“ISHIP” INTERNATIONAL STUDENT HEALTH INSURANCE PLAN

PPO + Vision/Dental

LifeWise
Assurance Company

INTRODUCTION

Welcome

Thank you for choosing LifeWise Assurance Company (LifeWise) for your healthcare coverage.

This benefit booklet tells you about your plan benefits and how to make the most of them. Please read this benefit booklet to find out how your healthcare plan works.

Some words have special meanings under this plan. See ***Definitions*** at the end of this booklet.

In this booklet, the words “we,” “us,” and “our” mean LifeWise. The words “you” and “your” mean any member enrolled in the plan. The word “plan” means your healthcare plan with us.

Please contact Customer Service if you have any questions about this plan. We are happy to answer your questions and hear any of your comments.

On our website, students.lifewiseac.com/iship you can also:

- Learn more about your plan.
- Find a healthcare provider near you.
- Look for information about many health topics.

We look forward to serving you. Thank you again for choosing LifeWise.

This benefit booklet is for members enrolled in this plan. This benefit booklet describes the benefits and other terms of this plan. It replaces any other benefit booklet you may have received.

We know that healthcare plans can be hard to understand and use. We hope this benefit booklet helps you understand how to get the most from your benefits.

The benefits and provisions described in this plan are subject to the terms of the master contract (contract) issued to the University of Washington.

Medical and payment policies we use in administration of this plan are available at students.lifewiseac.com.

If any provision of this Plan is superseded by state or federal law, the Plan will comply with the applicable law as it relates to those provisions.

Translation Services

If you need an interpreter to help with verbal translation services, please call us. Customer Service will be able to guide you through the service. The phone number is shown on the back cover of your booklet.

Group Name:	University of Washington
Effective Date:	September 1, 2026
Plan:	LifeWise ISHIP PPO + Vision/Dental
Certificate Form Number:	UWISHIP (09-2026)
Metal Level:	Platinum - Actuarial Value 0.885

HOW TO USE THIS BENEFIT BOOKLET

We realize that using a health care plan can seem complicated, so we've prepared this contract to help you understand how to get the most out of your benefits.

Please contact Customer Service if you have any questions about this plan. We are happy to answer your questions and hear any of your comments.

On our website at students.lifewiseac.com you can also:

- Learn more about your plan
- Find a healthcare provider near you
- Look for information about many health topics

Every section in this benefit booklet has important information. You may find that the sections below are especially useful.

- **How to Contact Us** – Our website, phone numbers, mailing addresses and other contact information are on the back cover.
- **Summary of Your Costs** – Lists your costs for covered services.
- **Important Plan Information** – Describes deductibles, copays, coinsurance, coinsurance maximums, out-of-pocket maximums and allowed amounts
- **How Providers Affect Your Costs** – How using an in-network provider affects your benefits and lowers your out-of-pocket costs
- **Prior Authorization** – Describes our prior authorization provision
- **Clinical Review** – Describes our clinical review provision
- **Personal Health Support Programs** – Describes our health support programs
- **Continuity of Care** – Describes how to continue care at the in-network level of benefits when a provider is no longer in the network
- **Covered Services** – A detailed description of what is covered
- **Exclusions and Limitations** – Describes services that are not covered
- **Other Coverage** – Describes how benefits are paid when you have other coverage or what you must do when a third party is responsible for an injury or illness
- **How Do I File A Claim** – Instructions on how to send in a claim
- **Complaints and Appeals** – What to do if you want to file a complaint or submit an appeal
- **Eligibility and Enrollment** – Describes who can be covered.
- **When Coverage Ends** – Describes when coverage ends
- **Other Plan Information** – Lists general information about how this plan is administered and required state and federal notices
- **Definitions** – Meanings of words and terms used

Where To Send Claims

MAIL YOUR CLAIMS TO

LifeWise Assurance Company

PO Box 91059

Seattle, WA 98111-9159

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To	Contact the Pharmacy Benefit Administrator At
Express Scripts	800-391-9701
ATTN: Commercial Claims	www.express-scripts.com
PO Box 14711	
Lexington, KY 40512-4711	

Customer Service

Mailing Address	Phone Numbers
LifeWise Assurance Company	Local and toll-free number:
PO Box 91059	800-971-1491
Seattle, WA 98111-9159	
Physical Address	Local and toll-free TTY number
7001 220th St. SW	for the deaf and hard-of-hearing:
Mountlake Terrace, WA 98043-2124	711

ISHIP Office
1878 Husky Health Center
(206) 543-6202
stdins@uw.edu

Care Management

Prior Authorization

LifeWise Assurance Company	Local and toll-free number:
PO Box 91059	800-971-1491
Seattle, WA 98111-9159	Fax 800-843-1114

Dental Estimate of Benefits

LifeWise Assurance Company
Attn: Dental Review
PO Box 91059, MS 173
Seattle, WA 98111-9159

Fax 425-918-5956

Complaints and Appeals

LifeWise Assurance Company
Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111-9202

Website

Visit our website students.lifewiseac.com for information and secure online access to claims information.

Virtual Care

Website: https://students.lifewiseac.com/find-care

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SUMMARY OF YOUR COSTS

Campus Clinics

Your provider network is: LifeWise Assurance Co.

Provider locations where the highest level of insurance benefits is provided:

- On *University of Washington Seattle* campus for students and covered family members: Husky Health Center, 4060 E. Stevens Way NE, Seattle, WA 98195. Phone: 206-685-1011; or UW Neighborhood Ravenna Clinic, 4915 25th Ave. NE, Suite 300-W, Seattle, WA 98105. Phone: 206-525-7777
- Off campus care *University of Washington Bothell* for students and covered family members: HealthPoint – Bothell Medical Clinic and Pharmacy, 10414 Beardslee Blvd. Suite 100, Bothell, WA 98011. Phone: 425-486-0658
- Off campus care *University of Washington Tacoma* for students and covered family members: Community Healthcare Medical Building at St. Joseph, 1608 S. J St., Third Floor, Tacoma, WA, 98405. Phone: 253-274-7503

Note: Students and their covered family members can receive services at any of the Campus Clinics. If one of the noted Campus Clinic providers is able to perform a service, then the deductible will be waived. If a Campus Clinic provider is not able to perform a service, then the deductible will apply (unless the benefit specifically notes that the deductible is waived). **If you receive services from a Non-Participating Provider, the provider may bill you for charges above the allowed amount. See *Balance Billing Protection* for more information.**

This is a summary of your costs for covered services. Your costs are subject to all of the following.

- The allowed amount. The maximum amount LifeWise pays for a covered service.
- The copays. These are set dollar amounts you pay at the time you get services. There is no deductible when you pay a copay, unless shown below. Copays apply to the out-of-pocket maximum unless stated otherwise in the summary.
- The deductible. The costs shown below are what you pay after the deductible is met. Sometimes the deductible is waived. This is also shown below. The deductible is waived at Campus Clinics.

	Campus Clinic Providers	In-Network Providers	Out-of-Network Providers
Individual Deductible Deductible waived at Campus Clinics	None	$125 per quarter/ $500 per plan year	
Family Deductible (embedded) Deductible waived at Campus Clinics	None	$250 per quarter/ $1,000 per plan year	

- The out-of-pocket maximum. This is the most you pay each plan year for services.

	Campus Clinic and other In-Network Providers	Out-of-Network Providers
Individual Out-of-Pocket Maximum	$3,400	$6,400
Family Out-of-Pocket Maximum	$6,800	$12,800

- **Prior authorization**. Some services must be authorized in writing before you get them, in order to be eligible for coverage. See ***Prior Authorization*** for details.
- For service provided in a facility or hospital, benefits may also be subject to the deductible and coinsurance for related facility fees billed by the hospital. See ***Hospital*** for these costs.

This plan complies with state and federal regulations about diabetes medical treatment coverage. See ***Preventive Care***, ***Prescription Drugs***, ***Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics***, and the ***Foot Care*** benefits.

The conditions, time limits and maximum limits are described in this booklet. Some services have special rules. See ***Covered Services*** for details.

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
COMMON MEDICAL SERVICES		
Office and Clinic Visits (including virtual care providers) You may have additional costs for other services such as x-rays, lab work, injectable drug therapies and hospital facility charges. See those covered services for details. See ***Preventive Care*** for preventive services.		
• Office visits, including virtual care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Office visit for women's health	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Non-hospital urgent care centers	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• All other office and clinic visits (including non-preventive nutritional therapy and consultations with a pharmacist) See ***Mental Health Care, Behavioral Health, and Substance Use Disorder*** and ***Virtual Care*** for these benefits.	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Preventive Care Benefits for preventive care that meet the federal guidelines are not subject to cost sharing when care is provided by an in-network provider.		
• Exams, screenings and immunizations (including seasonal immunizations in a provider's office) are limited in how often you can get them based on your age and gender	0% coinsurance, deductible waived	Not covered
• Seasonal and travel immunizations (pharmacy, mass immunizer, travel clinic and county health department)	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• Health education, preventive nutritional therapy for diseases such as diabetes, and nicotine dependency treatment	0% coinsurance, deductible waived	Not covered
• Diagnostic and supplemental breast exams	0% coinsurance, deductible waived	Deductible then 40% coinsurance
• Contraception Management and Sterilization. See ***Surgery*** for vasectomy.	0% coinsurance, deductible waived	Deductible then 40% coinsurance
Diagnostic X-ray, Lab, and Imaging		
• Preventive care screening/tests	0% coinsurance, deductible waived	Deductible then 40% coinsurance
• Basic diagnostic x-ray, and imaging	25% coinsurance, deductible waived	Deductible then 40% coinsurance
• Basic diagnostic lab and professional services	25% coinsurance, deductible waived	Deductible then 40% coinsurance
• Major diagnostic x-ray, and imaging	Deductible then 25% coinsurance	Deductible then 40% coinsurance

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
PEDIATRIC CARE (members under age 19)		
Pediatric Vision Services		
• Routine exams limited to one per plan year	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• One pair of glasses (frames and lenses) per plan year. Lens features limited to polycarbonate lenses and scratch resistant coating.	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• One pair of contacts or a 12-month supply of contacts per plan year instead of glasses (lenses and frames).	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• Contact lenses and glasses required for medical reasons	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• One comprehensive low vision evaluation and four follow up visits in a five plan year period	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• Low vision devices, high powered spectacles, medical vision hardware, magnifiers and telescopes when medically necessary	0% coinsurance, deductible waived	0% coinsurance, deductible waived
Pediatric Dental Services		
• Class I – Diagnostic and Preventive Services	No charge	Deductible then 30% coinsurance
• Class II – Basic Services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
• Class III – Major Services	Deductible then 50% coinsurance	Deductible then 50% coinsurance
• Medically Necessary Orthodontia	Deductible then 50% coinsurance	Deductible then 50% coinsurance

