PREMERA | BLUE CROSS

Highlights of your Health Care Coverage

Washington Counties Insurance Fund

Effective Date: 01/01/2025

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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

MEDICAL PLAN	PLAN 500	
	IN-NETWORK	**OUT-OF-NETWORK**
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
Telemedicine with Traditional Providers - General Medical	$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$30 Copay, applies to the Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Imaging and Lab	Covered In Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Diagnostic Lab	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
Basic 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
Major 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
Preventive Mammography	Covered in Full	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
Supplemental Breast Exam	Covered in Full	Covered as any other service
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
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

MEDICAL PLAN	PLAN 500	
	IN-NETWORK	**OUT-OF-NETWORK**
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 & HOME HEALTH CARE		
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
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
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
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum	In Network Deductible, then 0% Coinsurance, applies to the Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$150 Copay, then In Network Deductible and 20% Coinsurance; applies to the Out of Pocket Maximum	$150 Copay, then In Network Deductible and 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

MEDICAL PLAN	PLAN 500	
	IN-NETWORK	**OUT-OF-NETWORK**
ALTERNATIVE CARE		
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
Manipulations (Spinal and other) (20 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
CHEMICAL DEPENDENCY & MENTAL HEALTH		
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
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
REHABILITATION & NEURO		
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; Massage Therapy - 12 additional visits PCY (separate from OP rehab limit))	$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
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
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

MEDICAL PLAN	PLAN 500	
	IN-NETWORK	**OUT-OF-NETWORK**
Transplants (Unlimited)	Covered as any other service	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
Bariatric Surgery ($25,000 Lifetime, subject to medical necessity)	Covered as any other service	Not Covered
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
Routine Hearing 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
Hearing Hardware ($3,000 per ear with hearing loss every 36 months)	Covered in Full (up to benefit maximum)	Covered in Full (up to benefit 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.

Highlights of your Health Care Coverage

Washington Counties Insurance Fund

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Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

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

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.

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator – Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

037378 (07-01-2021)