

# WiseEssentials plan benefits

For plans beginning January 1, 2009



HEALTH PLAN OF WASHINGTON

MEDICAL PLAN (PCY = Per Calendar Year)	PREFERRED	NON-PREFERRED
<b>Annual Deductible</b> PCY (choose one)	\$1,750 / \$2,500 / \$3,500	\$3,500 / \$5,000 / \$7,000
<b>Coinsurance</b> (what you pay)	25%	50%
<b>Annual Coinsurance Maximum</b>	\$5,000	Unlimited
<b>Out-of-Pocket Maximum</b> (deductible + coinsurance maximum)	\$6,750 / \$7,500 / \$8,500	Unlimited
<b>COVERED SERVICES</b> (Lifetime maximum \$2 million)		
<b>Office Visits including Urgent Care &amp; Naturopathy</b>	<b>DEDUCTIBLE WAIVED</b> on first 6 visits then 25%; additional visits subject to deductible then 25%	Deductible, then 50%
<b>Preventive Care Exams</b> <i>Routine medical exam, sports physical &amp; women's health/well baby exams</i>		
<b>Preventive Screenings</b> <i>PAP smear, PSA testing, colorectal cancer screening, cholesterol screening &amp; bone density test</i>	Covered in Full	
<b>Immunizations</b>	Not Covered	Not Covered
<b>Pharmacy-Retail</b> (30-day supply) <i>Brand: \$3,000 PCY limit; Generic: Unlimited</i>	Not Covered (Pharmacy discount program* available)	Not Covered (Pharmacy discount program* available)
<b>Pharmacy-Mail Order</b> (90-day supply) <i>Brand: \$3,000 PCY limit; Generic: Unlimited</i>		
<b>Outpatient Diagnostic Imaging &amp; Lab Services</b>	<b>DEDUCTIBLE WAIVED</b> then 25% for \$1,750 deductible plan only Deductible, then 25% for all others	Deductible, then 50%
<b>Mammography</b>	<b>DEDUCTIBLE WAIVED</b> then 25%	
<b>Emergency Room Care</b> <i>Copay waived if direct admit to an inpatient facility</i>	\$100 copay, then subject to deductible, then 25%	\$100 copay, then subject to deductible, then 25%**
<b>Ambulance Transportation</b> <i>Air: unlimited; Ground: \$5,000 PCY limit</i>	Deductible, then 25%	Deductible, then 25%**
<b>Outpatient &amp; Inpatient Facility Care</b>		
<b>Rehabilitation</b> (Outpatient: 20 visits PCY; Inpatient: 8 days PCY) <i>Physical, Occupational, Massage &amp; Speech Therapy; Cardiac &amp; Pulmonary Rehabilitation</i>	Deductible, then 25%	Deductible, then 50%
<b>Durable Medical Equipment and Prosthetics</b> (\$5,000 PCY)	Not Covered	Not Covered
<b>Spinal and Other Manipulations</b> (12 visits PCY)	<b>DEDUCTIBLE WAIVED</b> \$25 Copay	Deductible, then 50%
<b>Acupuncture</b> (12 visits PCY)		
<b>Home Health Care</b> (130 visits PCY)		
<b>Skilled Nursing Facility</b> (45 days PCY) <i>Includes room and board, ancillaries &amp; professional fees</i>	Deductible, then 25%	Deductible, then 50%
<b>Hospice Care</b> (Inpatient: 10 days PCY; Respite: 240 hours PCY)		
<b>Maternity Care</b>	Not Covered	Not Covered
<b>Vision-Routine Exam</b> (One exam per two calendar years)	Not Covered	Not Covered
<b>Vision Hardware</b> (Per two calendar years)		
<b>Mental Health-Outpatient Office Visit</b> (6 visits PCY)	<b>DEDUCTIBLE WAIVED</b> then 25%	Deductible, then 50%
<b>Mental Health-Inpatient Facility Care</b> (6 days PCY)	Deductible, then 25%	
<b>Transplants</b> (12-month waiting period; \$250,000 lifetime benefit) <i>Organ &amp; Bone Marrow</i>	Deductible, then 25%	Not Covered

\* In order to validate current eligibility for this discount, the pharmacy will transmit your information to LifeWise Health Plan of Washington, including the details of the prescription to be filled. The information may also be used for other proper purposes.