Note: Not all services are provided at Campus Clinics.	**YOUR COSTS OF THE ALLOWED AMOUNT**	
	IN-NETWORK PROVIDERS Rubenstein Pharmacy, UMC/UWP and all In-Network Pharmacies	**OUT-OF-NETWORK PROVIDERS** Out-of-Network Pharmacies
Prescription Drugs– Retail Pharmacy Up to a 30-day supply. Up to a 12-month supply for contraceptive drugs and devices. The quarterly deductible is waived. Maximum copay/coinsurance of up to $150/prescription.		
• Preventive drugs required by federal health care reform. See ***Covered Services*** for details.	No charge	No charge
• Formulary preferred generic drugs	$20 copay, deductible waived (per 30-day supply)	50% coinsurance, deductible waived (based on billed charge)
• Formulary preferred brand-name drugs	$30 copay, deductible waived (per 30-day supply)	
• Formulary non-preferred drugs	$45 copay, deductible waived (per 30-day supply)	
• Specialty drugs	50% coinsurance, deductible waived	
• Oral anticancer drugs	25% coinsurance, deductible waived	40% coinsurance, deductible waived
**Your cost-shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug, and the deductible does not apply. Cost-shares for covered prescription insulin drugs apply towards the deductible.*		

Note: Not all services are provided at Campus Clinics.	**YOUR COSTS OF THE ALLOWED AMOUNT**	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
Surgery		
• Inpatient hospital	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Outpatient hospital, ambulatory surgical center	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Professional services	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Vasectomy	0% coinsurance, deductible waived	Deductible then 40% coinsurance
Emergency Services		
• Facility fees. The copay is waived if you are admitted as an inpatient through the emergency room. The copay is waived if you are transferred and admitted to a different hospital directly from the emergency room.	$100 copay, then deductible and 25% coinsurance	$100 copay, then deductible and 25% coinsurance
• Professional, diagnostic services, other services and supplies	Deductible then 25% coinsurance	Deductible then 25% coinsurance
Ambulance Services	Deductible then 25% coinsurance	Deductible then 25% coinsurance
Urgent Care Centers	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Hospital		
• Inpatient Care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Outpatient Care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Mental Health Care, Behavioral Health, and Substance Use Disorder		
• Office visits (including virtual care) and other outpatient services (there are no fees at the Counseling Center for registered students)	No charge	No cost-shares
• Inpatient and residential	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Maternity and Newborn Care Prenatal, postnatal, delivery, and inpatient care. See also ***Diagnostic X-ray, Lab, and Imaging***. For specialty care see also ***Office and Clinic Visits***.		
• Outpatient professional care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Inpatient professional care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Inpatient hospital, birthing center and short-stay hospital	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Abortion	No charge	Deductible then 40% coinsurance

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
AT HOME CARE **Home Health Care** Limited to 130 visits per plan year **Hospice Care**	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Home visits (not subject to the Home Health Care visit limit)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Respite care, inpatient or outpatient (limited to 14 days lifetime)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
REHABILITATION AND NEURODEVELOPMENTAL (HABILITIATION) THERAPY **Rehabilitation Therapy** See ***Mental Health Care, Behavioral Health, and Substance Use Disorder*** for therapies provided for mental health conditions such as autism.		
• Inpatient (limited to 30 days per plan year)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Outpatient (limited to 25 visits per plan year)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Neurodevelopmental (Habilitation) Therapy Neuropsychological testing to diagnose is not subject to any maximum. See ***Mental Health Care, Behavioral Health, and Substance Use Disorder*** for therapies provided for mental health conditions such as autism.		
• Inpatient (limited to 30 days per plan year)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Outpatient (limited to 25 visits per plan year)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Skilled Nursing Facility and Care		
• Skilled nursing facility care limited to 60 days per plan year	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Skilled nursing care in the long-term care facility care limited to 60 days per plan year	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics	Deductible then 25% coinsurance	Deductible then 40% coinsurance
OTHER COVERED SERVICES		
Acupuncture	Deductible then 25% coinsurance	Deductible then 40% coinsurance

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
Allergy Testing and Treatment	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Artificial Insemination • Evaluation and diagnosis for infertility • In vivo fertilization Assisted reproduction methods, other than in vivo fertilization, are not covered.	 Covered as any other service Deductible then 25% coinsurance	 Not covered Not covered
Blood Products and Services	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Virtual Care Virtual care select providers • General Medical Services • Mental Health Care • Substance Use Disorders Virtual care select providers can be found at students.lifewiseac.com/find-care or contact Customer Service for assistance. See ***Office and Clinic Visits*** and ***Mental Health Care, Behavioral Health, and Substance Use Disorders*** for virtual care benefits.	 Deductible then 25% coinsurance No charge No charge	 Not covered Not covered Not covered
Anticancer Medication, Radiation Therapy, and Dialysis	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Clinical Trials You may have additional costs for other services such as x-rays, lab, prescription drugs, and hospital facility charges. See those covered services for details.	Covered as any other service	Covered as any other service
DENTAL INJURY AND FACILITY ANESTHESIA • Dental Injury • Facility Anesthesia You may have additional costs for other services such as x-rays, lab, and hospital facility charges. See those covered services for details.	 Covered as any other service Deductible then 25% coinsurance	 Covered as any other service Deductible then 40% coinsurance

Foot Care Routine care that is medically necessary.	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Gender Affirming Care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Infusion Therapy	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Mastectomy and Breast Reconstruction	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Medical Foods	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Note: Not all services are provided at Campus Clinics.	**YOUR COSTS OF THE ALLOWED AMOUNT**	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
Chiropractic Adjustments Limited to 10 visits per plan year.	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Orthognathic Surgery (Jaw Augmentation or Reduction) No limit		
• Office and clinic visits	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Surgery and other professional care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Outpatient surgery facility care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Temporomandibular Joint (TMJ) Disorders		
• Office visits	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Inpatient facility fees	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Other professional services	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Injectable Drug Therapies	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Hearing Hardware One hearing aid per ear with hearing loss every 3 years	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Transplants		
• Office visits	Deductible then 25% coinsurance	Not covered*
• Inpatient facility fees	Deductible then 25% coinsurance	Not covered*
• Other professional services	Deductible then 25% coinsurance	Not covered*
• Travel and lodging. $5,000 limit per transplant	Deductible then 0% coinsurance	Deductible then 0% coinsurance
*All Approved Transplant Centers are covered at in-network benefit level.		
Vision for Adults The services below do not apply toward the out-of-pocket maximum. For vision exams and hardware for a child under age		

19 see ***Pediatric Vision Services***.		
• Vision exams (limited to 1 per plan year)	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• Vision hardware (maximum of $200 per plan year)	0% coinsurance, deductible waived	0% coinsurance, deductible waived

Dental for Adults (maximum of $1,500 per plan year, $25 individual/ $75 family deductible per plan year). The services below do not apply toward the overall deductible and out-of-pocket maximum amounts shown above. For dental care for a child under age 19 see ***Pediatric Dental Services***.		
• **Preventive Services** (includes routine exams, cleanings and x-rays). These services do not apply toward the $1,500 per plan year dental maximum. See ***Dental for Adults*** for more detail.	Dental deductible, then 0% coinsurance	Dental deductible, then 0% coinsurance
• **Restorative Services**. Services that restore the function of the tooth by replacing missing or damaged tooth structure. Restorative services include, but not limited to, extractions, fillings, root canals, crowns, and periodontal (gum) treatment.	Dental deductible, then 0% coinsurance	Dental deductible, then 0% coinsurance
Note: Not all services are provided at Campus Clinics.	**YOUR COSTS OF THE ALLOWED AMOUNT**	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
Emergency Medical Evacuation and Repatriation of Remains Services do not apply toward the out-of-pocket maximum shown above.		
• Emergency Medical Evacuation ($150,000 lifetime maximum)	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• Repatriation of Remains ($25,000 maximum)	0% coinsurance, deductible waived	0% coinsurance, deductible waived

IMPORTANT PLAN INFORMATION

This plan is a Preferred Provider Plan (PPO). Your provider network is: LifeWise Assurance Co. Your plan provides you benefits for covered services from providers within the LifeWise Assurance Co. network without referrals. You have access to one of the many providers included in your network of providers for covered services included in your plan. See ***How Providers Affect Your Costs*** for more information. You also have access to facilities, emergency rooms, surgical centers, equipment vendors or pharmacies providing covered services throughout the United States and wherever you may travel. **IMPORTANT NOTE**: Certain services received from out-of-network providers are not covered under this plan. See ***Summary of Your Costs***.

PLAN YEAR DEDUCTIBLE

A deductible is what you have to pay for covered services for each plan year before this plan provides benefits.

QUARTERLY/QUARTER DEDUCTIBLE

The amount you have to pay before LifeWise starts to pay for covered services for each quarter before this plan provides benefits.

INDIVIDUAL DEDUCTIBLE

This plan includes an individual deductible when you see in-network or out-of-network providers. After you pay this amount, this plan will begin paying for your covered services. See ***Summary of Your Costs*** for your individual deductible amount.

FAMILY DEDUCTIBLE

This plan includes a family deductible. When the total equals the family deductible set maximum, we consider the individual deductible of every enrolled family member to be met for the year. Only the amounts used to satisfy each enrolled family member's individual deductible will count toward the family deductible.

The family deductible is satisfied when two or more covered family members' allowed amounts for covered services for that plan year total and meets the family deductible amount. One member may not contribute more than the individual deductible amount. This type of deductible is called "embedded".

See ***Summary of Your Costs*** for your family deductible amount.

The **Plan Year and Quarterly/Quarter Deductible** is subject to the following:

- There is no carry over provision. Amount credited to your deductible during the current plan year or quarter will not carry forward to the next plan year or quarter deductible
- Amounts credited toward the deductible will not exceed the allowed amount.
- Copays are not applied to the deductible
- Amounts credited toward the deductible do not add to benefits with a benefit dollar maximum.
- Amounts credited toward the deductible accrue to benefits with visit limits.

Amounts that don't accrue toward the deductible are:

- Amounts that exceed the allowed amount
- Charges for excluded services
- Copays

COPAY OR COPAYMENT

A fixed amount you pay for each healthcare visit or service. If the amount billed is less than the copay, you only pay the amount billed. Only one office visit copay per provider per day will apply. If the copay amounts are different, the highest will apply. Copays apply to the out-of-pocket maximum.

COINSURANCE

It's a percentage of the allowed amount that you pay for the service. You start paying coinsurance after you've

met your deductible.

