

WiseEssentials plan benefits

For plans beginning January 1, 2008



HEALTH PLAN OF WASHINGTON

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

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 [†]	\$ 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 [†]	\$ 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 [†]	\$ 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 [†]	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 [†]	\$ 62		\$ 50	

[†] Applies to dependent children applying on the same plan as a parent or legal guardian.