

# WiseChoices Prime plan benefits

For plans beginning January 1, 2010



HEALTH PLAN OF WASHINGTON

MEDICAL PLAN (PCY = Per Calendar Year)	PREFERRED	NON-PREFERRED
<b>Annual Deductible</b> PCY (choose one)	Individual: \$1,500 / \$3,000 Family: \$4,500 / \$9,000	Individual: \$3,000 / \$6,000 Family: \$9,000 / \$18,000
<b>Coinsurance</b> (what you pay)	30%	50%
<b>Annual Coinsurance Maximum</b>	\$6,500 Indiv. or Family = 3x Indiv.	Unlimited
<b>COVERED SERVICES</b> (Lifetime maximum \$2 million)		
<b>Office Visits including Urgent Care &amp; Naturopathy</b>	<b>DEDUCTIBLE WAIVED</b> \$30 Copay	Deductible, then 50%
<b>Preventive Care Exams</b> <i>Routine medical exam, sports physical &amp; women's health/well baby exams</i>		
<b>Preventive Screenings</b> <i>PAP smear, PSA testing, colorectal cancer screening, cholesterol screening &amp; bone density test</i>		
<b>Immunizations</b>	Covered in Full*	Not Covered
<b>Pharmacy</b> (Generics: Unlimited; Brand: \$3,000 PCY limit) <i>Retail (30 day supply)</i> <i>Mail Order (90 day supply)</i>	Retail: \$10 / 30% / 50% / 30% Mail Order: \$25 / 25% / 45% / 30%	Not Covered
<b>Outpatient Diagnostic Imaging &amp; Lab Services</b>	Deductible, then 30%	Deductible, then 50%
<b>Mammography</b>	<b>DEDUCTIBLE WAIVED</b> then 30%	Deductible, then 50%
<b>Emergency Room Care</b> <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%**
<b>Ambulance Transportation</b> <i>Air: unlimited; Ground: \$5,000 PCY limit</i>		Deductible, then 30%**
<b>Outpatient &amp; Inpatient Facility Care</b>		
<b>Rehabilitation</b> (Outpatient: 20 visits PCY; Inpatient: 8 days PCY) <i>Physical, Occupational, Massage &amp; Speech Therapy; Cardiac &amp; Pulmonary Rehabilitation</i>	Deductible, then 30%	Deductible, then 50%
<b>Durable Medical Equipment and Prosthetics</b> (\$5,000 PCY)		
<b>Spinal and 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) <i>Includes room and board, ancillaries &amp; professional fees</i>	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 calendar years)	Covered in Full	Covered in Full
<b>Vision Hardware</b> (Per two calendar years)	\$200 for frames, lenses & contact lenses	\$200 for frames, lenses & contact lenses
<b>Mental Health—Outpatient Office Visit</b> (6 visits PCY)	<b>DEDUCTIBLE WAIVED</b> \$30 Copay	Deductible, then 50%
<b>Mental Health—Inpatient Facility Care</b> (6 days PCY)	Deductible, then 30%	
<b>Transplants</b> (12-month waiting period; \$350,000 lifetime benefit) <i>Organ &amp; 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.**