Highlights of your Health Care Coverage

Washington Counties Insurance Fund

Effective Date: 01/01/2017

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 750	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$750 PCY	$1,500 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)	$5,750 PCY	$11,500 PCY
Office Visit Cost Share	$30 Copay, applies to the OOPM	Out of Network 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	$30 Copay, applies to the OOPM	Out of Network Deductible/then 50%
Inpatient Professional Services	In Network Deductible/then 20%	Out of Network Deductible/then 50%
Contraceptive Management Services (Unlimited)	Covered In Full	Out of Network Deductible/then 50%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Out of Network Deductible/then 50%
Other Professional Diagnostic Imaging	In Network Deductible/then 20%	Out of Network Deductible/then 50%
Other Professional Diagnostic Laboratory/Pathology	In Network Deductible/then 20%	Out of Network Deductible/then 50%
Diagnostic Mammography	Covered In Full	Out of Network Deductible/then 50%
FACILITY CARE OPTIONS		
Inpatient Facility	In Network Deductible/then 20%	Out of Network Deductible/then 50%
Outpatient Surgery Facility	$75 Copay applies to OOPM/then Deductible/then 20%	Deductible/then 50%
Hospice Inpatient Facility (14 Days; 6 month limit per lifetime)	$100 Copay applies to OOPM/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 OOPM/then In Network Deductible, 20%	$150 Copay applies to the OOPM/then In Network Deductible, 20%
Emergency Room Physician	In Network Deductible/then 20%	In Network Deductible/then 20%
Urgent Care Facility	$30 Copay, applies to the OOPM	Out of Network Deductible/then 50%
Ambulance Transportation (Unlimited)	$50 copay applies to OOPM/then deductible/then 20%	$50 copay applies to OOPM/then deductible/then 20%
Air Ambulance (Unlimited)	$50 copay applies to OOPM/then deductible/then 20%	$50 copay applies to OOPM/then deductible/then 20%

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Prospect

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MEDICAL PLAN	PLAN 750	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
OTHER SERVICES		
Allergy/Therapeutic Injections	Deductible/then 20%	Deductible/then 50%
Mental Health Inpatient Facility Care (Unlimited)	Inpatient: Deductible/then 20% Outpatient Hosp: Ded/Coins	Inpatient: Deductible/then 50% Outpatient Hosp: Ded/Coins
Mental Health Outpatient Professional Care (Unlimited)	Office Visit Cost Share	Deductible/then 50%
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible/then 20%	Out of Network Deductible/then 50%
Chemical Dependency Outpatient Professional Care (Unlimited)	$30 Copay, applies to the OOPM	Out of Network Deductible/then 50%
Rehab Inpatient Facility (30 days PCY)	In Network Deductible/then 20%	Out of Network Deductible/then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (45 visits PCY)	$30 Copay, applies to the OOPM	Out of Network Deductible/then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer (Unlimited)	$30 Copay, applies to the OOPM	Out of Network Deductible/then 50%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: 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)	In Network Deductible/then 20%	Out of Network 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) (Spinal Manipulations 20 Visits PCY Massage Therapy 12 Visit PCY separate from Spinal Manipulations)	$30 Copay, applies to the OOPM	Out of Network Deductible/then 50%
Acupuncture (12 Visits PCY)	$30 Copay, applies to the OOPM	Out of Network Deductible/then 50%
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$30 Copay	Out of Network Deductible/then 50%
Pediatric Vision Exam (1 PCY under age 19)	$30 Copay, applies to the OOPM	$30 Copay, applies to the OOPM
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 highligh 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 750**
	Cost Share Category Tier1/Tier2/Tier3
PRESCRIPTION DRUGS	
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	$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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