

WiseEssentials Rx – PPO Network

\$1,880, \$2,500 or \$3,500 Deductible Options



You must see a preferred provider with LifeWise Health Plan to receive the 75% benefit level.
Please refer to the contract for details on how out of network claims are covered.

Before the deductible is met:

These benefits are not subject to the deductible when you use a preferred provider:

- 1. First six office visits per calendar year** - You pay 25% co-insurance.
Includes office visits, urgent care and naturopathy visits.
Deductible, then 25% co-insurance applies for additional visits.
- 2. Preventive Care - covered at 100%** (no annual benefit maximum)
Includes the following when billed as preventive: Routine physical exam, well child care, adult and child immunizations, routine laboratory, radiology and diagnostic procedures including mammography, pap smear, PSA and colonoscopy. (See contract for complete list of preventive care benefits)
- 3. Outpatient Diagnostic X-ray and Lab Services** - Deductible is waived on \$1,880 plan only
You pay 25% co-insurance. Includes major services such as MRI & CAT Scan @ outpatient center.
- 4. Alternative Care** - \$25 co-pay for spinal manipulations and acupuncture
(12 visit limit per calendar year for each)
- 5. Mental Health outpatient visits**- You pay 25% co-insurance
(Deductible waived for first 6 visits, additional are subject to deductible and co-insurance)
- 6. Prescription Drugs – Generic - \$15 co-pay** (\$40 for 90 day mail order)
No coverage for brand name drugs – Pharmacy discount program included

After the deductible has been met, all other covered benefits are provided.

- **\$100 Emergency room co-pay** (waived if admitted) plus 25% co-insurance
- **25% co-insurance for hospital and physician services** (preferred provider network)
- **\$5,000 annual co-insurance maximum** (preferred providers) plus deductible and co-pays
(After you have met your deductible, you pay 25% of the next \$20,000, then LifeWise covers 100% of allowable charges).
- **Inpatient rehabilitation** 8 days PCY
- **Outpatient rehab**- 20 visits PCY
- **Inpatient mental health** 6 days PCY
- **Includes 24 hour “on the job” coverage** (if not covered by L&I)
- **Uses same Preferred Provider network as Premera Blue Cross**
- **No fourth quarter deductible carry-over**

Partial list of Exclusions:

Brand name prescription drugs, maternity, acute nursing, durable medical equip, allergy testing/injections, diabetic supplies, chemical dependency, TMJ.

AGE	\$1880 DEDUCTIBLE		\$2500 DEDUCTIBLE		\$3500 DEDUCTIBLE	
	NS	SMOKER	NS	SMOKER	NS	SMOKER
<25	\$137	\$161	\$118	\$138	\$105	\$125
25-29	\$156	\$180	\$133	\$155	\$120	\$140
30-34	\$179	\$208	\$153	\$177	\$138	\$160
35-39	\$214	\$250	\$184	\$214	\$165	\$192
40-44	\$251	\$295	\$215	\$252	\$193	\$227
45-49	\$316	\$365	\$271	\$314	\$244	\$282
50-54	\$387	\$450	\$332	\$387	\$298	\$348
55-59	\$450	\$522	\$387	\$448	\$348	\$402
60-64	\$513	\$600	\$440	\$514	\$393	\$461
65>	\$513	\$600	\$440	\$514	\$393	\$461
Per child	\$116		\$98		\$89	

Please note: This plan is considered a catastrophic plan. If you change to a comprehensive plan at a later date, you will need to satisfy a new nine month waiting period for preexisting conditions you have been diagnosed, treated or medicated for in the past six months.

*This flyer was prepared by the Health Insurance Connection, Inc. This is a brief summary of benefits and is not a certificate of coverage. For full coverage provisions, including a description of waiting periods and limitations, refer to a benefit brochure and contract. This summary is not a contract. Rates are scheduled to increase January 1, 2013. However, due to health care reform mandated coverage there could be a slight increase before that date.

WiseEssentials Rx plan benefits

For plans beginning January 1, 2012



HEALTH PLAN OF WASHINGTON

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

(PCY = Per Calendar Year)

MEDICAL PLAN	PREFERRED	NON-PREFERRED
Annual Deductible PCY (Choose one)	\$1,880 / \$2,500 / \$3,500	\$3,760 / \$5,000 / \$7,000
Coinsurance (what you pay)	25%	50%
Annual Coinsurance Maximum	\$5,000	Unlimited
COVERED SERVICES Calendar year 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 ¹ Routine medical exam, sports physical & women's health/well baby exams	Covered in Full ²	
Preventive Screenings PAP smear, PSA testing, mammography, colonoscopies, cancer screening, cholesterol screening		
Immunizations		Not Covered
Pharmacy–Retail (30-day supply)	Generics only Retail: \$15	Not Covered
Pharmacy–Mail Order (90-day supply)	Mail Order: \$40	
Outpatient Diagnostic Imaging & Lab Services	DEDUCTIBLE WAIVED then 25% for \$1,880 deductible plan only Deductible, then 25% for all others	Deductible, then 50%
Emergency Room Care (copay waived if directly admitted to an inpatient facility)	\$100 copay, then subject to deductible, then 25%	\$100 copay, then subject to deductible, then 25% ³
Ambulance Transportation (Air: unlimited; Ground: \$5,000 PCY limit)	Deductible, then 25%	Deductible, then 25% ³
Outpatient & Inpatient Facility Care	Deductible, then 25%	Deductible, then 50%
Rehabilitation (Outpatient: 20 visits PCY; Inpatient: 8 days PCY) Physical, Occupational, Massage and Speech Therapy; Cardiac & Pulmonary Rehabilitation		
Durable Medical Equipment & Prosthetics	Not Covered	Not Covered
Spinal & Other Manipulations (12 visits PCY)	DEDUCTIBLE WAIVED \$25 Copay	Deductible, then 50%
Acupuncture (12 visits PCY)		
Home Health Care (130 visits PCY)	Deductible, then 25%	Deductible, then 50%
Skilled Nursing Facility (45 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	DEDUCTIBLE WAIVED on first 6 visits PCY, you pay 25%; additional visits subject to deductible, then 25%	Deductible, then 50%
Mental Health–Inpatient Facility Care	Deductible, then 25%	
Transplants (12-month waiting period; Organ & Bone Marrow)	Deductible, then 25%	Not Covered