VISIT, DAY, OR HOUR LIMITS

Some covered services have a maximum number of visits, days, or hours. After you reach this limit, you pay 100% out-of-pocket, whether or not you've met your deductible.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you pay for covered services each plan year before LifeWise pays 100% of the allowed amount. See ***Summary of Your Costs*** for further detail.

However, if you get out-of-network care, you are still responsible for any charges above the allowed amount, except as prohibited by state or federal law.

Expenses that do not apply toward the out-of-pocket maximum include:

- Charges above the allowed amount
- Services above any benefit maximum limit or durational limit
- Services not covered by this plan
- Covered services that do not apply to the out-of-pocket maximum as stated in ***Summary of Your Costs***

ALLOWED AMOUNT

This plan provides benefits based on the allowed amount for covered services. We reserve the right to determine the amount allowed for any given service or supply. The allowed amount is described below.

In-Network

The allowed amount is the fee that we have negotiated with providers who have signed contracts with us and are in your provider network.

Out-of-Network

For contracted providers the allowed amount is the fee that we have negotiated with providers who have signed contracts with us.

For non-contracted providers and non-emergent care, the allowed amount is the least of the following (unless a different amount is required under applicable law or agreement):

- An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us.
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), as implemented by LifeWise.

The provider's billed charges.

Non-Emergency Services Protected From Balance Billing

For these services, the allowed amount is calculated consistent with the requirements of federal or Washington state law.

Emergency Services

The allowed amount for non-participating providers will be calculated consistent with the requirements of federal or Washington state law.

You do not have to pay amounts over the allowed amount for emergency services delivered by non-participating providers or facilities.

If you have questions about this information, please call us at the number listed on your LifeWise ID card.

Ground or Air Ambulance

Your cost-sharing for non-participating ground or air ambulance services shall be no more than if the services

were provided by an in-network provider. The cost sharing amount shall be counted towards the in-network deductible and the in-network out of pocket maximum amount. Cost-sharing shall be based upon the lesser of the qualifying payment amount (as defined under federal or Washington law) or the billed amount.

For the above services, you will pay no more than the plan's in-network cost-shares. LifeWise Assurance Co. will work with the non-participating provider to resolve any issues about the amount paid. LifeWise will also send the plan's payments to the provider directly.

Note: Amounts you pay over the allowed amount don't count toward any applicable calendar year deductible, coinsurance, or out-of-pocket maximum.

Dental Services

In-Network Providers

The allowed amount is the fee that we have negotiated with our contracted providers.

Out-of-Network Providers

The allowed amount will be the maximum allowed amount as determined by us in the area where the services were provided, but in no case higher than the 90th percentile (in state) and 95th percentile (out-of-state) of provider fees in that geographic area.

HOW PROVIDERS AFFECT YOUR COSTS

MEDICAL SERVICES

This plan is a Preferred Provider plan (PPO). This means that your plan provides benefits to you for covered services from covered providers of your choice. Throughout this section you will find information on how to control your out-of-pocket costs and how the providers you see for covered services can affect this plan's benefits.

To help you manage the cost of healthcare, we have a network of healthcare providers. You have access to one of the many providers included in the LifeWise Assurance Co. provider network and network providers throughout the United States.

A list of in-network providers is available in our LifeWise provider directory. These providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you.

We update this directory regularly, but it is subject to change. We suggest that you call us for current information and to verify that your provider and their office location or provider group are included in the LifeWise Assurance Co. network before you receive services.

Our provider directory is available any time on our website at https://students.lifewiseac.com/find-care/. You may also request a copy of this directory by calling Customer Service at the number located on the back cover or on your LifeWise ID card.

In-Network Providers

In-network providers are networks of hospitals, physicians and other providers that are part of our LifeWise Assurance Co. network in Washington. These providers provide medical services at a negotiated fee. This fee is the allowed amount for in-network providers.

In-network providers will not charge more than the allowed amount. This means that your portion of the charges for covered services will be lower.

Contracted Health Care Benefit Managers

The list of LifeWise Assurance Company's contracted Health Care Benefit Managers (HCBM) and the services they manage are available at https://www.lifewiseac.com/companies-we-work-with and changes to these contracts or services are reflected on the website within 30 business days.

Non-Participating Providers

Non-participating providers are either (1) providers that are not part of your network (out-of-network) or (2)

providers that do not have a contract with us (non-contracted). Except as stated in ***Benefits For Out-of-Network or Non-Contracted Providers***, or in a few specific benefits, services from these providers are not covered.

- **Out-of-network providers.** Some providers in Washington have a contract with us but are not in the LifeWise Assurance Co. network. In cases where this plan covers services from these providers, they will not bill you for the amount above the allowed amount for a covered service.
- **Non-contracted providers.** There are also providers who do not have a contract with us. These providers are called "non-contracted" providers in this booklet. These providers may bill you the amount above the allowed amount for a covered service.

Balance Billing Protection

Non-participating providers have the right to charge you more than the allowed amount for a covered service. This is called "surprise billing" or "balance billing." However, Washington state and federal law protects you from balance billing for:

Emergency Services from a non-participating hospital, facility or from a non-participating provider at the hospital or facility.

Emergency services include certain post-stabilization services you may get after you are in stable condition. These include covered services provided as part of outpatient observation or during an inpatient or outpatient stay related to the emergency visit, regardless of which department of the hospital you are in.

Non-emergency Services from a non-participating provider at an in-network hospital or outpatient surgery center. If a non-emergency service is not covered under the in-network benefits and terms of coverage under your health plan, then the federal and state law regarding balance billing do not apply for these services.

Ground Ambulance Services from a non-participating ground ambulance service organization for covered ground ambulance services.

Air Ambulance
Your cost-sharing for non-participating air ambulance services shall be no more than if the services were provided by an in-network provider. The cost sharing amount shall be counted towards the in-network deductible and the in-network out of pocket maximum amount. Cost-sharing shall be based upon the lesser of the qualifying payment amount (as defined under federal law) or the billed amount.

For more information, refer to www.insurance.wa.gov/sites/default/files/2025-02/consumer-notice-surprise-billing-2024-FINAL.pdf.

For the above services, you will pay no more than the plan's in-network cost-shares. See ***Summary Of Your Costs***. LifeWise Assurance Company will work with non-participating provider to resolve any issues about the amount paid. LifeWise will also send the plan's payments to the provider directly.

Note: Amounts you pay over the allowed amount don't count toward the plan year or quarter deductible, coinsurance or out-of-pocket maximum***.***

Benefits for Out-of-Network or Non-Contracted Providers

The following covered services and supplies provided by out-of-network or non-contracted providers will always be covered:

- Emergency services for a medical emergency. See ***Definitions*** for definitions of these terms. This plan provides worldwide coverage for emergency services.

  The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider furnishing the services has a contract with us. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws.
- Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received from a hospital that has a provider contract with us.

If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-network or non-contracted provider. However, you or your in-network provider must request this before you get the care. See ***Prior Authorization*** for details.

PEDIATRIC DENTAL SERVICES

In-Network Providers

This plan makes available to you sufficient numbers and types of providers to give you access to all covered services in compliance with applicable Washington State regulations governing access to providers.

You receive the highest level of coverage when you receive services from in-network providers.

When you receive services from in-network providers, your claims will be submitted directly to us and available benefits will be paid directly to the pediatric dental care provider. In-network providers agree to accept our allowed amount as payment in full.

You're responsible only for your in-network cost-shares, and charges for non-covered services. See ***Summary of Your Costs*** for cost-share amounts.

To locate an in-network provider when you need services, please refer to our website or contact Customer Service. You'll find this information on the back cover.

Out-of-Network Providers

Out-of-network providers are providers that do not have contracts with us. Your bills will be reimbursed at the lower percentage (the out-of-network benefit level) and the provider will bill you for charges above the allowed amount. You may also be required to submit the claim yourself. See ***How Do I File A Claim***.

CARE MANAGEMENT

Care Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Management process is simple, but important, as explained below.

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for claims payment and to help us identify admissions that might benefit from case management.

PRIOR AUTHORIZATION

Your coverage for some services depends on whether the service is approved before you receive it. This process is called prior authorization.

A planned service is reviewed to make sure it is medically necessary and eligible for coverage under this plan. We will let you know in writing if the service is authorized. We will also let you know if the services are not authorized and the reasons why. If you disagree with the decision, you can request an appeal. See ***Complaints and Appeals*** or call us.

There are three situations where prior authorization is required:

- Before you receive certain medical services and drugs, or prescription drugs
- Before you schedule a planned admission to certain inpatient facilities
- When you want to receive the higher benefit level for services you received from an out-of-network provider, except for emergency services. See ***Exceptions To Prior Authorization For Out-of-Network Providers*** below for more information.

Prior authorization is also not required for the first six visits of rehabilitation therapy, neurodevelopmental (habilitation) therapy, chiropractic adjustments or acupuncture.

How to Ask for Prior Authorization

The plan has a specific list of services that must have prior authorization with any provider. The list is on our website. Before you receive services, we suggest that you review the list of services requiring prior authorization.

Services from In-Network Providers: It is your in-network provider's responsibility to get prior authorization. Your in-network provider can call us at the number listed on your ID card to request a prior authorization.

Services from Out-of-Network Providers: It is your responsibility to get prior authorization for any of the

services on the prior authorization list when you see an out-of-network provider. You or your out-of-network provider can call us at the number listed on your ID card to request a prior authorization.

We will respond to a request for prior authorization within 5 calendar days of receipt of all information necessary to make a decision. If your situation is clinically urgent (meaning that your life or health would be put in serious jeopardy if you did not receive treatment right away), you may request an expedited review. Expedited reviews are responded to as soon as possible taking into account the medical urgency, but no later than 48 hours after we get all the information necessary to make a decision. We will provide our decision in writing.

Our prior authorizations will be valid for 30 calendar days. This 30-day period is subject to your continued coverage under the plan. If you do not receive the services within that time, you will have to ask us for another prior authorization.

For a drug covered under the medical benefit, coverage is provided for approved therapies based on drug availability. When a generic or biosimilar drug ("generic biological product") of an approved drug is available, generic drug substitution applies. The generic or biosimilar drug provides the same therapeutic benefit for the approved condition. This can happen at any time throughout the year; if this does occur, we'll notify you in writing 90 days before the change happens.

Prior Authorization for Prescription Drugs

The plan has a specific list of prescription drugs that must have prior authorization before you get them at a pharmacy. The list is on our website at students.lifewiseac.com. Your provider can ask for a prior authorization by faxing an accurately completed prior authorization form to us. This form is also on the pharmacy section of our website.

If you do not get prior authorization, when you go to the pharmacy to get your prescription, your pharmacy will tell you that you need it. You or your pharmacy should call your provider to let them know. Your provider can fax us an accurately completed prior authorization form for review.

