WiseEssentials™

LIFEWISE
HEALTH PLAN OF OREGON

MEDICAL BENEFITS	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Annual Deductible PCY (choose one) (Family is 3x the individual deductible)	Individual: $1,500 / $2,500 / $5,000 / $7,500 /$10,000	2x individual deductible
Coinsurance[1] (what you pay)	25%	50%
Annual Coinsurance Maximum (family = 2x individual)[2]	$9,000	Unlimited
Lifetime Maximum	$2,000,000	

COVERED SERVICES	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
PREVENTIVE CARE		
Preventive Care Exams (routine medical exam, sports physical and women's health exams/well baby)[3]	DEDUCTIBLE WAIVED you pay $25 on first 6 visits; additional visits subject to deductible then 25%	Deductible, then 50%
Preventive Screenings (includes Pap smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)	Covered in full[4]	
Immunizations		
PROFESSIONAL CARE		
Office Visit including Urgent Care[3]	DEDUCTIBLE WAIVED you pay $25 on first 6 visits; additional visits subject to deductible then 25%	Deductible, then 50%
Other Outpatient and Inpatient Professional Services	Deductible, then 25%	
ALTERNATIVE CARE		
Chiropractic 12 visits PCY (visits shared with Acupuncture)	$25 Copay per visit	Deductible, then 50%
Acupuncture 12 visits PCY (visits shared with Chiropractic)		
Naturopathy[3]	DEDUCTIBLE WAIVED you pay $25 on first 6 visits; additional visits subject to deductible then 25%	
DIAGNOSTIC SERVICES		
Outpatient Diagnostic Imaging and Lab Services	Deductible, then 25% **($1,500 Deductible Plan: deductible waived)**	Deductible, then 50%
Mammography	Covered in full[4]	
PHARMACY		
Retail Pharmacy (30-day supply)	$20 Generics only	Not covered
Mail Service Pharmacy (90-day supply)	$50 Generics only	
EMERGENCY CARE		
Emergency Room Care (copay waived if direct admit to an inpatient facility)	$100 Copay, then subject to deductible, then 25%	
Ambulance Transportation Air (unlimited); Ground ($5,000 PCY limit)	Deductible, then 25%	
FACILITY CARE		
Inpatient Facility Care	Deductible, then 25%	Deductible, then 50%
Outpatient Facility Care		
Skilled Nursing Facility 45 days PCY; includes room and board, ancillaries and professional fees		
MATERNITY		
Maternity Care	Deductible, then 25%	Deductible, then 50%
VISION CARE		
Routine Vision Exam	Not covered	
Vision Hardware		
OTHER SERVICES		
Home Medical Equipment and Supplies $5,000 PCY	Deductible, then 25%	Deductible, then 50%
Home Health Care 130 visits PCY		
Hospice Care Inpatient: 10 days, Respite: 240 hours per 6 months lifetime maximum		
Rehabilitation (includes Physical, Occupational & Speech Therapy, Cardiac & Pulmonary Rehab; & Chronic Pain) Outpatient: 20 visits PCY; Inpatient: 8 days PCY		
Transplants (Organ & Bone Marrow) 24-month waiting period; $250,000 Lifetime Benefit		
Alcohol Dependency Treatment	This optional benefit is available at an additional cost. It is limited to $4,500 in any 24 consecutive months	

Deductible, coinsurance and copay represent what you pay. All coinsurance amounts are based on maximum allowable amounts. Benefits apply after calendar year deductible is met, unless otherwise noted as "no deductible," "copay," or "covered in full."

PCY= Per Calendar Year

[1] All coinsurance amounts are the member's percentage of maximum allowable amounts after deductible

[2] Does not include deductible

[3] Office visits, preventive exams and naturopathy are shared

[4] Benefits provided at 100% of maximum allowable amounts; not subject to deductible or coinsurance

Note: Prosthetics and orthotic devices are a covered service on LifeWise plans and are not subject to a PCY limit.

This is only a summary of major benefits. It is not a contract.

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