WiseEssentials Copay plan benefits

For plans beginning January 1, 2010

MEDICAL PLAN *(PCY = Per Calendar Year)*	**PREFERRED**	**NON-PREFERRED**
Annual Deductible *PCY (choose one; no family deductible)*	$5,000 / $7,500	$10,000 / $15,000
Coinsurance *(what you pay)*	25%	50%
Annual Coinsurance Maximum	$5,000	Unlimited
COVERED SERVICES *(Lifetime maximum $2 million)*		
Office Visits including Urgent Care & Naturopathy	**DEDUCTIBLE WAIVED** on first 3 visits PCY, you pay $25 copay only; additional visits subject to deductible, then 25%	Deductible, then 50%
Preventive Care Exams *Routine medical exam, sports physical & women's health/well baby exams*		
Preventive Screenings *PAP smear, PSA testing, colorectal cancer screening, cholesterol screening & bone density test*	Covered in Full*	
Immunizations	Not Covered	Not Covered
Pharmacy–Retail	Not Covered (Pharmacy discount program available)**	Not Covered (Pharmacy discount program available)**
Pharmacy–Mail Order		
Outpatient Diagnostic Imaging & Lab Services	Deductible, then 25%	Deductible, then 50%
Mammography	**DEDUCTIBLE WAIVED** then 25%	
Emergency Room Care *Copay waived if direct admit to an inpatient facility*	$100 copay, then subject to deductible, then 25%	$100 copay, then subject to deductible, then 25%***
Ambulance Transportation *Air: unlimited; Ground: $5,000 PCY limit*	Deductible, then 25%	Deductible, then 25%***
Outpatient & Inpatient Facility Care	Deductible, then 25%	Deductible, then 50%
Rehabilitation *(Outpatient: 20 visits PCY; Inpatient: 8 days PCY)* *Physical, Occupational, Massage & Speech Therapy; Cardiac & Pulmonary Rehabilitation*		
Durable Medical Equipment and Prosthetics	Not Covered	Not Covered
Spinal and 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 and 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 *(6 visits PCY)*	**DEDUCTIBLE WAIVED** $25 Copay	Deductible, then 50%
Mental Health–Inpatient Facility Care *(6 days PCY)*	Deductible, then 25%	
Transplants *(12-month waiting period; $350,000 lifetime benefit)* *Organ & Bone Marrow*	Deductible, then 25%	Not Covered

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

** In order to validate current eligibility for this discount, the pharmacy will transmit your information to LifeWise Health Plan of Washington, including the details of the prescription to be filled. The information may also be used for other proper purposes.

*** 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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