The plan may cover a small supply of the drug to allow more time for the prior authorization. The cost-shares shown in ***Summary Of Your Costs*** will apply. In-Network pharmacies will find out if an emergency fill is covered for your drug. The authorized amount of the emergency fill will be no more than the prescribed amount, up to a seven-day supply or the minimum packaging size available at the time the emergency fill is dispensed. See the process for emergency fills on our website at students.lifewiseac.com.

If an emergency fill is not allowed for your drug, you can still buy the prescription drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowed amount. See ***How Do I file A Claim***.

Sometimes, benefits for some prescription drugs may be limited to one or more of the following:

- A set number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment.
- Certain drugs for a specific diagnosis
- Certain drugs from certain pharmacies, or you may need to get a prescription drug from an appropriate medical specialist or a specific provider
- Step therapy, meaning you must try a generic drug or a specified brand name drug first

These limits are based on medical standards, the drug maker's advice, and your specific case. They are also based on FDA guidelines and medical articles and papers.

Exceptions to Prior Authorization for Benefit Coverage

The following services do not require prior authorization for benefit coverage, but they have separate requirements:

- The first six visits provided by an in-network provider for rehabilitation and neurodevelopmental (habilitation) therapy, chiropractic adjustments or acupuncture.
- Emergency services and emergency hospital admissions, including emergency drug or alcohol detox in a hospital.
- Childbirth admission to a hospital, or admissions for newborns who need emergency medical care at birth.

Emergency and childbirth hospital admissions do not require prior authorization, but you must notify us as soon as reasonably possible.

Prior Authorization for Services from Out-of-Network Providers

This plan provides benefits for non-emergency services from out-of-network providers at a lower benefit level. You may receive benefits for these services at the in-network cost-share if the services are medically necessary and only available from an out-of-network provider. You or your provider may request a prior authorization for the in-network benefit before you see the out-of-network provider.

The prior authorization request must include the following:

- A statement that the out-of-network provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from a network provider.
- Any necessary medical records supporting the request.

If we approve the request, the services will be covered at the in-network cost-share. **However, in addition to the cost-shares, you may be required to pay any amounts over the allowed amount if the provider does not have a contracting agreement with us.**

Exceptions to Prior Authorization for Out-of-Network Providers

Out-of-network providers can be covered without prior authorization for emergency services and hospital admissions for a medical emergency. This includes hospital admissions for emergency drug or alcohol detox or for childbirth.

If you are admitted to an out-of-network hospital due to an emergency condition, those services are always covered. We will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital.

If you choose to stay in the out-of-network hospital after you are medically stable and can safely transfer to an in-network hospital, you may be subject to additional charges which may not be covered by your plan.

CLINICAL REVIEW

LifeWise has developed or adopted guidelines and medical policies that outline clinical criteria used to make medical necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria. Our medical policies are on our website. You or your provider may review them at students.lifewiseac.com. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain the information, please send your request to Care Management at the address or fax number shown on the back cover.

LifeWise reserves the right to deny payment for services that are not medically necessary or that are considered experimental/investigative. A decision by LifeWise following this review may be appealed in the manner described in ***Complaints and Appeals***.

In general, when there is more than one treatment option, the plan will cover the least costly option that will meet your medical needs. LifeWise works cooperatively with you and your physician to consider effective alternatives to hospital stays and other high-cost care to make better use of this plan's benefits.

PERSONAL HEALTH SUPPORT PROGRAMS

The personal health support programs are designed to help make sure your health care and treatment improve your health. You will receive individualized and integrated support based on your specific needs. These services could include working with you and your provider to ensure appropriate and cost-effective medical care, to consider effective alternatives to hospitalization, or to support both of you in managing chronic conditions.

Your participation in a treatment plan through our personal health support programs is voluntary. To learn more about the programs, contact Customer Service at the number listed on your ID card.

CONTINUITY OF CARE

How Continuity of Care Works: You may qualify for Continuity of Care (COC) under certain circumstances when a provider leaves your health plan's network or your group transitions to a new carrier. This will depend on your medical condition at the time the change occurs. COC is a process that provides you with short-term, temporary coverage at in-network levels for care received by a non-participating provider.

COC applies in these situations:

- The contract with your provider ends.
- The benefits covered for your provider change in a way that results in a loss of coverage.
- The contract between your group and us ends and that results in a loss of coverage of your provider.

How you qualify for Continuity of Care If a primary care provider contract is terminated without cause, continuing care will be provided according to the details included in the member's notice of the contract termination. During this time, LifeWise will consider the professional provider to still have an agreement only while this policy remains in effect and

- For the period that is the longest of the following:
  - The end of the current policy year
  - Until the end of the next open enrollment period, as required under state law
  - Up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment
  - Through completion of postpartum care, if the member is pregnant on the date of termination; or
  - Until the end of the medically necessary treatment for the medical condition if the member has a terminal medical condition. In this paragraph, "terminal" means a life expectancy of less than one year.

We will notify you at least 30 days prior to your provider's termination date. When a termination for cause provides us less than 30 days notice, we will make a good faith effort to assure that a written notice is provided to you immediately.

You can request continuity of care by contacting Customer Service. See ***How to Contact Us***.

If you are approved for continuity of care, you will get continuing care from the terminating provider until the earlier of the following:

- The 90th day after we notified you that your Primary Care Provider (PCP)'s contract ended
- The day after you complete the active course of treatment entitling you to continuity of care

If you are pregnant, and eligible for continuity of care, you can continue with your provider throughout your pregnancy, plus 8 weeks postpartum care

Continuity of care does not apply if your provider:

- No longer holds an active license
- Relocates out of the service area
- Goes on leave of absence
- Is unable to provide continuity of care because of other reasons
- Does not meet standards of quality of care

When continuity of care terminates, you may continue to receive services from this same provider, however, we will pay benefits at the out-of-network benefit level. See ***How Providers Affect Your Costs*** for more information. If we deny your request for continuity of care, you may request an appeal of the denial. See ***Complaints and Appeals***.

LEVELS OF CARE

Healthcare is delivered in many settings with distinct levels of care. Each level of care involves a different intensity of service to treat your medical and behavioral health symptoms. LifeWise covers the least intensive level of care that is medically necessary to treat your symptoms. Care is often provided in a continuum beginning with acute

care and transitioning to outpatient care as symptoms or condition improve. Please see LifeWise medical policies for Medical Necessity criteria for each type of care.

Acute Inpatient Level of Care

- Medical, surgical or behavioral health hospitals. See ***Definitions*** for Hospital or Inpatient.

Acute facilities provide treatment for severe episodes of Illness, Injury, or behavioral health symptoms, and for recovery from surgery. You are monitored for medical, surgical and psychiatric symptoms, with 24-hour availability of appropriate medical and psychiatric practitioners, and 24/7 onsite nursing services. Care may begin in the emergency room or an outpatient medical, surgical, or behavioral health setting with transition to an acute inpatient level of care to address your needs. Specialty-appropriate physicians, nurse practitioners, or physician assistants perform physical examinations or psychiatric evaluations within one day of hospital admission. Hospitals provide daily physical examination or psychiatric evaluation, daily nursing observation, and daily treatment during the stay. A plan for treatment and transition to lower levels of care is established shortly after admission. A brief hospital stay while on Observation is considered to be Outpatient care.

Acute care facilities are licensed by the applicable state health department as a hospital or as a behavioral health evaluation and treatment facility.

Intermediate Level Facilities

- Long-term Acute Care Hospitals (LTAC or LTACH)
- Inpatient Rehabilitation Hospitals or Units
- Skilled Nursing Facilities. See ***Definitions*** for Skilled Nursing Facility and Skilled Nursing Care.
- Residential Treatment Programs in residential treatment facilities or wilderness settings

Intermediate care facilities are a bridge between acute and outpatient care settings. They serve those who do not require the intensity of service that acute hospitals provide, but are not yet ready to step-down to outpatient care. Their purpose is to improve function and stabilize you for transition to outpatient services. Intermediate level facilities provide care for patients' medical needs as well as daily living support. Patients typically reside in the facility for the duration of their treatment.
Intermediate level care may be provided in a free-standing facility or in a segregated location within another facility. Wilderness programs providing behavioral health care in an outdoor setting and with the structure and intensity of a residential treatment program are also intermediate level care. Inpatient Hospice and facilities providing Custodial Care are not intermediate level facilities.

Intermediate care facilities are licensed by the applicable state health department as a healthcare or behavioral health facility. A program operating under another type of state licensure, such as a child-care license, is not an intermediate facility. Intermediate care facilities have the following characteristics:

- Onsite nursing at all times (or, for behavioral health programs, on-call nursing and onsite mental health practitioner)
- Admission evaluation or psychiatric assessment by an appropriately licensed provider by at least shortly after admission and at least weekly (every seven days) thereafter
- Daily treatment by appropriate licensed clinical providers
- A plan for treatment established shortly after admission
- Discharge planning for transition to lower levels of care

Please see LifeWise medical policies for Medical Necessity criteria for each type of care.

Intermediate Level Ambulatory or Outpatient Care

- Partial Hospitalization Programs for Psychiatric or Substance Use Disorder Treatment
- Intensive Outpatient Psychiatric or Substance Use Disorder Treatment Programs
- Home Health Care
- Residential Neurological Rehabilitation or Rehab Without Walls

Intermediate level outpatient programs provide intensive services to those who can function safely in a community-based setting but require a higher level of care than is provided in an outpatient office visit. Intermediate level outpatient programs may be provided by inpatient or intermediate level facilities however patients typically reside at their own homes and visit the facilities for treatment only. Some may offer programs where you can pay to reside within the facility while an outpatient level of care is provided when facility is away from your home.

Outpatient Care

- Hospital Observation
- Hospital Emergency Department
- Ambulatory Surgical Center or Outpatient Surgical Center
- Ambulatory or Outpatient Rehabilitation
- Urgent Care
- Office Visits

- Virtual Care

Outpatient care may be provided in hospital, surgical center, clinic, or office settings, or remotely through virtual care. Outpatient services are unstructured and provide maximum freedom.

COVERED SERVICES

This section talks about the benefits that are available with this plan and your costs.

Services of these benefits are available when they meet all of these requirements:

- It must be given in connection with prevention or diagnosis and treatment of a covered illness, disease or injury.
- The service takes place in a medically necessary setting. This plan covers inpatient care only when you cannot get the services in a less intensive setting.
- Must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan.
- It must be given by a provider who's performing services within the scope of their license or certification.
- It must meet the standards set in our medical and payment policies. The plan uses policies to administer the terms of the plan.
- Some types of services may be limited or excluded under this plan.

Related Benefit Information

- To learn more about terms like medical necessity and provider, see ***Definitions.***
- See ***Exclusions and Limitations*** for a complete description of limitations and exclusions.
- This plan complies with state and federal regulations about diabetes medical treatment coverage. See ***Preventive Care, Prescription Drugs, Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics,*** and ***Foot Care*** benefits.

