

# WiseChoices™ Benefit highlights

Coinsurance and copay represent WHAT YOU PAY.

All preferred provider services are NOT subject to deductible, and coinsurance is either 20% or 30%.

PCY - Per Calendar Year	WiseChoices 0 20		WiseChoices 0 30	
	PREFERRED	NON-PREFERRED	PREFERRED	NON-PREFERRED
<b>Annual Deductible PCY</b> (choose one) (family = 3x)†	None	\$3,000	None	\$3,000
<b>Annual Coinsurance Maximum</b> (family = 3x)†	\$9,500	Unlimited	\$9,500	Unlimited
<b>Out-of-Pocket Maximum PCY</b> (family = 3x)† (Includes annual deductible and coinsurance maximum; once met, Preferred Providers covered in full)	\$9,500	Unlimited	\$9,500	Unlimited
<b>LIFETIME BENEFIT MAXIMUM</b>	\$2,000,000		\$2,000,000	
<b>COVERED SERVICES</b>				
<b>PREVENTIVE CARE</b>				
<b>Preventive Exams</b> (includes routine medical exam, sports physical, men's and women's health exam and well baby exam)	\$30 Copay	50%	\$30 Copay	50%
<b>Immunizations</b>	Covered in full	Not covered	Covered in full	Not covered
<b>Preventive Screenings</b> (includes Pap smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)	Covered in full	50%	Covered in full	50%
<b>PROFESSIONAL CARE</b>				
<b>Office Visits and Urgent Care</b>	\$30 Copay	50%	\$30 Copay	50%
<b>Outpatient and Inpatient Professional Services</b>	20% (Coinsurance only)		30% (Coinsurance only)	
<b>ALTERNATIVE CARE</b>				
<b>Spinal and Other Manipulations</b> 12 visits PCY	\$25 Copay		\$25 Copay	
<b>Acupuncture</b> 12 visits PCY	\$25 Copay	50%	\$25 Copay	50%
<b>Naturopathy</b>	\$30 Copay		\$30 Copay	
<b>Massage Therapy*</b> Inpatient: 8 days; Outpatient: 20 visits PCY	20% (Coinsurance only)		30% (Coinsurance only)	
<b>DIAGNOSTIC SERVICES</b>				
<b>Outpatient Diagnostic X-ray and Lab Services</b>	20% (Coinsurance only)	50%	30% (Coinsurance only)	50%
<b>Mammography</b>				
<b>PHARMACY**</b>				
<b>Retail Pharmacy</b> Up to 30-day supply	\$10/\$45/50%	In-network + 40%	\$10/\$45/50%	In-network + 40%
<b>Mail Service</b> Up to 90-day supply	\$25/\$112.50/45%		\$25/\$112.50/45%	
<b>EMERGENCY CARE</b>				
<b>Emergency Room Care</b> (copay waived if admitted)	\$100 Copay plus 20%		\$100 Copay plus 30%	
<b>Ambulance Transportation</b> Air - unlimited	20% (Coinsurance only)		30% (Coinsurance only)	
<b>Ambulance Transportation</b> Ground - \$5,000 PCY	20% (Coinsurance only)		30% (Coinsurance only)	
<b>FACILITY CARE</b>				
<b>Inpatient &amp; Outpatient Facility Care</b>	20% (Coinsurance only)	50%	30% (Coinsurance only)	50%
<b>Skilled Nursing Facility</b> 45 days PCY				
<b>MATERNITY</b> including prenatal care	20% (Coinsurance only)	50%	30% (Coinsurance only)	50%
<b>VISION CARE</b>				
<b>Routine Vision Exam</b> one exam per 2 calendar years	Covered in full		Covered in full	
<b>Vision Hardware</b> 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.