



WASHINGTON COUNTIES INSURANCE FUND
WASHINGTON COUNTIES INSURANCE POOL



Washington Counties Insurance Fund

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

Effective date: 1/1/2012

MEDICAL PLAN		WCIF 750 Plan	
MEDICAL COST SHARE OPTIONS	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK	
Individual Deductible PCY (Family Deductible 3x 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, Excludes Copay, Includes Deductible (Family OOP Max 2x Individual)	\$5,750 PCY	\$11,500 PCY	
Office Visit Cost Share (General and Family Practitioner)	First 6 visits \$25 Copay; then \$25 Copay, 20% Coinsurance	Deductible/Coinsurance	
COVERED SERVICES			
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION - UNLIMITED			
Preventive Office Visit			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA			
Immunizations	Covered in Full	Deductible/Coinsurance	
Mammography			
Well Child	Covered in Full	Deductible/Coinsurance	
Nicotine Dependency Programs (ND)	Covered in Full	Deductible/Coinsurance	
Diabetes Health Education (DE)	Covered in Full	Deductible/Coinsurance	
PROFESSIONAL CARE			
Urgent Care	See Office Visit Cost Share	Deductible/Coinsurance	
Inpatient Professional Services	Deductible/Coinsurance	Deductible/Coinsurance	
Contraceptive Management (Unlimited)	Covered in Full	Deductible/Coinsurance	
DIAGNOSTIC SERVICE OPTIONS			
Other Professional Diagnostic Imaging and Laboratory Services	First \$500: Covered in Full After First \$500: Deductible/Coinsurance	Deductible/Coinsurance	
FACILITY CARE OPTIONS			
Inpatient Facility	Deductible/Coinsurance	Deductible/Coinsurance	
Outpatient Surgery Facility	\$75 Copay, Deductible/Coinsurance	Deductible/Coinsurance	
Skilled Nursing Facility (90 days PCY)	Deductible/Coinsurance	Deductible/Coinsurance	
EMERGENCY CARE OPTIONS			
Emergency Care (Waive copay if admitted, always subject to deductible and coinsurance.)	\$150 Copay, Deductible/Coinsurance	Same as In-Network Benefit	
Ambulance Transportation	\$50 Copay, Deductible/Coinsurance	Same as In-Network Benefit	
Air Ambulance (Unlimited)	\$50 Copay, Deductible/Coinsurance	Same as In-Network Benefit	



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OTHER SERVICES	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK	
Acupuncture (12 visits PCY)	\$25 Copay	Deductible/Coinsurance	
Chemical Dependency Inpatient (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance	
Chemical Dependency Outpatient (Unlimited)	\$25 Copay	Deductible/Coinsurance	
Home Health Care (130 visits PCY)	Deductible/Coinsurance	Deductible/Coinsurance	
Hospice (Inpatient: 14 days; 6 month limit per lifetime)	Inpatient: \$100 Copay; Outpatient: Deductible/0% Coinsurance	Inpatient: \$100 Copay, Deductible Outpatient: Deductible/0% Coinsurance	
Manipulations (spinal and other) (20 visits PCY)	\$25 Copay	Deductible/Coinsurance	
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth) (MS: Unlimited; ME: Unlimited; Pro: Unlimited: Orth: \$300 PCY)	Deductible/Coinsurance	Deductible/Coinsurance	
Mental Health Inpatient Facility Care (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance	
Mental Health Outpatient Professional Care (Unlimited)	\$25 Copay	Deductible/Coinsurance	
Rehab Inpatient Facility (30 days PCY)	Deductible/Coinsurance	Deductible/Coinsurance	
Rehab Outpatient Care, Including Physical, Occupational, Speech Therapy (45 visits PCY)	\$25 Copay	Deductible/Coinsurance	
Massage Therapy (12 visits PCY)	\$25 Copay	Deductible/Coinsurance	
TMJ Disorders Inpatient (\$1,000 PCY/\$5,000 per Lifetime, Combined with Outpatient)	Deductible/Coinsurance	Deductible/Coinsurance	
TMJ Disorders Outpatient (\$1,000 PCY/\$5,000 per Lifetime, Combined with Inpatient)	See Office Visit Cost Share	Deductible/Coinsurance	
Transplants (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance	
SUPPLEMENTAL BENEFITS			
Routine Vision Exam (1 PCY)	\$25 Copay, then Coinsurance	Deductible/Coinsurance	
LIFETIME MAXIMUM	Unlimited		

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.

PHARMACY PLAN			
Pharmacy		Participating	Mail Order
Copays	Generic – Tier 1	\$5	\$15
	Brand Name – Tier 2	\$20	\$45
	Non-formulary – Tier 3	50%	50%
Maximum Day Supply		30 days	90 days

The above 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, please see your benefit booklet. To find out what tier applies to a specific medication, see our Preferred Drug List at www.premera.com.

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.