Medical services must meet the standards set in our medical and payment policies. The plan has policies that are used to administer the terms of the plan. Our policies are available to you and your provider at students.lifewiseac.com or by calling Customer Service.

Medical policies define medical necessity criteria for a specific procedure, drugs, biologic agents, devices, level of care or services. They also identify medical services that are not covered because they are experimental and investigational. Medical policies may be developed by Lifewise or licensed from national organizations that create evidence-based utilization standards

Payment policies define provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS).

COMMON MEDICAL SERVICES

The services listed in this section are covered as shown in ***Summary of Your Costs***. See the summary for your copays, deductible, coinsurance, benefit limits and if out-of-network services are covered.

Office and Clinic Visits

This plan covers professional office, clinic and home visits, and real-time visits via online and telephonic methods (virtual care). The visits can be for examination, consultation and diagnosis of an illness or injury, including second opinions, for any covered medical diagnosis or treatment plan.

You may have to pay a separate copay or coinsurance for other services you get during a visit. This includes services such as x-rays, lab work, injectable drug therapies, facility fees and office surgeries.

Some outpatient services you get from a specialist must be authorized in writing before you get them. See ***Prior Authorization*** for details. See ***Urgent Care Centers*** for care provided in an office or clinic urgent care center. See ***Preventive Care*** for coverage of preventive services.

Preventive Care

Preventive care is a specific set of evidence-based services expected to prevent future illness. It is performed for routine screening purposes when you do not have signs or symptoms of a condition. These services are based on guidelines established by government agencies and professional medical societies.

Services are considered preventive when recommended or required by:

- United States Preventive Services Task Force (A or B rating)
- Centers for Disease Control and Prevention (immunizations)
- Health Resources and Services Administration (screenings and care for women, children, teens)
- Washington state law
- Washington State Department of health (immunizations)

Visit healthcare.gov for more information.

- Preventive services provided by in-network providers are covered in full. If you go out of network, cost shares may apply.
- Monitoring a chronic medical condition is not preventive care.
- Even at a preventive visit, you may get non-preventive care:
  - Providers can order a non-preventive test (even alongside preventive tests).
  - If you discuss a sign, symptom, or condition, you may be billed for a regular professional visit.
- If a test was ordered to evaluate a sign, symptom, or health concern, it is diagnostic***.***
- The maximum number of visits covered is recommended by the United States Preventive Services Task Force, Centers of Disease Control and Prevention, and Health Resources and Services Administration, as applicable.

The plan covers the following as preventive services:

- Wellness exams, including those for school, sports, and jobs.
- Diagnostic and supplemental breast exams
  - Diagnostic breast examination for the purpose of this ***Preventive Care*** benefit means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast magnetic resonance imaging, breast ultrasound, or pathology evaluations (including biopsies and consultations), or other services based on guidelines established by government agencies and professional medical societies that is used to evaluate an abnormality:
    - Seen or suspected from a screening examination for breast cancer; or
    - Detected by another means of examination.
  - Supplemental breast examination for the purpose of this ***Preventive Care*** benefit means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound, that is:
    - Used to screen for breast cancer when there is no abnormality seen or suspected; and
    - Based on personal or family medical history, or additional factors that may increase the member's risk of breast cancer.
- Screening tests and imaging, such as:
  - Mammograms (including 3-D)
  - Pap smears
  - Prostate-specific antigen tests
  - BRCA genetic tests for members at risk for certain breast cancers
  - Diabetes screening
  - Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
- Colon cancer screening (for high-risk individuals and all individuals 45 years of age or older):
  - Pre-colonoscopy consultation and exam
  - Barium enema
  - Colonoscopy, sigmoidoscopy, and fecal occult blood tests
  - If polyps are found during the screening, their removal and lab tests are covered as preventive.
  - Medically necessary anesthesia
  - Colonoscopies as follow-up to a positive non-invasive stool-based screening tests
- Contraceptives and tubal ligation:

- Contraceptive devices, shots, and implants, including anesthesia. This plan will cover up to 12-month supply of contraceptive drugs.
- Plan B (emergency contraceptive)
- Tubal ligation (other services, like anesthesia, are covered as preventive only if tubal ligation is the primary procedure)

- Routine maternity care:
  - Routine prenatal and postnatal exams and tests
  - Breastfeeding support and counseling
  - Standard breast pump (bought from approved suppliers)
    Call LifeWise Customer Service for a list of approved suppliers.
  - Rental of hospital-grade breast pump
- Outpatient nutritional counseling and therapy for obese adults and children, and members at risk for health conditions affected by diet.
- Immunizations, including seasonal and for travel.
- Pre-exposure prophylaxis (PrEP) for members at high-risk for HIV infection.
- Post-exposure prophylaxis (PEP)
- Health education and training:
  - Outpatient programs and classes to help you manage pain or cope with covered conditions like heart disease, diabetes, or asthma
  - The program or class must take place in an approved setting, like a hospital.
- Nicotine habit-breaking programs.

This benefit does not cover:

- Gym memberships/fees or exercise classes or programs.
- Exams for insurance or work-related disability purposes.

For vasectomy. See ***Surgery***.

If tubal ligation is a secondary procedure, it is still covered as preventive. However, related services like anesthesia are covered under the primary procedure. See ***Hospital*** and ***Surgery***.

For tests and services to evaluate a sign, symptom or health, see ***Diagnostic X-ray, Lab, and Imaging.***

See ***Prescription Drugs*** for take-home or over-the-counter items.

See ***Maternity and Newborn Care*** for routine newborn exams when the child is in the hospital after birth.

Diagnostic X-ray, Lab, and Imaging

- This plan covers diagnostic x-ray, lab, and imaging services are basic and major medical tests that help find or identify diseases. Some tests or imaging may require LifeWise's approval to be covered. See ***Prior Authorization***.
- A typical diagnostic test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge.
- Major diagnostic images and scans:
  - High technology ultrasound
  - MRI (Magnetic Resonance Imaging)
  - MRA (Magnetic Resonance Angiography)
  - CT scan (Computed Tomography)
  - PET scan (Positron Emission Tomography)
  - Nuclear Cardiology
- Basic diagnostic images and scans
- Preventive care screening and tests. See ***Preventive Care***.
- You may have additional costs for other services such as hospital facility charges. See those covered services for details.
- Facility charges are covered under ***Hospital***.
- See ***Emergency Services*** for diagnostic tests in an emergency room.
- See ***Maternity and Newborn Care*** for diagnostic tests on a fetus.

- See ***Preventive Care*** for routine screening of health status and other services covered as preventive.
- Genetic testing may be covered in some cases. Call Customer Service before seeking testing since it may require ***Prior Authorization***. When prescribed by an in-network provider, prior authorization is not required for biomarker testing for members with stage 3 or 4 cancer, or for members with recurrent, relapsed, refractory, or metastatic cancer.

This benefit does not cover:

- Treatment of infertility, including but not limited to surgery (other than in vivo fertilization, see ***Artificial Insemination***), fertility drugs, and other medications associated with fertility treatment.
- Non-diagnostic testing or screening required for employment, schooling, or public health reasons that is not for the purpose of treatment.

Pediatric Care

Pediatric services are covered until the end of the month of a member's 19th birthday, when all eligibility requirements are met. These services are covered as stated in the ***Summary of Your Costs***.

Pediatric Vision Services

Coverage for routine eye exams and glasses includes the following:

- Vision exams, including dilation and with refraction, by an ophthalmologist or an optometrist. A vision exam may consist of external and ophthalmoscopic examination, determination of the best corrected visual acuity, determination of the refractive state, gross visual fields, basic sensorimotor examination and glaucoma screening.
- Glasses, frames and lenses
- Contact lenses in lieu of lenses for glasses
- Contact lenses required for medical reasons
- Comprehensive low vision evaluation and follow up visits
- Low vision devices, high power spectacles, magnifiers and telescopes when medically necessary

This benefit does not cover:

- This plan does not cover routine adult vision exams to test visual acuity and/or to prescribe any type of vision hardware for members age 19 and older.
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics, treatment or surgeries to improve the refractive character of the cornea or results of such treatments.

Pediatric Dental Services

Pediatric dental services are covered as stated in ***Summary of Your Costs*** and ***Pediatric Dental Services***.

The covered services under this plan are classified as ***Class I – Diagnostic and Preventive Services***, ***Class II – Basic Services, and Class III – Major Services***. The lists of services that relate to each type are outlined in the following pages under ***Covered Services***. These services are covered once all of the following requirements are met. It is important to understand all of these requirements so you can make the most of your dental benefits.

This plan covers pediatric dental services if all of the following are true:

- They must be dentally or medically necessary. See ***Definitions.***
- They must be named in this plan as covered
- They must be furnished by a licensed dentist (DMD or DDS) or denturist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of their license or certification, as allowed by law.
- They must not be excluded from coverage under this benefit

At times we may need to review diagnostic materials such as dental x-rays to determine your available benefits. We will request these materials directly from your dental provider. If we're unable to obtain the necessary materials, we'll provide benefits only for those dental services we can verify as covered.

Dental Estimate of Benefits

You can ask for a ***Dental Estimate of Benefits*** before you receive dental services to ensure covered services are dentally appropriate. A Dental Estimate of Benefits verifies your eligibility and benefits of this plan for you and your provider. It may also clarify what is covered or not covered. This can protect you from unexpected out-of-pocket expenses.

A Dental Estimate of Benefits isn't required for you to receive your dental benefits. However, we suggest that your dental care provider submit a dental estimate to us for any proposed dental services in which you are concerned about your out-of-pocket expenses.

Our Dental Estimate of Benefits is not a guarantee of payment. Payment of any service will be based on your eligibility and benefits available at the time you received services. See ***How to Contact Us*** for the address and fax for a dental estimate of benefits or call Customer Service.

Alternative Benefits

To determine benefits available under this plan, we consider alternative procedures or services with different fees that are consistent with acceptable standards of dental practice. In all cases where there's an alternative course of treatment that's less costly, we'll only provide benefits for the treatment with the lesser fee. If you and your dental care provider choose a more costly treatment, you're responsible for additional charges beyond those for the less costly alternative treatment.

Dental Care Services for Congenital Anomalies

This plan covers dental services when impairment is related to or caused by a congenital disease or anomaly from the moment of birth for a child afflicted with a congenital disease or anomaly.

