

# WiseChoices plan benefits

For plans beginning January 1, 2008



HEALTH PLAN OF WASHINGTON

	WiseChoices 0/20	WiseChoices 0/30	Applies to all WiseChoices plans
	PREFERRED	PREFERRED	NON-PREFERRED
<b>MEDICAL PLAN</b> (PCY = Per Calendar Year)			
<b>Annual Deductible</b> PCY (choose one)	\$0 Indiv. or \$0 Family	\$0 Indiv. or \$0 Family	\$3,000 Indiv. or \$9,000 Family
<b>Coinsurance</b> (what you pay)	20%	30%	50%
<b>Annual Coinsurance Maximum</b>	\$9,500 Indiv. or Family = 3x Indiv.	\$9,500 Indiv. or Family = 3x Indiv.	Unlimited
<b>Out-of-Pocket Maximum</b> (deductible + coinsurance maximum)	\$9,500 Indiv. or Family = 3x Indiv.	\$9,500 Indiv. or Family = 3x Indiv.	Unlimited
<b>COVERED SERVICES</b> (Lifetime maximum \$2 million)			
<b>Office Visits including Urgent Care &amp; Naturopathy</b>			
<b>Preventive Care Exams</b> <i>Routine medical exam, sports physical &amp; women's health/well baby exams</i>	DEDUCTIBLE WAIVED \$30 Copay	DEDUCTIBLE WAIVED \$30 Copay	Deductible, then 50%
<b>Preventive Screenings</b> <i>PAP smear, PSA testing, colorectal cancer screening, cholesterol screening &amp; bone density test</i>	Covered in Full	Covered in Full	Not Covered
<b>Immunizations</b>			Not Covered
<b>Pharmacy-Retail</b> (30-day supply) <i>Brand: \$3,000 PCY limit; Generic: Unlimited</i>	\$10/\$45/50%	\$10/\$45/50%	Preferred network cost + 40%
<b>Pharmacy-Mail Service</b> (90-day supply) <i>Brand: \$3,000 PCY limit; Generic: Unlimited</i>	\$25/\$112.50/45%	\$25/\$112.50/45%	Preferred network cost + 40%
<b>Outpatient Diagnostic Imaging &amp; Lab Services</b>	DEDUCTIBLE WAIVED then 20%	DEDUCTIBLE WAIVED then 30%	Deductible, then 50%
<b>Mammography</b>			Deductible, then 50%
<b>Emergency Room Care</b> <i>Copay waived if direct admit to an inpatient facility</i>	DEDUCTIBLE WAIVED \$100 copay, then 20%	DEDUCTIBLE WAIVED \$100 copay, then 30%	\$100 copay, then subject to deductible, then coinsurance**
<b>Ambulance Transportation</b> <i>Air: unlimited; Ground: \$5,000 PCY limit</i>			Deductible, then coinsurance**
<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 WAIVED then 20%	DEDUCTIBLE WAIVED then 30%	Deductible, then 50%
<b>Durable Medical Equipment and Prosthetics</b> (\$5,000 PCY)			Deductible, then 50%
<b>Spinal and Other Manipulations</b> (12 visits PCY)	DEDUCTIBLE WAIVED \$25 Copay	DEDUCTIBLE WAIVED \$25 Copay	Deductible, then 50%
<b>Acupuncture</b> (12 visits PCY)			Deductible, then 50%
<b>Home Health Care</b> (130 visits PCY)			Deductible, then 50%
<b>Skilled Nursing Facility</b> (45 days PCY) <i>Includes room and board, ancillaries &amp; professional fees</i>	DEDUCTIBLE WAIVED then 20%	DEDUCTIBLE WAIVED then 30%	Deductible, then 50%
<b>Hospice Care</b> (Inpatient: 10 days PCY; Respite: 240 hours PCY)			Deductible, then 50%
<b>Maternity Care</b>	DEDUCTIBLE WAIVED then 20%	DEDUCTIBLE WAIVED then 30%	Deductible, then 50%
<b>Vision-Routine Exam</b> (One exam per two calendar years)	Covered in Full	Covered in Full	Covered in Full
<b>Vision Hardware</b> (Per two calendar years)	\$200 for frames, lenses & contact lenses	\$200 for frames, lenses & contact lenses	\$200 for frames, lenses & contact lenses
<b>Mental Health-Outpatient Office Visit</b> (6 visits PCY)	DEDUCTIBLE WAIVED \$30 Copay	DEDUCTIBLE WAIVED \$30 Copay	Deductible, then 50%
<b>Mental Health-Inpatient Facility Care</b> (6 days PCY)	DEDUCTIBLE WAIVED then 20%	DEDUCTIBLE WAIVED then 30%	Deductible, then 50%
<b>Transplants</b> (12-month waiting period; \$250,000 lifetime benefit) <i>Organ &amp; Bone Marrow</i>	DEDUCTIBLE WAIVED then 20%	DEDUCTIBLE WAIVED then 30%	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™