\*\* 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.**

# WiseEssentials Copay plan benefits

## For plans beginning June 1, 2009

<b>MEDICAL PLAN</b> (PCY = Per Calendar Year)	<b>PREFERRED</b>	<b>NON-PREFERRED</b>
<b>Annual Deductible</b> PCY (choose one; no family deductible)	\$5,000 / \$7,500	\$10,000 / \$15,000
<b>Coinsurance</b> (what you pay)	25%	50%
<b>Annual Coinsurance Maximum</b>	\$5,000	Unlimited
<b>Out-of-Pocket Maximum</b> (deductible + coinsurance maximum)	\$10,000 / \$12,500	Unlimited
<b>COVERED SERVICES</b> (Lifetime maximum \$2 million)		
<b>Office Visits including Urgent Care &amp; Naturopathy</b>	<b>DEDUCTIBLE WAIVED</b> on first 3 visits at \$25 copay; additional visits subject to deductible, then 25%	Deductible, then 50%
<b>Preventive Care Exams</b> <i>Routine medical exam, sports physical &amp; women's health/well baby exams</i>		
<b>Preventive Screenings</b> <i>PAP smear, PSA testing, colorectal cancer screening, cholesterol screening &amp; bone density test</i>		
<b>Immunizations</b>	Not Covered	Not Covered
<b>Pharmacy—Retail</b>	Not Covered (Pharmacy discount program available)*	Not Covered (Pharmacy discount program available)*
<b>Pharmacy—Mail Order</b>		
<b>Outpatient Diagnostic Imaging &amp; Lab Services</b>	Deductible, then 25%	Deductible, then 50%
<b>Mammography</b>	<b>DEDUCTIBLE WAIVED</b> then 25%	
<b>Emergency Room Care</b> <i>Copay waived if direct admit to an inpatient facility</i>	\$100 copay, then subject to deductible, then 25%	\$100 copay, then subject to deductible, then 25%**
<b>Ambulance Transportation</b> <i>Air: unlimited; Ground: \$5,000 PCY limit</i>	Deductible, then 25%	Deductible, then 25%**
<b>Outpatient &amp; Inpatient Facility Care</b>	Deductible, then 25%	Deductible, then 50%
<b>Rehabilitation</b> (Outpatient: 20 visits PCY; Inpatient: 8 days PCY) <i>Physical, Occupational, Massage &amp; Speech Therapy; Cardiac &amp; Pulmonary Rehabilitation</i>		
<b>Durable Medical Equipment and Prosthetics</b>	Not Covered	Not Covered
<b>Spinal and Other Manipulations</b> (12 visits PCY)	<b>DEDUCTIBLE WAIVED</b> \$25 Copay	Deductible, then 50%
<b>Acupuncture</b> (12 visits PCY)		
<b>Home Health Care</b> (130 visits PCY)	Deductible, then 25%	Deductible, then 50%
<b>Skilled Nursing Facility</b> (45 days PCY) <i>Includes room and board, ancillaries &amp; professional fees</i>		
<b>Hospice Care</b> (Inpatient: 10 days PCY; Respite: 240 hours PCY)		
<b>Maternity Care</b>	Not Covered	Not Covered
<b>Vision—Routine Exam</b>	Not Covered	Not Covered
<b>Vision Hardware</b>		
<b>Mental Health—Outpatient Office Visit</b> (6 visits PCY)	<b>DEDUCTIBLE WAIVED</b> \$25 Copay	Deductible, then 50%
<b>Mental Health—Inpatient Facility Care</b> (6 days PCY)	Deductible, then 25%	
<b>Transplants</b> (12-month waiting period; \$250,000 lifetime benefit) <i>Organ &amp; Bone Marrow</i>	Deductible, then 25%	Not Covered

\* In order to validate current eligibility for this discount, the pharmacy will transmit your information to LifeWise Health Plan of Washington, including the details of the prescription to be filled. The information may also be used for other proper purposes.