Dental care coverage includes the following:

Class I Services – Diagnostic and Preventive Services

- Routine comprehensive and periodic oral evaluations are limited to 2 visits per plan year. See definition of ***Comprehensive Oral Evaluation***.
- Limited oral evaluations – problem focused or emergent. See definition of ***Limited Oral Evaluation – Problem Focused.***
- Pre-diagnostic visual oral screenings or assessments. See definition of ***Visual Oral Screenings or Assessments***.
- Periodic and comprehensive oral examinations, limited to two per member per calendar year, beginning before one year of age
- X-rays include:
  - Complete series (full-mouth) x-ray
  - Panoramic films
  - Bitewing x-rays
  - Periapical x-rays
  - Occlusal intraoral x-rays
  - Cephalometric films
  - Photographic images (oral and facial)
- Prophylaxis (cleaning) is limited to 2 per plan year
- Fluoride treatment (including fluoride varnish)
- Oral hygiene instruction if not performed on the same day as prophylaxis (cleaning)
- Sealants
- Fixed space maintainers only when designed to preserve space for permanent teeth
  - Re-cement or re-bond space maintainers
  - Removal of fixed space maintainer
  - Replacement of space maintainers will be covered only when dentally necessary
- Diagnostic casts or study models

Class II – Basic Services

- Fillings, consisting of amalgam and resin-based composite on any tooth surface are limited to once every 24 months. Multiple restorations on any tooth surface will be considered one surface regardless of the number or combination of restorations.
- Prefabricated stainless steel crowns including those made with porcelain, ceramic or resin material are limited to once every 36 months on permanent or primary teeth
- Repair to bridge (fixed partial denture), complete and partial dentures is limited to once in a 12 month period of insertion
- Recement or rebond permanent crown, onlay, inlay, bridge or fixed partial denture
- Repair to crowns (indirect), only, inlay is limited to once per tooth
- Repair to complete and partial dentures is limited to once in a 12 month period
- Non-surgical periodontics include:
  - Full mouth debridement is limited to once per 3 years
  - Periodontal maintenance following periodontal therapy is limited to 4 per plan year
- Simple extractions
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- House/extended care facility call is limited to 2 per facility per day, when medically or dentally necessary
- Occlusal guard (nightguard) is covered for bruxism and other occlusal factors when dentally necessary
- Other oral Surgery related to the teeth and supporting structures in a dental office including:
  - Surgical extraction and removal of erupted or impacted tooth
  - Biopsy of oral tissue, hard or soft
  - Removal of odontogenic cyst or tumor
  - Alveoplasty
  - Vestibuloplasty
  - Frenuloplasty/frenulectomy
  - Residual root removal
- Endodontics Services include:
  - Direct pulp cap
  - Therapeutic pulpotomy
  - Pulpal debridement
  - Pulpal therapy (resorbable filling)
  - Pulp vitality tests
  - Endodontic treatment for root canals and retreatment of root canals, the service start date is the date the canal is opened. The service completion date is the date the canal is filled.
  - Endodontic retreatment includes the removal of post, pin, and old root canal filling material, and all procedures necessary to prepare the canal with placement of new filling material Endodontic retreatment provided by the original treating provider or clinic is subject to review for medical or dental necessity.
  - Apexification for apical closures is limited to anterior permanent teeth only.
  - Apicoectomy and retrograde filling
- Periodontal scaling and root planing is limited to once per quadrant every 24 months
- Surgical periodontics include:
  - Gingivectomy and gingivoplasty is limited to once every 3 years per quadrant
  - Osseous surgery including flap entry and closure, and mucogingival surgery
- Anesthesia in conjunction with covered services in a dental care provider's office includes:
  - General anesthesia, deep sedation or intravenous (conscious) sedation when necessary due to age, condition or degree of difficulty
  - Non-intravenous conscious sedation
  - Nitrous oxide is limited to once per day
- Local anesthesia and regional blocks are considered part of the global fee if billed with any covered service

Class III – Major Services

- Inlay, onlay, and crowns (indirect) are covered for anterior teeth only, and limited to once every five years when there is significant loss of clinical crown and no other dentally appropriate restoration will restore function. For inlay, onlays, and crowns the service start date is the preparation date. The completion date is the seat date.
- Crown build-ups including pins, and cast post and core
- Initial placement of bridges (fixed partial dentures). Replacement is limited to once every 7 years after the original was placed. For fixed partial bridgework the service start date is the preparation date. The completion date is the seat date.
- Initial placement of complete dentures, including overdentures is covered when the denture cannot be made serviceable by a less costly procedure. For dentures the service start date is the impression date. The completion date is the delivery date.
    - Includes six-months post-delivery care (e.g., adjustments, soft relines, and repairs) after placement.
    - Replacement of complete denture or overdenture is limited to 1 every 5 years after the original was placed.
- Initial placement of resin base partial dentures are covered when one or more anterior teeth are missing or four or more posterior teeth (excluding third molars) per arch and the remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis. For resin base partial dentures, the service start date is the impression date. The completion date is the delivery date.
    - Includes six-months post-delivery care (e.g. adjustments, soft relines, and repairs) after placement
    - Replacement of resin partials is limited to once every three years
- Denture rebase and reline is limited to once in a three year period when performed at least six-months after placement
- Denture adjustment, excluding six-months post-delivery care
- Dental implant crown and implant abutment related procedures are limited to 1 every 7 years. For implant supported crowns the service start date is the preparation date. The completion date is the seat date.
- Repair of implant supported prosthesis or abutment, limited to one per tooth
- Treatment of post-surgical complications such as dry socket by a dental provider
- Hospital call including emergency care limited to 1 per day, when dentally necessary
- Therapeutic parenteral/therapeutic drugs such as antibiotics, steroids, and anti-inflammatory medication administered in a dental office
- Medically Necessary Orthodontia Services for cleft lip and palate, cleft palate, cleft lip with alveolar process involvement or other craniofacial anomalies
- Services for congenital anomalies when impairment is related to or caused by congenital disease or anomaly from the moment of birth for a child afflicted with a congenital disease or anomaly.
- Behavior management (behavior guidance techniques used by dental provider)Medically necessary orthodontia services

This benefit includes braces and orthodontic retainer for specific malocclusions associated with:

- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement
- Craniofacial anomalies (Hemifacial Microsomia, Craniosynostosis syndromes, Arthrogryposis and Marfan syndrome)

Orthodontic services require prior authorization before services are received. See ***Prior Authorization*** for details. To request a prior authorization, please contact Customer Service.

This benefit does not cover:

- Application of any type of desensitizing medicament
- Cast-metal framework, flexible base, and removable unilateral partial dentures
- Cleaning of appliances
- Connector bar or stress breaker

- Coping
- Diagnostic tests and examinations including collection, preparation, analysis, viral culture, genetic and caries susceptibility tests, and adjunctive pre-diagnostic tests.
- Diagnostic tomographic surveys, cone beam, MRI, ultrasound, 3-D imaging, and posterior-anterior or lateral skull and facial bone survey films
- Duplicate appliances
- Duplicate x-rays
- Extra dentures or other duplicate appliances, including replacements due to loss or theft
- Fabrication of an athletic mouthguard
- Facility charges (hospital and ambulatory surgical center) for dental procedures
- Gold foil restorations
- Home use products. Services and supplies that are normally intended for home use such as take-home fluoride, toothbrushes, floss and toothpaste
- Immediate dentures
- Implants and implant related services including but not limited to:
  - Surgical placement of implants including endosteal, eposteal, and transosteal;
  - Interim endosseous implants;
  - Endodontic endosseous implants;
  - Sinus augmentations or lift;
  - Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
  - Radiographic/surgical implant index;
  - Unspecified implant procedures.
- Indirect pulp caps
- Labial veneers
- Localized delivery of antimicrobial agents
- Medication and supply such as take-home drugs, pre-medications, therapeutic drug injections and supplies
- Occlusion analysis and limited and complete occlusal adjustments
- Oral pathology laboratory including collection of tissue samples, cultures and specimens
- Oral surgery treating fracture of the mandible (jaw)
- Pin retention in addition to restoration
- Plaque control programs (dietary instruction and home fluoride kits)
- Precision attachments, replacement of replaceable parts for semi-precision or precision attachments and personalization of appliances
- Provisional Splinting
- Sedative fillings
- Surgical procedures including:
  - Exfoliative cytology sample collection or brush biopsy
  - Radical resection of maxilla or mandible
  - Removal of non-odontogenic cyst, tumor or lesion
  - Surgical stent
  - Surgical procedures for isolation of a tooth with rubber dam
- Temporary, interim or provisional services for crowns, bridges or dentures
- Tobacco cessation and nutritional counseling for control of dental disease
- Tooth preparation, acid etching, all adhesives, and liners
- Tooth transplantation including re-implantation from one site to another and splinting and/or stabilization

Prescription Drugs

This benefit covers prescription drugs that are approved by the U.S. Food and Drug Administration (FDA) that your provider prescribes, and you get from a licensed pharmacy.

This plan uses a formulary drug list shown in ***Summary of Your Costs***.

Some prescription drugs, and compounded medications equal to or greater than $200 per claim, require prior authorization. Compounded medications are made by a licensed pharmacist who combines, mixes, or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. See ***Prior Authorization*** for details.

Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by one of the following:

- One of the following standard reference compendia:
  - The American Hospital Formulary Service-Drug Information
  - The American Medical Association Drug Evaluation
  - The United States Pharmacopoeia-Drug Information
  - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts)
- The Federal Secretary of Health and Human Services

"Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

Benefits aren't available for any drug when the US Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigative drugs not otherwise approved for any indication by the FDA.

A covered drug you may be taking can change to a different cost sharing tier or become not covered. This can happen at any time throughout the year, if this does occur, we'll notify you in writing 60 days before the change happens.

Formulary Drug List

This benefit uses a specific list of covered prescription drugs, sometimes referred to as a "formulary drug list." Our Pharmacy and Therapeutics Committee, which includes medical providers and pharmacists from the community, frequently reviews current medical studies and pharmaceutical information. The Committee makes recommendations on which drugs are included on our formulary drug lists. The formulary drug lists are updated quarterly based on the Committee's recommendations.

The formulary drug list includes both generic and brand name drugs. Consult the List of Covered Drugs (formulary drug list) on our website or contact Customer Service for a complete list of your plan's covered prescription drugs.

Drugs not included in the drug list (non-formulary drugs) are not covered by this plan.

Generic Drug Substitution

This plan requires the use of appropriate generic drugs (as defined below). When available, a generic drug will be dispensed in place of a brand name drug. If there is no generic equivalent, you pay only the applicable brand name cost-share. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, you will have to pay the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost-share. Please ask your pharmacist about the higher costs you will pay if you select a brand name drug.

A "generic drug" is a prescription drug manufactured and distributed after the brand name drug patent of the innovator company has expired. Generic drugs have an AB rating from the U.S. Food and Drug

Administration (FDA). The FDA considers them to be therapeutically equivalent to the brand name product. For the purposes of this plan, classification of a particular drug as a generic is based on generic product availability and cost as compared to the reference brand name drug.

