

Highlights of your Health Care Coverage

Washington Counties Insurance Fund

Effective Date: 01/01/2026

³ 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
CHRONIC CONDITION MANAGEMENT PROGRAMS		

MEDICAL PLAN		PLAN 500	
	IN-NETWORK	OUT-OF-NETWORK	
Diabetes Management Plus	Included	Not Applicable	
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	

MEDICAL PLAN		PLAN 500	
	IN-NETWORK	OUT-OF-NETWORK	
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	
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	
Ambulatory Surgery Center	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			
Birth Center	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	
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	

MEDICAL PLAN		PLAN 500	
	IN-NETWORK	OUT-OF-NETWORK	
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	
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			
Inpatient Rehab (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	
Outpatient Rehab, Including Physical and Occupational Therapy (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	
Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited)	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum	
Outpatient Massage Therapy (Applies to the outpatient rehab limit; 12 add'l massage therapy visits available PCY)	\$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum	

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Outpatient Speech Therapy (Applies to the outpatient 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	
Inpatient Neurodevelopmental Therapy	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 Neurodevelopmental Therapy (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	
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	
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 (1 device per ear every 36 months)	Covered in Full	Covered in Full	
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 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/\$105/\$210	
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; 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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