

# WiseChoices Prime plan benefits

For plans beginning January 1, 2011



HEALTH PLAN OF WASHINGTON

These plans are “non-grandfathered” under federal healthcare reform legislation.

(PCY = Per Calendar Year)

MEDICAL PLAN	PREFERRED	NON-PREFERRED
<b>Annual Deductible</b> PCY (Choose one)	Individual: \$1,500 Family: \$4,500	Individual: \$3,000 Family: \$9,000
<b>Coinsurance</b> (what you pay)	30%	50%
<b>Annual Coinsurance Maximum</b>	Individual: \$6,500 Family: 3x Individual	Unlimited
<b>COVERED SERVICES</b> Calendar year maximum: \$2 million		
<b>Office Visits including Urgent Care &amp; Naturopathy</b>	<b>DEDUCTIBLE WAIVED</b> \$30 Copay	
<b>Preventive Care Exams</b> <sup>1</sup> Routine medical exam, sports physical & women's health/well baby exams	Covered in Full <sup>2</sup>	Deductible, then 50%
<b>Preventive Screenings</b> PAP smear, PSA testing, mammography, colonoscopies, cancer screening, cholesterol screening		
<b>Immunizations</b>		Not Covered
<b>Pharmacy–Retail</b> (30-day supply)	Select drug list <sup>3</sup> Retail: \$10 / 30% / 50% / 30% Mail Order: \$25 / 25% / 45% / 30% Brand: \$3,000 PCY limit; Generic: unlimited	Not Covered
<b>Pharmacy–Mail Order</b> (90-day supply)		
<b>Outpatient Diagnostic Imaging &amp; Lab Services</b>	Deductible, then 30%	Deductible, then 50%
<b>Emergency Room Care</b> (copay waived if directly admitted to an inpatient facility)	\$100 copay, then subject to deductible, then 30%	\$100 copay, then subject to deductible, then 30% <sup>4</sup>
<b>Ambulance Transportation</b> (Air: unlimited; Ground: \$5,000 PCY limit)		Deductible, then 30% <sup>4</sup>
<b>Outpatient &amp; Inpatient Facility Care</b>		
<b>Rehabilitation</b> (Outpatient: 20 visits PCY; Inpatient: 8 days PCY) Physical, Occupational, Massage and Speech Therapy; Cardiac & Pulmonary Rehabilitation	Deductible, then 30%	Deductible, then 50%
<b>Durable Medical Equipment &amp; Prosthetics</b>		
<b>Spinal &amp; 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) Includes room & board, ancillaries & professional fees	Deductible, then 30%	Deductible, then 50%
<b>Hospice Care</b> (Inpatient: 10 days PCY; Respite: 240 hours PCY)		
<b>Maternity Care</b>	Deductible, then 30%	Deductible, then 50%
<b>Vision–Routine Exam</b> (One exam per two year calendar years)	Covered in Full	Covered in Full
<b>Vision Hardware</b> (per two calendar years)	\$200 for frames, lenses and contact lenses	\$200 for frames, lenses and contact lenses
<b>Mental Health–Outpatient Office Visit</b>	<b>DEDUCTIBLE WAIVED</b> \$30 Copay	Deductible, then 50%
<b>Mental Health–Inpatient Facility Care</b>	Deductible, then 30%	
<b>Transplants</b> (12-month waiting period; Organ & Bone Marrow)	Deductible, then 30%	Not Covered

<sup>1</sup> A full list of preventive screenings, tests and other preventive services, is available on [lifewisewa.com](http://lifewisewa.com). You can receive these preventive services covered in full if you use preferred providers and are within the frequency, age, risk and gender guidelines outlined in the list.

<sup>2</sup> Benefits provided at 100% of allowable charges; not subject to deductible, copay or coinsurance.

<sup>3</sup> See the Select Drug List Benefit Booklet on [lifewisewa.com](http://lifewisewa.com) for information.

<sup>4</sup> 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.**