



Highlights of your Health Care Coverage

Washington Counties Insurance Fund

Effective Date: 01/01/2016

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MEDICAL PLAN	WCIF 500	
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$500 PCY	\$1,000 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$2,750 PCY	\$5,500 PCY
Office Visit Cost Share	\$25 Copay, applies to the Out of Pocket Maximum	Deductible/then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in Full	Deductible/then 50%
Immunizations (Unlimited)	Covered In Full	Deductible/then 50%
Health Education (HE) (Unlimited)	Covered In Full	Deductible/then 50%
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Deductible/then 50%
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Deductible/then 50%
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	\$25 Copay, applies to Out of Pocket Max	Deductible/then 50%
Telehealth Virtual Care	\$10 Office Visit Cost Share	Deductible/then 50%
Inpatient Professional Services	Deductible/then 20%	Deductible/then 50%
Contraceptive Management Services (Unlimited)	Covered In Full	Deductible/then 50%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Deductible/then 50%
Other Professional Diagnostic Imaging	Deductible/then 20%	Deductible/ then 50%
Other Professional Diagnostic Laboratory/Pathology	Deductible/then 20%	Deductible/then 50%
Diagnostic Mammography	Covered in Full	Deductible/then 50%
FACILITY CARE OPTIONS		
Inpatient Facility	Deductible/then 20%	Deductible/then 50%
Outpatient Surgery Facility	\$75 Copay applies to the OOPM/then Deductible/then 20%	Deductible/then 50%
Hospice Inpatient Facility (14 Days; 6 month limit per lifetime)	\$100 copay applies to OOP Max, then Covered in Full	\$100 copay applies to OOPM/then Deductible/then Covered in Full
EMERGENCY CARE AND TRANSPORTATION OPTIONS		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$150 Copay, applies to the Out of Pocket Maximum; then Deductible/then 20%	\$150 Copay, applies to the Out of Pocket Maximum; then In Network Deductible/then 20%
Emergency Room Physician	Deductible/then 20%	In Network Deductible/then 20%
Ambulance Transportation (Unlimited)	\$50 copay applies to OOPM then Deductible/then 20%	\$50 copay applies to OOPM then In Network Deductible/then 20%
Air Ambulance (Unlimited)	\$50 copay applies to OOPM then Deductible/then 20%	\$50 copay applies to OOPM then In Network Deductible/then 20%

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	IN-NETWORK	OUT-OF-NETWORK
OTHER SERVICES		
Allergy/Therapeutic Injections	Deductible/then 20%	Deductible/then 50%
Mental Health Inpatient Facility Care (Unlimited)	Deductible/then 20%	Deductible/then 50%
Mental Health Outpatient Professional Care (Unlimited)	\$25 Copay, applies to the Out of Pocket Maximum	Deductible/then 50%
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible/then 20%	Deductible/then 50%
Chemical Dependency Outpatient Professional Care (Unlimited)	\$25 Copay, applies to the Out of Pocket Maximum	Deductible/then 50%
Rehab Inpatient Facility (30 days PCY)	Deductible/then 20%	Deductible/then 50%
Rehab Outpatient Care, Including Physical, Occupational, and Speech Therapy (45 visits PCY)	\$25 Copay, applies to the Out of Pocket Maximum	Deductible/then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer (Unlimited)	\$25 Copay, applies to the Out of Pocket Maximum	Deductible/then 50%
Medical Supplies, Equipment, Prosthetics (Unlimited)	Deductible/then 20%	Deductible/then 50%
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY) (Unlimited Diabetes Related)	Deductible/then 20%	Deductible/then 50%
Home Health Visits (130 visits PCY)	Deductible/then 20%	Deductible/then 50%
Hospice Care (240 hours respite care; 6 month limit per lifetime)	Deductible/then Covered in Full	Deductible/then Covered in Full
TMJ (Temporomandibular Joint Disorders) (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service))	Covered as any other service	Covered as any other service
Transplants (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Covered as any other service
ALTERNATIVE CARE		
Manipulations (Spinal and other) (15 Visits PCY)	\$25 Copay, applies to the Out of Pocket Maximum	Deductible/then 50%
Massage Therapy (12 Visit PCY)(separate from Spinal Manipulations)		
Acupuncture (12 Visits PCY)	\$25 Copay, applies to the Out of Pocket Maximum	Deductible/then 50%
Nutritional Therapy (Unlimited)	Covered In Full	Deductible/then 50%
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	\$25 Copay applies to the Out of Pocket Maximum	Deductible/then 50%
Pediatric Vision Exam (1 PCY under age 19)	\$25 Copay, applies to the Out of Pocket Maximum	\$25 Copay, applies to the Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

Copays are not subject to the deductible unless otherwise noted. Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.



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Pharmacy Benefits

Tier 1 = Generic
Tier 2 = Preferred Brand Name
Tier 3 = Non Preferred Brand Name

Below is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the Preferred Drug List for your plan when using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To find out what tier applies to a specific medication, see out Preferred Drug List in your pharmacy packet or at www.premera.com.

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PHARMACY PLAN		RX 500
		Cost Share Category Tier1/Tier2/Tier3
PRESCRIPTION DRUGS		
Retail Cost Shares		\$5/\$20/\$50
Mail Cost Shares		\$15/\$45/\$150
Day Supply		Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PCY		\$0
Out of Pocket Maximum		Applies to the medical out of pocket maximum
Annual Benefit Maximum		Unlimited
Drug List		Preferred B3

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