LifeWise
Health Plan of Washington

# Highlights of your Health Care Coverage

Effective Date: 01/01/2027

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

| MEDICAL PLAN | CASCADE SELECT SILVER CSR2 | |
|---|---|---|
| | LIFEWISE ALPINE IN-NETWORK | OUT-OF-NETWORK |
| **Deductible** (In-network only - Family embedded deductible 2X Individual) | $550 | Not Covered |
| **Coinsurance** | 20% | Not Covered |
| **Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy)** (Family embedded OOP max 2X Individual) | $4,000 | Not Covered |
| **Designated PCP Office Visit Cost Share** | First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Specialist and non designated PCP Office Visit Cost Share** | $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Annual Maximum** | Unlimited | Not Covered |
| **1 Ambulatory Patient Services** | | |
| **Professional Office Visit** | Designated PCP: First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum; Specialist and non designated PCP: $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Telemedicine by Traditional Provider – General Medical** | Designated PCP: First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum; Specialist and non designated PCP: $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Urgent Care Office Visits** | $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |



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| | LIFEWISE ALPINE IN-NETWORK | OUT-OF-NETWORK |
| **Outpatient Professional Services** | $550 Deductible, then 20% Coinsurance, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Contraceptive Management Services** (Unlimited) | Covered in Full | Not Covered |
| **2 Emergency and Transportation Services** | | |
| **Emergency Room - Facility** | $550 Deductible, then $425 Copay, applies to the $4,000 Out of Pocket Maximum | $550 Deductible, then $425 Copay, applies to the $4,000 Out of Pocket Maximum |
| **Ambulance Service - Ground** (Unlimited) | $175 Copay, applies to the $4,000 Out of Pocket Maximum | $175 Copay, applies to the $4,000 Out of Pocket Maximum |
| **Ambulance Service - Air** (Unlimited) | $175 Copay, applies to the $4,000 Out of Pocket Maximum | $175 Copay, applies to the $4,000 Out of Pocket Maximum |
| **3 Hospitalization** | | |
| **Inpatient Medical and Surgical Room and Board** (Unlimited) | $550 Deductible, then $425 Copay per Day up to 5 Days per Admit, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Inpatient Professional Services** | $550 Deductible, 0% Coinsurance, applies to $4,000 Out of Pocket Maximum | Not Covered |
| **Skilled Nursing Facility** (60 days PCY; includes room and board, and facility billed professional and ancillary fees) | $550 Deductible, then $425 Copay per Day, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Hospice Inpatient Facility** (Unlimited) | $550 Deductible, then $425 Copay per Day up to 5 Days per Admit, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Organ Transplants** (Unlimited) | Covered as any other service | Not Covered |
| **4 Maternity & Newborn Care** | | |
| **Maternity Delivery - Inpatient Facility** (Coverage for subscriber, spouse, dependent) | $550 Deductible, then $425 Copay per Day up to 5 Days per Admit, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Maternity Prenatal, Delivery and Postnatal Care - Professional Services** (Coverage for subscriber, spouse, dependent) | Covered in Full | Not Covered |
| **Fertility Treatment & Assisted Reproduction Procedures** (Artificial insemination in vivo covered; other assisted reproduction treatments excluded) | $550 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum | Not covered |
| **5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment** | | |
| **Chemical Dependency Office Visit** (Unlimited) | First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Chemical Dependency Outpatient Facility** (Unlimited) | $5 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |

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| **Chemical Dependency Inpatient Facility** (Unlimited) | $550 Deductible, then $425 Copay per Day up to 5 Days per Admit, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Mental Health Office Visit** (Unlimited) | First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Mental Health Outpatient Facility** (Unlimited) | $5 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Mental Health Inpatient Facility** (Unlimited) | $550 Deductible, then $425 Copay per Day up to 5 Days per Admit, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **6 Prescription Drug** | | |
| **Formulary Drug List** | M4<br>Tier 1 = Preferred Generic<br>Tier 2 = Preferred Brand<br>Tier 3 = Non-preferred Generic and Brand<br>Tier 4 = Specialty | Not Covered |
| **Prescription Drugs - Retail** (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days) | Tier 1 = $10<br>Tier 2 = $35<br>Tier 3 = $160<br>Tier 4 = $160<br>(cost shares apply to the OOP Max) | Not Covered |
| **Prescription Drugs - Mail** (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days) | Tier 1 = $30<br>Tier 2 = $105<br>Tier 3 = $480<br>Tier 4 = $160<br>(cost shares apply to the OOP Max) | Not Covered |
| **7 Rehabilitative & Habilitative Services & Devices** | | |
| **Inpatient Rehabilitation** (30 days PCY) | $550 Deductible, then $425 Copay per Day up to 5 Days per Admit, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Outpatient Rehabilitation - Physical, Occupational Therapy** (25 visits PCY) | $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Outpatient Habilitation - Physical, Occupational Therapy** (25 visits PCY) | $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Outpatient Massage Therapy** (Applies to the outpatient rehab limit) | $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Outpatient Speech Therapy** (Applies to the outpatient rehab limit) | $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Inpatient Habilitation** (30 days PCY) | $550 Deductible, then $425 Copay per Day up to 5 Days per Admit, applies to the $4,000 Out of Pocket Maximum | Not Covered |

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| **Durable Medical Equipment** (Unlimited) | $550 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum | Not Covered |
| **8 Laboratory/Imaging Services** | | |
| **Diagnostic Laboratory & Pathology** | $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Diagnostic Imaging - Basic** | $30 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Diagnostic Imaging - Major (MRI, CT, PET)** | $550 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum | Not Covered |
| **9 Preventive/Wellness Services** | | |
| **Preventive Office Visit** (Unlimited, subject to standard medical guidelines) | Covered in Full | Not Covered |
| **Immunizations** (Unlimited, subject to standard medical guidelines) | Covered in Full | Not Covered |
| **Preventive Laboratory Screens** | Covered in Full | Not Covered |
| **Preventive Imaging** | Covered in Full | Not Covered |
| **Breast Cancer Screening (including mammography)** | Covered in Full | Not Covered |
| **10 Pediatric Services, including Oral & Vision Care** | | |
| **Pediatric Vision Exam** (1 PCY Under age 19) | Covered in Full | Covered in Full |
| **Pediatric Eyewear** (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).) | Covered in Full | Covered in Full |
| **Pediatric Dental - Major** | Not Covered | Not Covered |
| **Virtual Care Services** | | |
| **Telemedicine – General Medical (Virtual Care Only)** | Designated PCP: First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum; Specialist and non designated PCP: $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Telemedicine - Mental Health (Virtual Care Only)** | Subject to Mental Health Office Visit Cost Share | Not Covered |
| **Telemedicine - Chemical Dependency (Virtual Care Only)** | Subject to Chemical Dependency Outpatient Office Visit Cost Share | Not Covered |
| **Routine Hearing** | | |
| **Routine Hearing Exam** (1 PCY) | First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum | First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum |
| **Routine Hearing Aids and Hardware** (1 device per ear every 3 years) | Waive Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum | Waive Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum |
| **Alternative Care** | | |

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| **Chiropractic** (10 visits PCY) | First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Acupuncture** (Unlimited) | First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |
| **Naturopath** | Designated PCP: First 2 visits $1 Copay, additional visits $5 Copay, applies to the $4,000 Out of Pocket Maximum; Specialist and non designated PCP: $20 Copay, applies to the $4,000 Out of Pocket Maximum | Not Covered |

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

*This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.*

## Notice of availability and nondiscrimination 800-592-6804 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរស័ព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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