2017 WFCA SELF-FUNDED MEDICAL PLAN—TRADITIONAL PLAN

Traditional 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	$50 per person	
Per Family	$150 per family	
Deductible is waived for:	Basic, Preventive Care, Prescription Drugs and Vision Benefits	
Deductible Carryover?	Yes	
Common Accident Deductible?	Yes	
Medical Out-of-Pocket Maximum	**Per Calendar Year**	
Per Person	$425 per person ($375 + $50 Deductible)	
Per Family	$1,275 per family ($1,125 + $150 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 Prescription Drugs only.*	**Per Calendar Year**	
Per Person	$2,000 per person (Deductible waived)	
Per Family	$4,000 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?	No	
Former Commissioners - Eligible for Coverage?	No	
LEOFF II / PERS Retirees - Eligible for Coverage?	No	
LEOFF I Actives & Retirees Eligible?	Yes. 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?	Yes. If *not eligible for Medicare*, may enroll in this or other medical plans available to dependents. 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—TRADITIONAL PLAN (continued)

WHEN COVERAGE BEGINS		
Are new employees covered as of date of hire?	Yes	
Covered for on-the-job illness and injury?	Yes	
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		
Active Employees	**For: Active LEOFF I**	
Rates Valid For:	1/1/2017 through 12/31/2017	
Who is Enrolled?	**Monthly Premium**	**Total Cost**
Employee only	$846.76	
Spouse	$759.18	
1 Child	$394.77	
2 or more Children	$703.85	
Not Medicare-Eligible	**For: Retired LEOFF I & Dependents**	
Rates Valid For:	1/1/2017 through 12/31/2017	
Who is Enrolled?	**Monthly Premium**	**Total Cost**
Employee only	$1,623.93	
Spouse	$809.77	
1 Child	$421.10	
2 or more Children	$750.78	
Medicare-Eligible	**For: Retired LEOFF I & Dependents**	
Rates Valid For:	1/1/2017 through 12/31/2017	
Who is Enrolled?	**Monthly Premium**	**Total Cost**
Employee only	$903.22	
Spouse	$596.98	
1 Child	$473.72	
2 or more Children	$844.64	

[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—TRADITIONAL 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 NETWORK	There is no preferred network. You may choose any licensed provider.
DEDUCTIBLE— *Applies to all services unless noted as "Waived."*	**$50** per person per Calendar Year **$150** per Family per Calendar Year
MEDICAL OUT-OF-POCKET MAXIMUM— *Outpatient prescription drugs, vision coinsurance for members age 19 and older, and non-covered services do not apply to the Out-of-Pocket Maximum and do not increase benefits to the 100% level.*	**$425** per person per Calendar Year **$1,275** per Family per Calendar Year
OUTPATIENT PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM	**$2,000** per person per Calendar Year **$4,000** per Family per Calendar Year

NOTE: *Medicare-eligible Dependents of LEOFF I Retirees are not eligible for Outpatient Prescription Drug benefits under this Plan.*

PRIMARY BENEFITS	EMPLOYEE	DEPENDENT
I. PHYSICIAN SERVICES		
Inpatient	**Deductible Waived,** Paid at 100%	Paid at 100%
Outpatient		
Office Visit—Illness	**Deductible Waived,** Paid at 100%	Paid at 100%
Office Visit—Injury	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Outpatient surgery—Office	**Deductible Waived,** Paid at 100%	Paid at 100%
Outpatient surgery—Other Setting	**Deductible Waived,** Paid at 100%	Paid at 100%
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 100%
III. HOSPITAL SERVICES		
Inpatient—*First 365 days per Lifetime* Includes Room and Board, Intensive Care & Coronary Care Units, Hospital Miscellaneous Expenses, X-ray & Lab	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Inpatient—*After 365 days per Lifetime* Includes Room and Board, Intensive Care & Coronary Care Units, Hospital Miscellaneous Expenses, X-ray & Lab	Paid at 80%	Paid at 80%
Outpatient Outpatient Department/Ambulatory Surgical Center/Birthing Center/X-ray & Lab	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Emergency Room Includes Emergency Services, Supplies, X-ray & Lab	**Deductible Waived,** Paid at 100%	**Deductible Waived, $50** Copay,* then paid at 100%
** 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.*		
Inpatient X-ray & Lab	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Outpatient X-ray and Lab—*Outside Lab*		
Illness	**Deductible Waived,** Paid at 100%	Paid at 100% up to $100, then paid at 80% after Deductible
Injury	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%

