WiseSavings plan benefits

For plans beginning January 1, 2010

MEDICAL PLAN *(PCY = Per Calendar Year)*	**PREFERRED**	**NON-PREFERRED**	**PREFERRED**	**NON-PREFERRED**
Annual Deductible *PCY (Choose one)*	$1,820 / $3,000 Per Individual		$3,640 / $6,000 Family*	
Coinsurance *(what you pay)*	20%	40%	20%	40%
Annual Coinsurance Maximum	$2,500 / $1,750	Unlimited	$5,000 / $3,500	Unlimited
COVERED SERVICES *(Lifetime maximum $2 million)*				
Office Visits including Urgent Care & Naturopathy	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Preventive Care Exams *($300 PCY limit)* *Routine medical exam, sports physical & women's health/ well baby exams*	Covered in Full**	Not Covered	Covered in Full**	Not Covered
Preventive Screenings *PAP smear, PSA testing, colorectal cancer screening, cholesterol screening & bone density test*	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Immunizations	Covered in Full**	Not Covered	Covered in Full**	Not Covered
Pharmacy–Retail	Not Covered Pharmacy discount program*** available		Not Covered Pharmacy discount program*** available	
Pharmacy–Mail Order				
Outpatient Diagnostic Imaging & Lab Services	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Mammography	**DEDUCTIBLE WAIVED** then 20%		**DEDUCTIBLE WAIVED** then 20%	
Emergency Room Care	Deductible, then 20%	Deductible, then 20%****	Deductible, then 20%	Deductible, then 20%****
Ambulance Transportation *Air: unlimited; Ground: $5,000 PCY limit*				
Outpatient & Inpatient Facility Care	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Rehabilitation *(Outpatient: 15 visits PCY; Inpatient: 10 days PCY)* *Physical, Occupational, Massage and Speech Therapy; Cardiac & Pulmonary Rehabilitation*				
Durable Medical Equipment & Prosthetics *($5,000 PCY)*				
Spinal & Other Manipulations *(12 visits PCY)*	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Acupuncture *(12 visits PCY)*				
Home Health Care *(120 visits PCY)*	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Skilled Nursing Facility *(20 days PCY)* *Includes room & board, ancillaries & professional fees*				
Hospice Care *(Inpatient: 10 days PCY; Respite: 240 hours PCY)*				
Maternity Care	Not Covered		Not Covered	
Vision–Routine Exam	Not Covered		Not Covered	
Vision Hardware				
Mental Health–Outpatient Office Visit *(6 visits PCY)*	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%	Deductible, then 40%
Mental Health–Inpatient Facility Care *(6 days PCY)*				
Transplants *(12-month waiting period; $350,000 lifetime benefit)* *Organ & Bone Marrow*	Deductible, then 20%	Not Covered	Deductible, then 20%	Not Covered

* Family = Individual + one or more family members. Services for all family members covered under the same HSA-qualified plan are applied to the family deductible. The family deductible must be met before services are covered for any enrolled family members.

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

*** In order to validate current eligibility for this discount, the pharmacy will transmit your information to LifeWise Health Plan of Washington, including the details of the prescription to be filled. The information may also be used for other proper purposes.

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**** 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.