WiseAdvantage plan benefits

For plans beginning January 1, 2012

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

(PCY = Per Calendar Year)

MEDICAL PLAN	PREFERRED	NON-PREFERRED
Annual Deductible PCY (Choose one)	Individual: $1,800 Family: $5,400	Individual: $3,600 Family: $10,800
Coinsurance (what you pay)	35%	50%
Annual Coinsurance Maximum	Individual: $6,500 Family: 3x Individual	Unlimited
COVERED SERVICES Calendar year maximum: $2 million		
Office Visits including Urgent Care & Naturopathy	**DEDUCTIBLE WAIVED** $30 Copay	Deductible, then 50%
Preventive Care Exams[1] Routine medical exam, sports physical & women's health/well baby exams	Covered in Full[2]	Deductible, then 50%
Preventive Screenings PAP smear, PSA testing, mammography, colonoscopies, cancer screening, cholesterol screening	Covered in Full[2]	Deductible, then 50%
Immunizations	Covered in Full[2]	Not Covered
Pharmacy–Retail (30-day supply)	Preferred Generics/Non-Preferred Generics Retail[3]: $15 / 50% Mail Order[3]: $45 / 50%	Not Covered
Pharmacy–Mail Order (90-day supply)	Preferred Generics/Non-Preferred Generics Retail[3]: $15 / 50% Mail Order[3]: $45 / 50%	Not Covered
Outpatient Diagnostic Imaging & Lab Services	Deductible, then 35%	Deductible, then 50%
Emergency Room Care (copay waived if directly admited to an inpatient facility)	$100 copay, then subject to deductible, then 35%	$100 copay, then subject to deductible, then 35%[4]
Ambulance Transportation (Air: unlimited; Ground: $5,000 PCY limit)	Deductible, then 35%	Deductible, then 35%
Outpatient & Inpatient Facility Care	Deductible, then 35%	Deductible, then 50%
Rehabilitation (Outpatient: 20 visits PCY; Inpatient: 8 days PCY) Physical, Occupational, Massage and Speech Therapy; Cardiac & Pulmonary Rehabilitation	Deductible, then 35%	Deductible, then 50%
Durable Medical Equipment & Prosthetics	Deductible, then 35%	Deductible, then 50%
Spinal & Other Manipulations (12 visits PCY)	**DEDUCTIBLE WAIVED** $25 Copay	Deductible, then 50%
Acupuncture (12 visits PCY)	**DEDUCTIBLE WAIVED** $25 Copay	Deductible, then 50%
Home Health Care (130 visits PCY)	Deductible, then 35%	Deductible, then 50%
Skilled Nursing Facility (45 days PCY) Includes room & board, ancillaries & professional fees	Deductible, then 35%	Deductible, then 50%
Hospice Care (Inpatient: 10 days PCY; Respite: 240 hours PCY)	Deductible, then 35%	Deductible, then 50%
Maternity Care	Deductible, then 35%	Deductible, then 50%
Vision–Routine Exam (One exam per two year calendar years)	Covered in Full	Covered in Full
Vision Hardware (per two calendar years)	$200 for frames, lenses and contact lenses	$200 for frames, lenses and contact lenses
Mental Health–Outpatient Office Visit	**DEDUCTIBLE WAIVED** $30 Copay	Deductible, then 50%
Mental Health–Inpatient Facility Care	Deductible, then 35%	Deductible, then 50%
Transplants (12-month waiting period; Organ & Bone Marrow)	Deductible, then 35%	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] Brand: Pharmacy discount program available.

[4] 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.

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