AGE BAND	\$1,750 DEDUCTIBLE		\$2,500 DEDUCTIBLE		\$3,500 DEDUCTIBLE	
	NON-SMOKER	SMOKER	NON-SMOKER	SMOKER	NON-SMOKER	SMOKER
<25	\$ 87	\$ 100	\$ 74	\$ 86	\$ 66	\$ 77
25-29	98	113	82	96	75	87
30-34	113	131	96	111	86	100
35-39	135	157	114	132	103	120
40-44	159	185	135	157	121	142
45-49	200	232	169	196	152	176
50-54	244	284	207	240	186	217
55-59	284	331	240	279	217	252
60-64	325	375	274	320	247	288
65>	325	375	274	320	247	288
Per Child <sup>†</sup>	\$ 72		\$ 61		\$ 55	

### Notes:

- For children covered on their own policy, please use the "25 & under" rate.
- To qualify for non-smoker rate, an individual must not have used any tobacco product during the past 12 months.
- Eligible family members include you, your spouse, and unmarried children under age 23 who are partially or totally dependent on you for support.

## WiseChoices™ 0/20 and 0/30

AGE BAND	0/20 \$0 DEDUCTIBLE		0/30 \$0 DEDUCTIBLE	
	NON-SMOKER	SMOKER	NON-SMOKER	SMOKER
<25	\$ 196	\$ 229	\$ 179	\$ 208
25-29	222	257	201	234
30-34	256	298	233	271
35-39	305	355	278	323
40-44	363	421	330	382
45-49	452	526	410	478
50-54	554	644	503	586
55-59	646	751	587	682
60-64	735	858	670	779
65>	735	858	670	779
Per Child <sup>†</sup>	\$ 164		\$ 148	

## WiseChoices™ 20 and 30

AGE BAND	20 \$1,000 DEDUCTIBLE		30 \$1,500 DEDUCTIBLE	
	NON-SMOKER	SMOKER	NON-SMOKER	SMOKER
<25	\$ 170	\$ 197	\$ 143	\$ 168
25-29	191	222	162	189
30-34	222	257	187	218
35-39	263	306	224	260
40-44	312	364	265	309
45-49	391	453	331	385
50-54	478	556	405	472
55-59	557	648	473	550
60-64	637	738	536	627
65>	637	738	536	627
Per Child <sup>†</sup>	\$ 141		\$ 120	

## WiseSavings™ Individual HSA

AGE BAND	\$1,750 DEDUCTIBLE		\$3,000 DEDUCTIBLE	
	NON-SMOKER	SMOKER	NON-SMOKER	SMOKER
<25	\$ 100	\$ 118	\$ 78	\$ 92
25-29	114	132	88	103
30-34	131	153	103	120
35-39	157	183	123	142
40-44	185	216	146	169
45-49	232	270	181	211
50-54	284	330	222	258
55-59	331	385	260	301
60-64	375	440	292	344
65>	375	440	292	344
Per Child <sup>†</sup>	Not Applicable		Not Applicable	

## WiseSavings™ Family HSA

AGE BAND	\$3,500 DEDUCTIBLE		\$6,000 DEDUCTIBLE	
	NON-SMOKER	SMOKER	NON-SMOKER	SMOKER
<25	\$ 75	\$ 87	\$ 60	\$ 70
25-29	85	98	67	78
30-34	97	113	78	91
35-39	116	135	93	109
40-44	137	159	110	129
45-49	172	200	138	160
50-54	211	244	169	197
55-59	245	284	197	229
60-64	279	326	224	261
65>	279	326	224	261
Per Child <sup>†</sup>	\$ 62		\$ 50	

<sup>†</sup> Applies to dependent children applying on the same plan as a parent or legal guardian.