MEDICAL SUMMARY OF BENEFITS—TRADITIONAL PLAN (continued)

PRIMARY BENEFITS (continued)	EMPLOYEE	DEPENDENT
V. MATERNITY & NEWBORN CARE *Limited to Employee and Spouse only (maternity).*	Paid same as any other condition.	
VI. CHEMICAL DEPENDENCY & MENTAL HEALTH TREATMENT		
Inpatient Facility/Physician Services	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Outpatient Facility/Physician Services	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
VII. HOME HEALTH CARE *Limited to 130 visits per Calendar Year.*	**Deductible Waived,** Paid at 100%	
VIII. HOSPICE *Limited to six (6) months of care per Calendar Year.*	**Deductible Waived,** Paid at 100%	
IX. OUTPATIENT PRESCRIPTION DRUGS—*Deductible Waived.*		
For LEOFF I *(Active & Retired)*	**MAXORPLUS PHARMACIES**	**NON-MEMBER PHARMACIES**
Retail—*Limited to a 34-day supply.*		
Generic Drug	Paid at 100%	Paid at 100%
Formulary Brand Name Drug	Paid at 100%	Paid at 100%
Non-Formulary Brand Name Drug	Paid at 100%	Paid at 100%
Mail-Order—*Limited to a 90-day supply.*		
Generic Drug	Paid at 100%	Not covered
Formulary Brand Name Drug	Paid at 100%	Not covered
Non-Formulary Brand Name Drug	Paid at 100%	Not covered
For LEOFF I Dependents *(who are not Eligible for Medicare)**		
Retail—*Limited to a 34-day supply.*		
Generic Drug	**$10** Copay	Paid at 50%
Formulary Brand Name Drug	**$15** Copay	Paid at 50%
Non-Formulary Brand Name Drug	**$15** Copay	Paid at 50%
Mail-Order—*Limited to a 90-day supply.*		
Generic Drug	**$20** Copay	Not covered
Formulary Brand Name Drug	**$30** Copay	Not covered
Non-Formulary Brand Name Drug	**$30** Copay	Not covered
**LEOFF I Dependents who are Eligible for Medicare are not eligible for Outpatient Prescription Drug benefits.*		
X. SKILLED NURSING FACILITY *Limited to 365 days per Lifetime.*	**Deductible Waived,** Paid at 100%	Paid at 100%
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.*	**Deductible Waived,** Paid at 100%	Paid at 100%
Ambulance	**Deductible Waived,** Paid at 100% up to $150 per trip, then 80% after Deductible	**Deductible Waived,** Paid at 100% up to $150 per trip, then 80% after Deductible
Blood	Paid at 80%	Paid at 80%
Diabetes Care Training	Paid at 80%	Paid at 80%
Durable Medical Equipment (DME), Prosthetic & Orthopedic Appliances	Paid at 80%	Paid at 80%
Habilitative Services—*Includes Occupational, Neurodevelopmental, Physical, & Speech Therapies.*	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Hearing Aids		
Exam—*Limited to one (1) exam per 24 months.*	**Deductible Waived,** Paid at 100%	
Hardware—*Limited to $700 per 24 months.*	**Deductible Waived,** Paid at 100%	

MEDICAL SUMMARY OF BENEFITS—TRADITIONAL PLAN (continued)

XII. OTHER BENEFITS (continued)	EMPLOYEE	DEPENDENT
Home Infusion Therapy	Paid at 80%	Paid at 80%
Inpatient Rehabilitation—*Includes cardiac rehabilitation.*	**Deductible Waived,** Paid at 100%	Paid at 100%
Manipulations & Related Modalities—*Limited to thirty (30) visits per Calendar Year.*	**Deductible Waived,** Paid at 50%	**Deductible Waived,** Paid at 50%
Massage Therapy—*Limited to sixteen (16) visits per Calendar Year.*	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
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.*	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Outpatient Dialysis Treatment—*Subject to the requirements of the Outpatient Dialysis Program (as defined).*	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
PKU	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Outpatient Rehabilitation—*Includes cardiac, physical, occupational, pulmonary and speech therapies.*	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
Temporomandibular Joint Dysfunction (TMJ) *Limited to $1,000 per Calendar Year; $5,000 per Lifetime.*	**Deductible Waived,** Paid at 100%	Paid at 100%
Voluntary Male Sterilization	**Deductible Waived,** Paid at 100%	Paid at 80%
Eligible Non-Listed Services	Paid at 100%	Paid at 100%

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%