\*\* 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.**  
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# WiseSimplicity plan benefits

For plans beginning June 1, 2009

MEDICAL PLAN (PCY = Per Calendar Year)	PREFERRED	NON-PREFERRED
<b>Annual Deductible</b> PCY (no family deductible)	\$10,000	\$20,000
<b>Coinsurance</b> (what you pay)	0%	50%
<b>Annual Coinsurance Maximum</b> (no family coinsurance maximum)	\$0	Unlimited
<b>Out-of-Pocket Maximum</b> (deductible + coinsurance maximum)	\$10,000	Unlimited
<b>COVERED SERVICES</b> (Lifetime maximum \$2 million)		
<b>Office Visits including Urgent Care &amp; Naturopathy</b>	Deductible, then 0%	Deductible, then 50%
<b>Preventive Care Exams</b> (1 exam PCY) <i>Routine medical exam, sports physical &amp; women's health/well baby exams</i>	<b>DEDUCTIBLE WAIVED</b> then 0%	
<b>Preventive Screenings</b> <i>PAP smear, PSA testing, colorectal cancer screening, cholesterol screening &amp; bone density test</i>	Deductible, then 0%	Deductible, then 50%
<b>Immunizations</b>	Deductible, then 0%	Not Covered
<b>Pharmacy–Retail</b>	Not Covered (Pharmacy discount program available*)	Not Covered (Pharmacy discount program available*)
<b>Pharmacy–Mail Order</b>		
<b>Outpatient Diagnostic Imaging &amp; Lab Services</b>	Deductible, then 0%	Deductible, then 50%
<b>Mammography</b>	<b>DEDUCTIBLE WAIVED</b> then 0%	
<b>Emergency Room Care</b> <i>Copay waived if direct admit to an inpatient facility</i>	\$100 copay, then subject to deductible, then 0%	\$100 copay, then subject to deductible, then 0%**
<b>Ambulance Transportation</b> <i>Air: unlimited; Ground: \$5,000 PCY limit</i>	Deductible, then 0%	Deductible, then 0%**
<b>Outpatient &amp; Inpatient Facility Care</b>		Deductible, then 50%
<b>Rehabilitation</b> (Outpatient: 20 visits PCY; Inpatient: 8 days PCY) <i>Physical, Occupational, Massage &amp; Speech Therapy; Cardiac &amp; Pulmonary Rehabilitation</i>		
<b>Durable Medical Equipment and Prosthetics</b>	Not Covered	Not Covered
<b>Spinal and Other Manipulations</b> (12 visits PCY)	Deductible, then 0%	Deductible, then 50%
<b>Acupuncture</b> (12 visits PCY)		
<b>Home Health Care</b> (130 visits PCY)	Deductible, then 0%	Deductible, then 50%
<b>Skilled Nursing Facility</b> (45 days PCY) <i>Includes room and board, ancillaries &amp; professional fees</i>		
<b>Hospice Care</b> (Inpatient: 10 days PCY; Respite: 240 hours PCY)		
<b>Maternity Care</b>	Not Covered	Not Covered
<b>Vision–Routine Exam</b>	Not Covered	Not Covered
<b>Vision Hardware</b>		
<b>Mental Health–Outpatient Office Visit</b> (6 visits PCY)	Deductible, then 0%	Deductible, then 50%
<b>Mental Health–Inpatient Facility Care</b> (6 days PCY)		
<b>Transplants</b> (12-month waiting period; \$250,000 lifetime benefit) <i>Organ &amp; Bone Marrow</i>	Deductible, then 0%	Not Covered

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