¹ A full list of preventive screenings, tests and other preventive services, is available on 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.

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

³ 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.

Predictable and reliable coverage— now in a dental plan.

Adding a LifeWise Individual Dental Copay Plan to your health plan means you'll have complete, high-quality coverage. Since research indicates that good oral health is key to your overall well-being, there's really no reason not to enroll. Especially when you consider our new dental plans offer predictable costs on over 200 dental procedures. With a strong and growing provider network, you're sure to find a preferred dentist conveniently located near you.

Our dental plans feature:

Choice of deductible

Choose either a \$50 or \$75 annual deductible plan.

Predictability of costs

You'll pay a set copay for each of the over 200 covered services.

Easy plan administration

One application, one bill, one ID card, one customer service line and one resource rich website.

Wide range of coverage

You'll be covered for the most commonly used preventive, diagnostic, basic and major dental services.

Choice of providers

A strong and growing provider network.

On-going support

You'll receive online access to a wealth of dental health information at lifewisewa.com/dental.

Visit lifewisewa.com to see if you have a preferred

INDIVIDUAL DENTAL COPAY	
AGE BAND	Deductible: \$50 / \$75
0-2	\$3.00 / \$2.50
3-18	\$26.00 / \$22.00
19-25	\$32.90 / \$27.80
26-34	\$35.30 / \$29.80
35-44	\$37.40 / \$31.50
45-49	\$42.80 / \$36.10
50-54	\$47.60 / \$40.20
55-59	\$51.30 / \$43.30
60-64	\$57.60 / \$48.60
65+	\$64.00 / \$53.90

dentist nearby using our "Find a Doctor" tool. Choose "Dental - Individual Copay Plans" from the Network drop-down list.

A complete list of covered services and copays is available at lifewisewa.com/dental.

Here are a few examples of common services our plan covers when you choose a preferred provider:

PCY = Per Calendar Year

Effective November 1, 2011

Annual Deductible PCY	Individual: \$50 / \$75 Family: \$150 / \$225		
Benefit Maximum per person, PCY	\$1,000		
COMMONLY USED COVERED SERVICES	PREFERRED	NON-PREFERRED	
DIAGNOSTIC AND PREVENTIVE (no deductible applies)	\$50 or \$75 deductible plan	\$50 deductible plan	\$75 deductible plan
Oral Exams limited to 2 PCY	\$0		
Bitewing X-rays	\$0		
Cleanings limited to 2 PCY	\$20	20%	30%
Fluoride Treatments limited to 2 applications PCY for members under the age of 20	\$0		
Sealants limited to permanent teeth; for members under age 19	\$0		
BASIC (deductible applies first)	\$50 or \$75 deductible plan	\$50 deductible plan	\$75 deductible plan
Emergency Palliative Treatment	\$5		
Fillings one surface, amalgam; primary or permanent; limited to once per tooth surface every 24 consecutive months	\$30		
Periodontal Maintenance limited to 4 visits per calendar year	\$40	40%	50%
Recementing of Crowns	\$20		
Crown Repair	\$25		
Simple Extractions erupted tooth or exposed root	\$30		
Space Maintainers fixed, unilateral; for members under age 20	\$65		
MAJOR (12 month waiting period; deductible applies first)	\$50 or \$75 deductible plan	\$50 deductible plan	\$75 deductible plan
Crowns, Onlays, Dentures, Partials and Bridges	Copays vary based on the tooth location and type of material used. Visit lifewisewa.com/dental for a complete list of covered services and copays for more information.		
Endodontic (Root Canal) Treatment limited to 2 per arch when performed in conjunction with overdentures	anterior tooth: \$385 molar tooth: \$515 bicuspid tooth: \$435	60%	70%
General Anesthesia for first 30 minutes; limited to covered dental procedures at a dental-care provider's office when dentally necessary	\$165		
Oral Surgery for surgical removal of residual tooth roots	\$115		
Periodontal Scaling one to three teeth; limited to 2 every 12 consecutive months	\$60		
Periodontal Surgery osseous surgery; one to three contiguous teeth; limited to 2 every 12 consecutive months	\$350		

* If you visit a non-preferred provider, you'll pay the applicable non-preferred coinsurance based on the type of service provided. You'll also be responsible for amounts charged in excess of the allowable charge. Visit lifewisewa.com/dental for details on non-preferred provider coverage.