

**Washington 90/80 Plans**

| <b>Medical Deductible, Rx Deductible, and Out-of-Pocket Maximum</b>  | <b>Individual</b>  | <b>Family</b>                                   |         |
|--|--|---|---------|
| Calendar Year Deductible and Rx Deductible (Rx Deductible is per person, no family maximum)                                  | \$150 (Rx \$50)  | \$450   |         |
|  | \$300 (Rx \$75)  | \$900   |         |
|  | \$500 (Rx \$100)   | \$1,500   |         |
|  | \$1,000 (Rx \$200)   | \$3,000   |         |
| Out-of-Pocket Maximum (includes deductible)  |  |   |         |
|  | \$150 Deductible   | \$1,000   | \$2,000 |
|  | \$300 Deductible   | \$1,200   | \$2,400 |
|  | \$500 Deductible   | \$1,500   | \$3,000 |
| \$1000 Deductible  | \$2,000  | \$4,000   |         |
| Lifetime Maximum Per Person  | \$2,000,000  | N/A   |         |
| <b>Professional Services</b>   | <b>Plan Pays:</b>  |   |         |
|  | <b>PPO</b>   | <b>Non-PPO</b>                                  |         |
| Office Visit*  | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Well Child   | 90% (Deductible waived, see policy for details)  | 80% (Deductible waived, see policy for details) |         |
| Preventive Care (Insureds 19 or older have \$300 annual maximum)**   | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Maternity Care   | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Urgent Care Clinic/Emergency Room  | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| **\$300 preventive care benefit is paid before deductible on the \$150 deductible and the \$300 deductible plans             |  |   |         |
| <b>Facility Services</b>   | <b>Plan Pays:</b>  |   |         |
|  | <b>PPO</b>   | <b>Non-PPO</b>                                  |         |
| Inpatient (semi-private room accommodations, hospital services and supplies, maternity care, skilled nursing facility, etc.) | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Outpatient (surgery and related services, diagnostic x-ray and laboratory, etc.)   | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Emergency Room   | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Inpatient Mental Illness   | Eligible expenses are paid at up to a maximum of 15 days each calendar year.   |   |         |
|  | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Outpatient Mental Illness  | Eligible outpatient visits are limited to 20 visits covered by plan per calendar year.   |   |         |
|  | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Inpatient and Outpatient Treatment of Chemical Dependency  | Eligible expenses are covered to a maximum \$14,000 in a consecutive 24-month period.  |   |         |
| <b>Miscellaneous</b>   | <b>Plan Pays:</b>  |   |         |
|  | <b>PPO</b>   | <b>Non-PPO</b>                                  |         |
| Prescriptions  | After the per person deductible, the member pays the greater of \$10 or 20% for generic prescription drugs and the greater of \$30 or 30% for brand prescription drugs. (For prescription deductible, please refer to deductible information above.) |   |         |
|  | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Ambulance Services   | The benefit for ground ambulance is limited to \$1,000 per occurrence and the benefit for air ambulance is limited to \$10,000 per occurrence.   |   |         |
| Durable Medical Equipment  | 80% (after deductible) up to a maximum benefit of \$3,000 per Calendar Year. Certain types of Equipment are paid at 80% (after deductible) up to a maximum benefit of \$7,500 per Calendar Year. Please see policy for specific details.             |   |         |
| Chiropractic   | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Prosthetics  | 80% (after deductible) for a natural limb or eye which is lost while insured. (Only the initial prosthesis is eligible to a maximum payable amount of \$5,000 by plan.)  |   |         |
|  | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Colonoscopies  | Subject to the guidelines of the American Cancer Society   |   |         |
|  | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Mammograms   | Subject to the following guidelines: One baseline for women between ages 35 and 39; Every two years for women 40 through 49; and Annually for women 50 years or older.   |   |         |
|  | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Treatment for craniomandibular and temporomandibular joint disorders   | Eligible expenses are covered to a maximum \$1,000 per calendar year and a maximum \$5,000 per lifetime.   |   |         |
|  | 90% (After Deductible)   | 80% (After Deductible)                          |         |
| Circumcision   | If performed within 30 days of birth or adoption to a maximum plan payment of \$150.   |   |         |
| Sleep Studies  | 50% (after deductible) of eligible expenses to a lifetime maximum plan payment of \$1,000.   |   |         |
| Sleep Apnea  | 50% (after deductible) of eligible expenses to a lifetime maximum plan payment of \$5,000.   |   |         |
| Organ Transplants  | Please see policy for specific details.  |   |         |

**This is a partial summary of benefits only. The benefit booklet contains complete benefits, exclusions and limitations and is the governing document. Preexisting conditions are excluded from coverage for a period of 3 months, however, credit will be given toward the satisfaction of the preexisting condition exclusionary period for prior creditable coverage.**