This benefit also covers "biological products." Examples are serums and antitoxins. Generic drug substitution applies to biological products.

Exceptions You or your provider may ask that the plan cover a brand name drug instead of a generic equivalent without a penalty. To waive the penalty, your provider must show that 1 of 3 things is true:

- You cannot tolerate the generic equivalent drug
- The drug is not safe or effective for your condition
- The dosage you need is not available in a generic equivalent drug
- If your request is approved, you pay only the applicable brand name cost-share. If your request is not approved and you choose to purchase the brand name drug, you will pay the penalty described under ***Generic Drug Substitution*** section

Exceptions Request for Non-Formulary Drugs

You or your provider may request that you get a non-formulary drug or a dose that is not on the formulary drug list either in writing, electronically, or by telephone. Under some circumstances, such as the ones listed below, a non-formulary drug may be covered if one of the following is true:

- There is no formulary drug or alternative available
- You cannot tolerate the formulary drug
- The formulary, drug or dose is not safe or effective for your condition

Your provider must give us a written or oral statement providing a justification in support of the need for the non-formulary drug to treat your condition, including a statement that all formulary drugs on any tier will be (or have been) ineffective, and would not be as effective as the non-formulary drug, or would have adverse side effects. We will review your request and let you or your provider know within 72 hours in writing if it is approved. If approved, your cost will be as shown on the ***Summary of Your Costs*** for formulary generic and brand name drugs and will be covered for the length of time outlined in the approval letter. If your request is not approved, the non-formulary drug will not be covered.

Expedited Exceptions Request for Non-Formulary Drugs

If exigent circumstances exist, you or your provider may request an expedited review for a non-formulary drug or a dose that is not on the formulary drug list. Exigent circumstances include when you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum body function or when you are undergoing a current course of treatment using a non-formulary drug. In addition to your provider's justification for the non-formulary drug as described above, your provider will need to give us an oral or written statement that confirms that an exigency exists, including the basis for the exigency--the harm that could reasonably come to you if the requested non-formulary drug was not provided within the timeframes of the standard exceptions request. We will review your request and let you or your provider know within 24 hours in writing if it is approved. If approved, your cost will be as shown on the ***Summary of Your Costs*** for formulary generic and brand name drugs and will be covered for the duration of the prescription. If your request is not approved, the drug will not be covered.

External Review for Non-Formulary Drugs

If you disagree with our decision you may ask for an appeal additional review through the plan's complaint and appeals process, we will let you and your provider know the decision within 72 hours (24 hours in the case of an expedited review). See ***Complaints and Appeals*** for details.

Covered Prescription Drugs

- FDA approved formulary drugs. Federal law requires a prescription for these drugs. They are known as "legend drugs."
- All FDA-approved HIV antiviral drugs required to be covered by state or federal law

- FDA-approved prescription hormone therapy (does not include glucagon-like peptide-1 and glucagon-like peptide-1 receptor agonists); up to 12-month refill supply of prescription hormone therapy that can be safely stored at room temperature
- Glucagon and allergy emergency kits
- Inhalers, supplies and peak flow meters
- Some drugs that treat complex or rare health conditions may only available at specialty pharmacies.
- Prescribed preventive drugs required by the Affordable Care Act
- Compound drugs when the main drug ingredient is a covered prescription drug
- Certain prescription and generic over-the-counter drugs to break a nicotine habit
- Drugs associated with an emergency medical condition (including drugs from a foreign country)
- Epinephrine autoinjectors
- Prescribed epinephrine autoinjectors for the treatment of allergic reaction. (Your cost shares for at least one covered epinephrine autoinjector product containing at least two autoinjectors will not exceed $35, not subject to the deductible. Cost shares for covered prescription epinephrine autoinjectors apply towards the deductible.)

Asthma Inhalers

- Prescribed asthma inhalers for the treatment of asthma. (Your cost shares for covered prescription asthma inhalers for at least one covered inhaled corticosteroid and at least one covered inhaled corticosteroid combination that is FDA approved for the treatment of asthma will not exceed $35 per 30-day supply of the drug, not subject to the deductible. Cost shares for covered prescription asthma inhalers apply towards the deductible.)

Pharmacy Management

Sometimes benefits for prescription drugs may be limited to one or more of the following:

- A specific number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment
- Certain drugs for a specific diagnosis
- Certain drugs from certain pharmacies, or you may need to get prescriptions from an appropriate medical specialist or a specific provider
- Step therapy, meaning you must try a generic drug or a specified brand name drug first
- Drug synchronization, meaning the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period. Cost-shares are adjusted if the fill is less than the standard refill amount in compliance with state law.

These limitations are based on medical criteria, the drug maker's recommendations, and the circumstances of the individual case. They are also based on US Food and Drug Administration guidelines, published medical literature and standard medical references.

Specialty Pharmacy Programs

The Specialty Pharmacy Program includes drugs that are used to treat complex or rare conditions. These drugs need special handling, storage, administration, or patient monitoring. This plan covers these drugs as shown in ***Summary of Your Costs***.

Specialty drugs are high-cost often self-administered drugs. They are used to treat conditions such as rheumatoid arthritis, hepatitis, multiple sclerosis or growth disorders (excluding idiopathic short stature without growth hormone deficiency).

Visit the pharmacy section of our website at student.lifewiseac.com. or call Customer Service for more information.

Drug Discount Card Program

In some cases, you may pay less for covered drugs than what's shown in the ***Summary of Your Costs*** if our pharmacy program finds a discount or coupon resulting in a lower drug price.

Dispensing Limits

Benefits are limited to a certain number of days' supply as shown in ***Summary of Your Costs***. Sometimes a drug maker's packaging may affect the supply in some other way. We will cover a supply greater than normally allowed under your plan if the packaging does not allow a lesser amount. Exceptions to this limit may be allowed as required by law. For example, a pharmacist can authorize an early refill of a prescription for topical ophthalmic products in certain circumstances. You must pay a copay for each limited days' supply.

Preventive Drugs

Benefits for certain preventive care prescription drugs will be as shown in ***Summary of Your Costs*** when received from network pharmacies. Contact Customer Service or visit our website to inquire about whether a drug is on our preventive care list.

You can get a list of covered preventive drugs by calling Customer Service. You can also get this by going to the preventive care list on our website at students.lifewiseac.com.

Using In-network Pharmacies

When you use an in-network pharmacy, always show your LifeWise ID Card. As a member, you will not be charged more than the allowed amount for each prescription or refill. The pharmacy will also submit your claims to us. You only have to pay the deductible, copay or coinsurance as shown in ***Summary of Your Costs***.

If you do not show your LifeWise ID Card, you will be charged the full retail cost. Then you must send us your claim for reimbursement. Reimbursement is based on the allowed amount. See ***How Do I File A Claim***.

Diabetic Drugs and Supplies

Prescribed drugs for shots that you give yourself, such as insulin. (Your cost shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug, not subject to the deductible. Cost shares for covered prescription insulin drugs apply towards the deductible.)

When injectable diabetic drug needles and syringes are purchased separately, the deductible and applicable cost-share applies to all items. The deductible and applicable cost-share also applies to purchases of alcohol swabs, test strips, testing agents, blood glucose monitors and lancets.

When injectable diabetic drug needles and syringes are purchased along with injectable diabetic drugs, the needles and syringes are covered in full.

Oral Anticancer Drugs

Drugs you take by mouth that can be used to kill cancer cells or slow their growth. This benefit only covers the drugs that you get from a pharmacy.

Contraceptives

- All FDA-approved prescription and over-the-counter oral contraceptive drugs, supplies, and devices, including emergency contraceptives that are required to be covered by state or federal law. You must buy over-the-counter supplies and devices at the pharmacy counter.
- Can receive up to a 12-month supply for contraceptive drugs.
- For details on how to submit a pharmacy claim, see ***How Do I File a Claim.***

Human Growth Hormone

Human growth hormone is covered only for medical conditions that affect growth. It is not covered when the cause of short stature is unknown. Human growth hormone is a specialty drug.

This benefit does not cover:

- Drugs and medicines that you can legally buy over the counter (OTC) without a prescription. OTC drugs are not covered even if you have a prescription. Examples include, but are not limited to, nonprescription drugs and vitamins, herbal or naturopathic medicines, and nutritional and dietary supplements such as infant formulas or protein supplements. This exclusion does not apply to OTC drugs that are required to be covered by state or federal law.
- Drugs for cosmetic use such as for wrinkles.
- Drugs used to improve your looks, such as drugs to increase hair growth or alter the appearance of your skin.
- For blood or blood derivatives coverage see ***Blood Products and Services.***
- Any prescription refill beyond the number of refills shown on the prescription or any refill after one year from the original prescription.
- Replacement of lost or stolen drugs.
- Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and healthcare provider administered injectable medications, unless included in the formulary drug list. See ***Infusion Therapy and Injectable Drug Therapies*** for covered infusion therapy services.
- Drugs dispensed for use in a healthcare facility or provider's office, unless included in the formulary drug list.
- Immunizations. See ***Preventive Care***.
- Drugs to enhance fertility or to treat sexual dysfunction.
- Weight loss drugs or supplements for weight loss or weight control.
- Therapeutic devices or appliances. See ***Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics***.

Your Right to Safe and Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call Customer Service. The phone numbers are shown on the back cover.

If you want to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

Questions and Answers about Your Prescription Drug Benefits

1. **Does this plan exclude certain drugs my health care provider may prescribe, or encourage substitution for some drugs?**

   Your prescription drug benefit uses a "formulary drug list." We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the formulary drug list. This plan doesn't cover certain categories of drugs. These are listed above**.** Non-formulary drugs may be covered only on an exception basis for members meeting medical necessity criteria.

   Certain formulary drugs are subject to prior authorization. As part of this review, some prescriptions may require additional medical information from the prescribing provider, or substitution of equivalent drug.

   See ***Prior Authorization*** for details.

2. **When can my plan change the formulary drug list? If a change occurs, will I have to pay more to use a drug I had been using?**

   The formulary drug list is updated frequently throughout the year. See ***Formulary Drug List*** above. If changes are made to the formulary drug list that may negatively impact your cost share , you will receive a letter advising you of the change.

3. **What should I do if I want a change from limitations, exclusions, substitutions or cost increases for**

drugs specified in this plan?

The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can't be changed. Provisions regarding substitution of some drugs are described above in question 1.

You can appeal any decision you disagree with. See ***Complaints and Appeals***, or call Customer Service at the telephone numbers listed on the back cover for information on how to initiate an appeal.

4. How much do I have to pay to get a prescription filled?

The amount you pay for covered drugs dispensed by a retail pharmacy or specialty pharmacy is described in the ***Summary of Your Costs***.

