued)	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
VI. CHEMICAL DEPENDENCY & MENTAL HEALTH TREATMENT		
Inpatient Physician Services	**$ 15** Copay, then paid at 80%	**$ 30** Copay, then paid at 60%
Inpatient Facility	**$100** Copay/day,***** then paid at 80%	**$100** Copay/day,***** then paid at 60%
Outpatient Physician Services	**$ 15** Copay, then paid at 80%	**$ 30** Copay, then paid at 60%
Outpatient Facility Services	**$100** Copay/day,* then paid at 80%	**$100** Copay/day,* 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 per Lifetime.*	Paid at 80%	
IX. OUTPATIENT PRESCRIPTION DRUGS *****Deductible Waived*****		
	MaxorPlus Pharmacies	**Non-Member Pharmacies**
Retail—*Limited to a 34-day supply.*		
Generic Drug	40% Coinsurance	
Formulary Brand Name Drug	50% Coinsurance	Not Covered
Non-Formulary Brand Name Drug	50% Coinsurance	
Mail-Order—*Limited to a 90-day supply.*		
Generic Drug	40% Coinsurance	
Formulary Brand Name Drug	50% Coinsurance	Not Covered
Non-Formulary Brand Name Drug	50% Coinsurance	
Specialty Medications—*Limited to a 34-day supply; only first fill at pharmacy, then mail-order through MaxorPlus.*		
Generic Drug	40% Coinsurance	
Formulary Brand Name Drug	50% Coinsurance	Not Covered
Non-Formulary Brand Name Drug	50% Coinsurance	
NOTE: *Medicare-eligible Retirees and Dependents are not eligible for Outpatient Prescription Drug coverage under this Plan.*		
X. SKILLED NURSING FACILITY *Limited to 30 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.*	**$15** Copay, then Paid at 80%	**$30** Copay, then Paid at 60%
Ambulance— *Limited to $5,000 per Calendar Year.*	Paid at 80%	Paid at 80%
Blood	Paid at 80%	Paid at 80%
Diabetes Care Training	**$15** Copay, then Paid at 80%	**$30** Copay, then Paid at 60%
Durable Medical Equipment (DME), Prosthetic & Orthopedic Appliances— *Limited to $5,000 per Calendar Year.*	Paid at 80%	Paid at 60%
Habilitative Services—*Includes Neurodevelopmental, Occupational, Physical, & Speech Therapies.* *Limited to forty (40) visits each per Calendar Year all modalities combined. No visit limits for children through age 6.*	Paid at 80%	Paid at 60%
Home Infusion Therapy	Paid at 80%	Paid at 60%
Inpatient Rehabilitation— *Limited to fifteen (15) days each for habilitative or rehabilitative services per Calendar Year.*	Paid at 80%	Paid at 60%
Manipulations & Related Modalities— *Limited to ten (10) visits per Calendar Year.*	**$15** Copay, then Paid at 80%	**$30** Copay, then Paid at 60%
Massage Therapy— *Limited to sixteen (16) visits per Calendar Year.*	**$15** Copay, then paid at 80%	**$30** Copay, then paid at 60%

MEDICAL SUMMARY OF BENEFITS—RETIREE PLAN (continued)

XII. OTHER BENEFITS (continued)	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Mastectomy & Breast Reconstruction	Covered the same as any other condition.	
Medical Supplies	Paid at 80%	Paid at 80%
Nutritional Counseling (*other than Diabetes Care Training)—Limited to four (4) visits per Calendar Year.*	**$15** Copay, then Paid at 80%	**$30** 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 each per Calendar Year all modalities combined.*	Paid at 80%	Paid at 60%
Voluntary Male Sterilization— *Limited to Retiree & Spouse only.*	Paid the same as any other condition.	
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.