

WiseChoices plan benefits

For plans beginning January 1, 2009



HEALTH PLAN OF WASHINGTON

	WiseChoices 20	WiseChoices 30	Applies to all WiseChoices plans
	PREFERRED	PREFERRED	NON-PREFERRED
MEDICAL PLAN (PCY = Per Calendar Year)			
Annual Deductible PCY (choose one)	\$1,000 Indiv. or \$3,000 Family	\$1,500 Indiv. or \$4,500 Family	\$3,000 Indiv. or \$9,000 Family
Coinsurance (what you pay)	20%	30%	50%
Annual Coinsurance Maximum	\$8,500 Indiv. or Family = 3x Indiv.	\$8,500 Indiv. or Family = 3x Indiv.	Unlimited
Out-of-Pocket Maximum (deductible + coinsurance maximum)	\$9,500 Indiv. or Family = 3x Indiv.	\$10,000 Indiv. or Family = 3x Indiv.	Unlimited
COVERED SERVICES (Lifetime maximum \$2 million)			
Office Visits including Urgent Care & Naturopathy			
Preventive Care Exams <i>Routine medical exam, sports physical & women's health/well baby exams</i>	DEDUCTIBLE WAIVED \$30 Copay	DEDUCTIBLE WAIVED \$30 Copay	Deductible, then 50%
Preventive Screenings <i>PAP smear, PSA testing, colorectal cancer screening, cholesterol screening & bone density test</i>	Covered in Full	Covered in Full	
Immunizations			Not Covered
Pharmacy-Retail (30-day supply) <i>Brand: \$3,000 PCY limit; Generic: Unlimited</i>	\$10/\$45/50%	\$10/\$45/50%	Preferred network cost + 40%
Pharmacy-Mail Service (90-day supply) <i>Brand: \$3,000 PCY limit; Generic: Unlimited</i>	\$25/\$112.50/45%	\$25/\$112.50/45%	
Outpatient Diagnostic Imaging & Lab Services	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Mammography	DEDUCTIBLE WAIVED then 20%	DEDUCTIBLE WAIVED then 30%	
Emergency Room Care <i>Copay waived if direct admit to an inpatient facility</i>	\$100 copay, then subject to deductible, then 20%	\$100 copay, then subject to deductible, then 30%	\$100 copay, then subject to deductible, then coinsurance*
Ambulance Transportation <i>Air: unlimited; Ground: \$5,000 PCY limit</i>			Deductible, then coinsurance*
Outpatient & Inpatient Facility Care			
Rehabilitation (Outpatient: 20 visits PCY; Inpatient: 8 days PCY) <i>Physical, Occupational, Massage & Speech Therapy; Cardiac & Pulmonary Rehabilitation</i>	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Durable Medical Equipment and Prosthetics (\$5,000 PCY)			
Spinal and Other Manipulations (12 visits PCY)	DEDUCTIBLE WAIVED \$25 Copay	DEDUCTIBLE WAIVED \$25 Copay	Deductible, then 50%
Acupuncture (12 visits PCY)			
Home Health Care (130 visits PCY)			
Skilled Nursing Facility (45 days PCY) <i>Includes room and board, ancillaries & professional fees</i>	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Hospice Care (Inpatient: 10 days PCY; Respite: 240 hours PCY)			
Maternity Care	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Vision-Routine Exam (One exam per two calendar years)	Covered in Full	Covered in Full	Covered in Full
Vision Hardware (Per two calendar years)	\$200 for frames, lenses & contact lenses	\$200 for frames, lenses & contact lenses	\$200 for frames, lenses & contact lenses
Mental Health-Outpatient Office Visit (6 visits PCY)	DEDUCTIBLE WAIVED \$30 Copay	DEDUCTIBLE WAIVED \$30 Copay	Deductible, then 50%
Mental Health-Inpatient Facility Care (6 days PCY)	Deductible, then 20%	Deductible, then 30%	
Transplants (12-month waiting period; \$250,000 lifetime benefit) <i>Organ & Bone Marrow</i>	Deductible, then 20%	Deductible, then 30%	Not Covered

* Unlike services received at other non-preferred providers, this service is subject to the preferred provider deductible and coinsurance.

Deductible, coinsurance and copay represent what you pay. Benefits apply after calendar year deductible is met, unless otherwise noted as "Deductible Waived," "Copay" or "Covered in Full."

This is only a summary of the major benefits provided by our plans. This is not a contract.