

Highlights of your Health Care Coverage

Washington Counties Insurance Fund

Effective Date: 01/01/2019

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN		PLAN 500	
	IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$500	\$1,000	
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	\$5,500	
Office Visit Cost Share	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum	
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum	
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum	
Health Education (HE) (Unlimited)	Covered in Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum	
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum	
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum	

PROFESSIONAL CARE		
Professional Office Visit	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Inpatient Professional Services	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Other Professional Diagnostic Imaging	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Professional Diagnostic Major Imaging	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
FACILITY CARE OPTIONS		
Inpatient Facility	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Outpatient Surgery Facility	\$75 Copay, then In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Hospice Inpatient Facility (14 Days; 6 month limit per lifetime)	\$100 Copay, applies to the Out of Pocket Maximum, then Covered in full	\$100 Copay, applies to the Out of Pocket Maximum, then Covered in Full
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$150 Copay, then In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	\$150 Copay, then In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum

Emergency Room Physician	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum
Urgent Care Center	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Ambulance Transportation (Unlimited)	\$50 Copay, then In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	\$50 Copay, then In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum
Air Ambulance (Unlimited)	\$50 Copay, then In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	\$50 Copay, then In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Home Health Visits (130 visits PCY)	In Network Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Hospice Care (240 hours respite care; 6 month limit per lifetime)	In Network Deductible, applies to the Out of Pocket Maximum, then Covered in Full	Out of Network Deductible, applies to the Out of Pocket Maximum, 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	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Transplants (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
ALTERNATIVE CARE		
Manipulations (Spinal and other) (Spinal Manipulations 20 Visits PCY, Massage Therapy 12 Visits PCY separate from Spinal Manipulations)	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Acupuncture (12 Visits PCY)	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Pediatric Vision Exam (1 PCY under age 19)	\$30 Copay, applies to the Out of Pocket Maximum	\$30 Copay, applies to the Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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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Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List in your Pharmacy Packet or at www.premera.com

PHARMACY PLAN		RX 500
PRESCRIPTION DRUGS		
Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands	
Retail Cost Shares	\$5/\$35/\$70	
Mail Cost Shares	\$15/\$79/\$210	
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	
Individual Deductible PCY	No Individual Deductible	
Family Deductible PCY	No Family Deductible	
Out of Pocket Maximum	Applies to the medical out of pocket maximum	
Annual Benefit Maximum	Unlimited	

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