

WiseChoices Prime plan benefits

For plans beginning July 1, 2010



HEALTH PLAN OF WASHINGTON

MEDICAL PLAN (PCY = Per Calendar Year)	PREFERRED	NON-PREFERRED
Annual Deductible <i>PCY (choose one)</i>	Individual: \$1,500 / \$3,000 Family: \$4,500 / \$9,000	Individual: \$3,000 / \$6,000 Family: \$9,000 / \$18,000
Coinsurance <i>(what you pay)</i>	30%	50%
Annual Coinsurance Maximum	\$6,500 Indiv. or Family = 3x Indiv.	Unlimited
COVERED SERVICES <i>(Lifetime maximum \$2 million)</i>		
Office Visits including Urgent Care & Naturopathy	DEDUCTIBLE WAIVED \$30 Copay	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
Pharmacy <i>(Generics: Unlimited; Brand: \$3,000 PCY limit)</i>	Retail: \$10 / 30% / 50% / 30%	Not Covered
<i>Retail (30 day supply)</i> <i>Mail Order (90 day supply)</i>	Mail Order: \$25 / 25% / 45% / 30%	
Outpatient Diagnostic Imaging & Lab Services	Deductible, then 30%	Deductible, then 50%
Mammography	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 30%	\$100 copay, then subject to deductible, then 30%**
Ambulance Transportation <i>Air: unlimited; Ground: \$5,000 PCY limit</i>		Deductible, then 30%**
Outpatient & Inpatient Facility Care	Deductible, then 30%	Deductible, then 50%
Rehabilitation <i>(Outpatient: 20 visits PCY; Inpatient: 8 days PCY)</i> <i>Physical, Occupational, Massage & Speech Therapy; Cardiac & Pulmonary Rehabilitation</i>		
Durable Medical Equipment and Prosthetics <i>(\$5,000 PCY)</i>		
Spinal and Other Manipulations <i>(12 visits PCY)</i>	DEDUCTIBLE WAIVED \$25 Copay	Deductible, then 50%
Acupuncture <i>(12 visits PCY)</i>		
Home Health Care <i>(130 visits PCY)</i>	Deductible, then 30%	Deductible, then 50%
Skilled Nursing Facility <i>(45 days PCY)</i> <i>Includes room and board, ancillaries & professional fees</i>		
Hospice Care <i>(Inpatient: 10 days PCY; Respite: 240 hours PCY)</i>		
Maternity Care	Deductible, then 30%	Deductible, then 50%
Vision—Routine Exam <i>(One exam per two calendar years)</i>	Covered in Full	Covered in Full
Vision Hardware <i>(Per two calendar years)</i>	\$200 for frames, lenses & contact lenses	\$200 for frames, lenses & contact lenses
Mental Health—Outpatient Office Visit	DEDUCTIBLE WAIVED \$30 Copay	Deductible, then 50%
Mental Health—Inpatient Facility Care	Deductible, then 30%	
Transplants <i>(12-month waiting period; \$350,000 lifetime benefit)</i> <i>Organ & Bone Marrow</i>	Deductible, then 30%	Not Covered

* Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

** 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.