



WASHINGTON COUNTIES INSURANCE FUND
WASHINGTON COUNTIES INSURANCE POOL



BLUE CROSS

Washington Counties Insurance Fund

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

Effective date: 1/1/2012

MEDICAL PLAN		WCIF HDHP Plan	
MEDICAL COST SHARE OPTIONS		HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
Individual Deductible PCY - Applies to Prescriptions (Aggregate Family Deductible replaces Individual Deductible)		\$1,250 PCY/\$2,500 PCY	Shared with In-Network Deductible
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		20%	50%
Individual Out of Pocket Maximum PCY, Includes Deductible (Aggregate Family OOP replaces Individual OOP)		\$5,000 PCY/\$10,000 PCY	Shared with In-Network Out of Pocket Max
Office Visit Cost Share (General and Family Practitioner)		Deductible/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 Visit		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		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Professional Services		Deductible/Coinsurance	Deductible/Coinsurance
Contraceptive Management (Unlimited)		Deductible/Coinsurance	Deductible/Coinsurance
DIAGNOSTIC SERVICE OPTIONS			
Other Professional Diagnostic Imaging and Laboratory Services (Including diagnostic mammography)		Deductible/Coinsurance	Deductible/Coinsurance
FACILITY CARE OPTIONS			
Inpatient Facility		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Surgery Facility		Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (90 days PCY)		Deductible/Coinsurance	Deductible/Coinsurance
EMERGENCY CARE OPTIONS			
Emergency Care (Always subject to deductible and coinsurance)		Deductible/Coinsurance	Same as In-Network Benefit
Ambulance Transportation		Deductible/Coinsurance	Same as In-Network Benefit
Air Ambulance (Unlimited)		Deductible/Coinsurance	Same as In-Network Benefit



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OTHER SERVICES	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
Acupuncture (12 visits PCY)	Deductible/Coinsurance	Deductible/Coinsurance
Chemical Dependency Inpatient (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
Chemical Dependency Outpatient (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
Home Health Care (130 visits PCY)	Deductible/Coinsurance	Deductible/Coinsurance
Hospice (Inpatient: 14 days; 6 month Lifetime max)	Deductible/0% Coinsurance	Deductible/0% Coinsurance
Manipulations (spinal and other) (15 visits PCY)	Deductible/Coinsurance	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)	Deductible/Coinsurance	Deductible/Coinsurance
Rehab Inpatient Facility (30 days PCY)	Deductible/Coinsurance	Deductible/Coinsurance
Rehab Outpatient Care, Including Physical, Occupational, Speech Therapy; (45 visits PCY)	Deductible/Coinsurance	Deductible/Coinsurance
Massage Therapy (12 visits PCY)	Deductible/Coinsurance	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)	Deductible/Coinsurance	Deductible/Coinsurance
Transplants (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs (Up to 90-day supply per prescription)	Deductible/Coinsurance	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	Deductible/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.

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.