Deductible, coinsurance and copay represent WHAT YOU PAY.

All services subject to plan's deductible, unless otherwise noted. Coinsurance is either 20% or 30% and is determined by the deductible you choose.

PCY - Per Calendar Year	WiseChoices 20		WiseChoices 30	
	PREFERRED	NON-PREFERRED	PREFERRED	NON-PREFERRED
Annual Deductible PCY (choose one) (family = 3x)†	$1,000	$3,000	$1,500	$3,000
Annual Coinsurance Maximum (family = 3x)†	$8,500	Unlimited	$8,500	Unlimited
Out-of-Pocket Maximum PCY (family = 3x)† (Includes annual deductible and coinsurance maximum; once met, Preferred Providers covered in full)	$9,500	Unlimited	$10,000	Unlimited
LIFETIME BENEFIT MAXIMUM	$2,000,000		$2,000,000	
COVERED SERVICES				
PREVENTIVE CARE				
Preventive Exams (includes routine medical exam, sports physical, men's and women's health exam and well baby exam)	$30 Copay	50%	$30 Copay	50%
Immunizations	Covered in full	Not covered	Covered in full	Not covered
Preventive Screenings (includes Pap smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)	Covered in full	50%	Covered in full	50%
PROFESSIONAL CARE				
Office Visit including Urgent Care	$30 Copay	50%	$30 Copay	50%
Outpatient and Inpatient Professional Services	20%		30%	
ALTERNATIVE CARE				
Spinal and Other Manipulations 12 visits PCY	$25 Copay	50%	$25 Copay	50%
Acupuncture 12 visits PCY	$25 Copay		$25 Copay	
Naturopathy	$30 Copay		$30 Copay	
Massage Therapy* Inpatient: 8 days; Outpatient: 20 visits PCY	20%		30%	
DIAGNOSTIC SERVICES				
Outpatient Diagnostic X-ray and Lab Services	20%	50%	30%	50%
Mammography	20% (Coinsurance only)		30% (Coinsurance only)	
PHARMACY**				
Retail Pharmacy Up to 30-day supply	$10/$45/50%	In-network + 40%	$10/$45/50%	In-network + 40%
Mail Service Up to 90-day supply	$25/$112.50/45%		$25/$112.50/45%	
EMERGENCY CARE				
Emergency Room Care (copay waived if admitted)	$100 Copay plus deductible and 20%		$100 Copay plus deductible and 30%	
Ambulance Transportation Air - unlimited	20%		30%	
Ambulance Transportation Ground - $5,000 PCY	20%		30%	
FACILITY CARE				
Inpatient & Outpatient Facility Care	20%	50%	30%	50%
Skilled Nursing Facility 45 days PCY				
MATERNITY including prenatal care	20%	50%	30%	50%
VISION CARE				
Routine Vision Exam one exam per 2 calendar years	Covered in full		Covered in full	
Vision Hardware per 2 calendar years	$200 for frames, lenses and contact lenses		$200 for frames, lenses and contact lenses	

† Family = 3x individual for the deductible and coinsurance maximum.

* Shared with physical, occupational and speech therapy; cardiac and pulmonary rehabilitation; and chronic pain.

** Cost share for generic/preferred/non-preferred brands. Benefit for generic drugs unlimited. Benefit for all brand-name drugs limited to $3,000 per calendar year.

Note: All coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with LifeWise Health Plan of Washington. Please note that this is a general summary. Your individual health plan contract will describe the actual terms, conditions and exclusions of coverage.