

PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD - 2018

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION * Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,340	\$1,340 (Part A Deductible)	\$0
61st thru 90th day	All but \$335 a day	\$335 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ***
– Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$167.50 a day	Up to \$167.50 a day	\$0
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the certificate's "Core Benefits." During this time the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR - 2018

** Once you have been billed \$183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$183 of Medicare Approved Amounts**	\$0	\$183 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$183 of Medicare Approved Amounts**	\$0	\$183 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$183 of Medicare Approved Amounts**	\$0	\$183 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Benefit Overview



Express Scripts Medicare® (PDP)

YOUR 2018 PRESCRIPTION DRUG PLAN BENEFIT Washington Counties Insurance Fund

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service. For maintenance medications, you have the choice of filling prescriptions for more than a one-month supply at pharmacies with preferred cost-sharing, including CVS and select independent local pharmacies. These pharmacies may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within our network.

Deductible stage	You do not pay a yearly deductible.			
Initial Coverage stage	You will pay the following until your total yearly drug costs (what you and the plan pay) reach \$3,750:			
		Retail One-Month (31-day) Supply	Retail Three-Month (90-day) Supply	Home Delivery Three-Month (90-day) Supply
	Tier 1: Generic Drugs	\$5 copayment	Preferred cost-sharing \$10 copayment Standard cost-sharing \$15 copayment	\$10 copayment
	Tier 2: Preferred Brand Drugs	\$40 copayment	Preferred cost-sharing \$80 copayment Standard cost-sharing \$120 copayment	\$80 copayment
	Tier 3: Non-Preferred Drugs	\$75 copayment	Preferred cost-sharing \$180 copayment Standard cost-sharing \$225 copayment	\$180 copayment
Tier 4: Specialty Tier Drugs	33% coinsurance	33% coinsurance	33% coinsurance	
	<p>If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.</p> <p>You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts PharmacySM. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.</p>			

	If you have any questions about this coverage, please contact the Retiree Customer Service Center at 1.800.236.4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.
Coverage Gap stage	After your total yearly drug costs reach \$3,750, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage, until you qualify for the Catastrophic Coverage stage.
Catastrophic Coverage stage	After your yearly out-of-pocket drug costs reach \$5,000, you will pay the greater of 5% coinsurance or: <ul style="list-style-type: none"> • a \$3.35 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage • an \$8.35 copayment for all other covered drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.

IMPORTANT PLAN INFORMATION

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one-month supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact the plan or the Retiree Customer Service Center for more details.

Additional Information About This Coverage

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **www.express-scripts.com**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.

- To access your plan's list of covered drugs, visit our website at **www.express-scripts.com**.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- Each month, you may need to pay a monthly premium amount to continue your participation in this plan. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is \$0.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

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