

# WiseSimplicity 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	\$10,000	\$20,000
<b>Coinsurance</b> (what you pay)	0%	50%
<b>Annual Coinsurance Maximum</b> (no family coinsurance maximum)	\$0	Unlimited
<b>COVERED SERVICES</b> Calendar year maximum: \$2 million		
<b>Office Visits including Urgent Care &amp; Naturopathy</b>	Deductible, then Covered in Full	
<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> (one exam PCY)	Deductible, then 50%
<b>Preventive Screenings</b> PAP smear, PSA testing, mammography, colonoscopies, cancer screening, cholesterol screening	Covered in Full <sup>2</sup>	
<b>Immunizations</b>		Not Covered
<b>Pharmacy–Retail</b>	Not Covered (pharmacy discount program available) <sup>3</sup>	Not Covered
<b>Pharmacy–Mail Order</b>		
<b>Outpatient Diagnostic Imaging &amp; Lab Services</b>	Deductible, then Covered in Full	Deductible, then 50%
<b>Emergency Room Care</b> (copay waived if directly admitted to an inpatient facility)	\$100 copay, then subject to deductible, then Covered in Full	\$100 copay, then subject to deductible, then Covered in Full <sup>4</sup>
<b>Ambulance Transportation</b> (Air: unlimited; Ground: \$5,000 PCY limit)	Deductible, then Covered in Full	Deductible, then Covered in Full <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 Covered in Full	Deductible, then 50%
<b>Durable Medical Equipment &amp; Prosthetics</b>	Not Covered	Not Covered
<b>Spinal &amp; Other Manipulations</b> (12 visits PCY)	Deductible, then Covered in Full	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 Covered in Full	Deductible, then 50%
<b>Hospice Care</b> (Inpatient: 10 days PCY; Respite: 240 hours PCY)		
<b>Maternity Care</b>	Not Covered	Not Covered
<b>Vision–Routine Exam</b>		
<b>Vision Hardware</b>	Not Covered	Not Covered
<b>Mental Health–Outpatient Office Visit</b>		
<b>Mental Health–Inpatient Facility Care</b>	Deductible, then Covered in Full	Deductible, then 50%
<b>Transplants</b> (12-month waiting period; Organ & Bone Marrow)	Deductible, then 25%	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> In order to validate current eligibility for this discount, the pharmacy will transmit your information to LifeWise, including the details of the prescription to be filled. The information may also be used for other proper purposes.

<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.**