

WiseSavings plan benefits

For plans beginning January 1, 2008



HEALTH PLAN OF WASHINGTON

MEDICAL PLAN (PCY = Per Calendar Year)	PREFERRED	NON-PREFERRED	PREFERRED	NON-PREFERRED
Annual Deductible PCY (Choose one)	\$1,750 / \$3,000 Per Individual		\$3,500 / \$6,000 Family**	
Coinsurance (what you pay)	20%	40%	20%	40%
Annual Coinsurance Maximum	\$2,500 / \$1,750	Unlimited	\$5,000 / \$3,500	Unlimited
Out-of-Pocket Maximum (deductible + coinsurance maximum)	\$4,250 / \$4,750	Unlimited	\$8,500 / \$9,500	Unlimited
COVERED SERVICES (Lifetime maximum \$2 million)				
Office Visits including Urgent Care & Naturopathy	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Preventive Care Exams (\$300 PCY) <i>Routine medical exam, sports physical & women's health/ well baby exams</i>	Covered in Full	Not Covered	Covered in Full	Not Covered
Preventive Screenings <i>PAP smear, PSA testing, colorectal cancer screening, cholesterol screening & bone density test</i>	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Immunizations	Covered in Full	Not Covered	Covered in Full	Not Covered
Pharmacy-Retail (30-day supply)	Not Covered Pharmacy discount program* available		Not Covered Pharmacy discount program* available	
Pharmacy-Mail Service (90-day supply)	Not Covered Pharmacy discount program* available		Not Covered Pharmacy discount program* available	
Outpatient Diagnostic Imaging & Lab Services	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Mammography	DEDUCTIBLE WAIVED then 20%	Deductible, then 40%	DEDUCTIBLE WAIVED then 20%	Deductible, then 40%
Emergency Room Care	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%
Ambulance Transportation <i>Air: unlimited; Ground: \$5,000 PCY limit</i>	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%
Outpatient & Inpatient Facility Care	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Rehabilitation (Outpatient: 15 visits PCY; Inpatient: 10 days PCY) <i>Physical, Occupational, Massage and Speech Therapy; Cardiac & Pulmonary Rehabilitation</i>	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Durable Medical Equipment & Prosthetics (\$5,000 PCY)	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Spinal & Other Manipulations (12 visits PCY)	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Acupuncture (12 visits PCY)	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Home Health Care (120 visits PCY)	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Skilled Nursing Facility (20 days PCY) <i>Includes room & board, ancillaries & professional fees</i>	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Hospice Care (Inpatient: 10 days PCY; Respite: 240 hours PCY)	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
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)	Not Covered		Not Covered	
Mental Health-Outpatient Office Visit (6 visits PCY)	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Mental Health-Inpatient Facility Care (6 days PCY)	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Transplants (12-month waiting period; \$250,000 lifetime benefit) <i>Organ & Bone Marrow</i>	Deductible, then 20%	Not Covered	Deductible, then 20%	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.

** Family = Individual + one or more family members. Services for all family members covered under the same HSA-qualified plan are applied to the family deductible. The family deductible must be met before services are covered for any enrolled family members.

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.