

WiseEssentials Rx plan benefits

For plans beginning January 1, 2010



HEALTH PLAN OF WASHINGTON

| MEDICAL PLAN (PCY = Per Calendar Year) | PREFERRED | NON-PREFERRED |
|---|---|--|
| Annual Deductible PCY (choose one) | \$1,850 / \$2,500 / \$3,500 | \$3,700 / \$5,000 / \$7,000 |
| Coinsurance (what you pay) | 25% | 50% |
| Annual Coinsurance Maximum | \$5,000 | Unlimited |
| COVERED SERVICES (Lifetime maximum \$2 million) | | |
| Office Visits including Urgent Care & Naturopathy | DEDUCTIBLE WAIVED on first 6 visits PCY, you pay 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> | | |
| Immunizations | Covered in Full* | Not Covered |
| Pharmacy (\$3,000 PCY limit) <i>Retail (30 day supply) Mail Order (90 day supply)</i> | Generics only Retail: \$15 Mail Order: \$40 | Not Covered |
| Outpatient Diagnostic Imaging & Lab Services | DEDUCTIBLE WAIVED then 25% for \$1,850 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 | | |
| Rehabilitation (Outpatient: 20 visits PCY; Inpatient: 8 days PCY) <i>Physical, Occupational, Massage & Speech Therapy; Cardiac & Pulmonary Rehabilitation</i> | Deductible, then 25% | Deductible, then 50% |
| Durable Medical Equipment and Prosthetics | 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) | | |
| Skilled Nursing Facility (45 days PCY) <i>Includes room and board, ancillaries & professional fees</i> | Deductible, then 25% | Deductible, then 50% |
| Hospice Care (Inpatient: 10 days PCY; Respite: 240 hours PCY) | | |
| Maternity Care | Not Covered | Not Covered |
| Vision—Routine Exam | | |
| Vision Hardware | Not Covered | Not Covered |
| 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; \$350,000 lifetime benefit) <i>Organ & Bone Marrow</i> | Deductible, then 25% | 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.