5. Do I have to use certain pharmacies to pay the least out of my own pocket under this plan?

Yes. You only receive benefits when you have your prescriptions filled by participating pharmacies. The majority of pharmacies in Washington are part of our pharmacy network.

You can find a participating pharmacy near you by consulting your provider directory, or calling the Pharmacy Locator Line at the toll-free telephone number found on the back of your LifeWise ID card.

6. How many days' supply of most medications can I get without paying another copay or other repeating charge?

The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies are described in the "Dispensing Limit" provision above.

Benefits for refills will be provided only when the member has used a specific amount of a supply of a single medication. This is known as a refill threshold. This threshold is calculated based on both of the following:

- The number of units and days' supply dispensed on the last refill
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill

The refill threshold may vary by the type of medication.

7. What other pharmacy services does my health plan cover?

This benefit is limited to covered prescription drugs and specified supplies and devices dispensed by a licensed participating pharmacy. Other services, such as diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this booklet.

Surgery

This plan covers inpatient and outpatient surgical services at a hospital or ambulatory surgical center, surgical suite or provider's office. Some outpatient surgeries must be authorized in writing before you have them. See ***Prior Authorization*** for details.

This benefit covers:

- Surgical services, including injections, when performed on an inpatient or outpatient basis
- Anesthesia or sedation
- Medically necessary postoperative care
- Correction of functional disorders
- Cornea transplantation, skin grafts, and repair of a dependent child's congenital anomaly.
- Cochlear implants
- Blood transfusion, including blood derivatives. Storage is covered only when medically necessary.
- Medically necessary surgery to correct the cause of infertility. This doesn't include assisted reproduction techniques (other than in vivo fertilization, see ***Artificial Insemination***) or sterilization reversal.

- Biopsies and scope insertion procedures such as endoscopies
- Diagnostic colonoscopy and sigmoidoscopy services not covered under ***Preventive Care***.
- Reconstructive surgery that is needed because of an injury, infection or other illness.
- Sexual reassignment surgery if medically necessary. See ***Gender Affirming Care*** for details.
- Vasectomy

This benefit does not cover:

- Removal of excess skin or fat related to either weight loss surgery or the use of drugs for weight loss.
- Breast reconstruction. See ***Mastectomy and Breast Reconstruction*** for those covered services.
- The use of an anesthesiologist for monitoring and administering general anesthesia for colon health screenings unless medically necessary when specific medical conditions and risk factors are present.
- Transplant services. See ***Transplants*** for details.
- Cosmetic surgery
- See ***Artificial Insemination*** for in vivo fertilization.

Emergency Services

This benefit covers:

- Emergency room and doctor services.
- Equipment, supplies and drugs used in the emergency room.
- Services and exams used for stabilizing an emergency medical condition, including mental health, or substance use disorder. This includes emergency services arising from complications from a service that was not covered by the plan.
- Diagnostic tests performed with other emergency services.
- Emergency detoxification

You need to let us know if you are admitted to the hospital from the emergency room as soon as possible. See ***Prior Authorization*** for details.

Ambulance Services

This plan covers emergency ambulance services to the nearest facility that can treat your condition. The medical care you get during the trip is also covered. These services are covered only when any other type of transport would put your health or safety at risk. Covered services also include transport from one medical facility to another as needed for your condition. Transportation to your home is covered when medically necessary.

This plan covers ground and air ambulance services from licensed providers only and only for the member who needs transport. Payment for covered services will be paid to the ambulance provider or to both the ambulance provider and you.

Air or sea emergency transportation is only covered when all the above requirements for ambulance services are met and:

- Transport takes you to the nearest available facility that can treat your condition.
- Geographic restraints prevent use of a ground transport.
- Ground emergency transportation would put your health or safety at risk

Ground ambulance services means:

- The rendering of medical treatment and care at the scene of a medical emergency or while transporting a member to an appropriate emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose; and
- Ground ambulance transport between emergency services providers, emergency services providers and medical facilities, and between medical facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose.

Prior authorization is required for non-emergency ambulance services. See ***Prior Authorization*** for details.

Urgent Care Centers

This plan covers care you get in an urgent care center and supplies. Urgent care centers have extended hours and are open to the public. You can go to an urgent care center for an illness or injury that needs treatment right away. Examples are minor sprains, cuts and ear, nose and throat infections. Covered services include the doctor's services.

You may have to pay a separate copay or coinsurance for other services you get during a visit. This includes things such as x-rays, lab work, injectable drug therapies and office surgeries. See those covered services for details.

If an urgent care visit is provided in a center located in a hospital, benefits may also be subject to the plan year or quarter deductible and coinsurance for related to facility fees charged by the hospital.

Hospital

This benefit covers:

- Inpatient room and board
- Providers services
- Intensive care or special care units
- Operating rooms, procedure rooms and recovery rooms.
- Surgical supplies and anesthesia
- Drugs, blood, medical equipment and oxygen for use in the hospital.
- X-ray, lab and testing billed by the hospital

Even though you stay at an in-network hospital, you may get care from doctors or other providers who do not have a network contract at all. In that case, you will not have to pay any amounts over the allowed amount for covered services.

You pay out-of-network cost-shares if you get care from a provider not in your network. You will not be balanced billed for certain services provided by a non-participating provider. See ***How Providers Affect Your Costs*** for details.

We must approve all planned inpatient stays before you enter the hospital. See ***Prior Authorization*** for details.

This benefit does not cover:

- Hospital stays that are only for testing, unless the tests cannot be done without inpatient hospital facilities, or your condition makes inpatient care medically necessary
- Any days of inpatient care beyond what is medically necessary to treat the condition

The following facilities are not considered hospitals if it operates mainly for any of the purposes below:

- Rest, nursing, or convalescent homes
- Residential treatment centers
- Health resorts
- Facilities that provide hospice care for terminally ill patients
- Homes for the care of the elderly
- Facilities to treat and rehabilitate patients with alcohol or drug addictions (substance use disorder)
- Facilities that treat patients with tuberculosis

Mental Health Care, Behavioral Health, and Substance Use Disorder

This plan covers mental health care and treatment for substance use disorder. This plan will also cover alcohol and drug services from a state-approved treatment program. This plan will comply with federal mental health parity requirements. Please call Customer Service for help in finding a physician approved to provide these services.

Some services require prior authorization. See ***Prior Authorization*** for details.

Mental Health Care

This benefit covers:

- Inpatient, residential treatment and outpatient care (including virtual care) to manage or reduce the effects of the mental condition
- Individual or group therapy
- Family therapy
- Lab and testing
- Take-home drugs you get in a facility

In this benefit, outpatient visit means a clinical treatment session with a mental health provider.

Behavioral Health (also called "Applied Behavioral Analysis (ABA) Therapy")

This plan covers applied behavioral analysis (ABA) therapy. The member must be diagnosed with one of the following disorders:

- Autistic disorder
- Autism spectrum disorder
- Asperger's disorder
- Childhood disintegrative disorder
- Pervasive developmental disorder
- Rett's disorder

Covered ABA therapy includes treatment or direct therapy for identified members and/or family members. Also covered are an initial evaluation and assessment, treatment review and planning, supervision of therapy assistants, and communication and coordination with other providers or school staff as needed. Delivery of all ABA services for a member may be managed by a Board-Certified Behavior Analyst (BCBA) or one of the licensed providers below, who is called a Program Manager. Covered ABA services are limited to activities that are considered to be behavior assessments or interventions using applied behavioral analysis techniques. ABA therapy must be provided by:

- A licensed physician (MD or DO) who is a psychiatrist, developmental pediatrician or pediatric neurologist
- A licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
- A licensed occupational or speech therapist
- A licensed psychologist (Ph.D.)
- A licensed community mental health agency or behavioral health agency that is also state-certified to provide ABA therapy.
- A Board-Certified Behavior Analyst (BCBA). This means a provider who is state-licensed if the State licenses behavior analysts and if not, who is certified by the Behavior Analyst Certification Board. BCBAs are only covered for ABA therapy that is within the scope of their license or board certification.
- A therapy assistant/behavioral technician/paraprofessional, when their services are supervised and billed by a licensed provider or a BCBA.

The Mental Health, Behavioral Health, and Substance Use Disorder benefit does not cover:

- Tests that are not used to assess a covered mental or substance use disorder condition or to plan treatment. This plan does not cover tests to decide legal competence or for school or job placement.
- Halfway houses, quarterway houses, recovery houses and other sober living residences

Substance Use Disorder (also called "Chemical Dependency")

This benefit covers:

- Inpatient and residential treatment and outpatient care (including virtual care) to manage or reduce the effects of the alcohol or drug dependence

- Individual, family or group therapy
- Lab and testing
- Take-home drugs you get in a facility

To be covered, mental health care, behavioral health, and substance use disorder treatment must be provided by:

- A physician (MD or DO) who is a psychiatrist, developmental pediatrician, or pediatric neurologist
- A hospital
- A state hospital maintained by the state of Washington for the care of the mentally ill.
- A state-licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
- A state-licensed mental health clinician (e.g., licensed clinical social worker, licensed marriage and family counselor, licensed mental health counselor)
- A state-licensed occupational or speech therapist
- A state-licensed psychologist
- A state-licensed community mental health agency or behavioral health agency
- Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care.

Maternity and Newborn Care

This plan covers health care providers and facility charges for prenatal care, delivery and postnatal care. Hospital stays for maternity and newborn care less than 48 hours for a vaginal delivery or less than 96 hours following a cesarean section do not require prior authorization. A length of stay that will be longer than these limits must be authorized in writing. See ***Prior Authorization*** for details.

Newborn children are covered automatically for the first 3 weeks from birth when the member is eligible to receive obstetrical care benefits under this plan.

To continue benefits beyond the 3-week period see the dependent eligibility and enrollment guidelines outlined under ***Eligibility and Enrollment***.

Please also see ***Preventive Care*** for services like post-partum depression screening and diabetes screening.

This benefit covers:

- Home birth services, including associated supplies, provided by a licensed health care provider who is working within their license and scope of practice
- Nursery services and supplies for newborn
- Genetic testing of the child's father is covered
- Abortion
- Donor human milk
- For routine prenatal and postnatal exams and tests (including in utero care), see ***Preventive Care***.

This benefit does not cover:

- Outpatient x-ray, lab and imaging. These services are covered under ***Diagnostic X-ray, Lab and Imaging***.
- Home birth services provided by family members or volunteers
- Assisted reproduction technologies such as:
  - Artificial insemination (other than in vivo fertilization, see ***Artificial Insemination***) or in vitro fertilization
  - Services to make you more fertile or for multiple births
- Reversing sterilization surgery

AT HOME CARE

This section will go over the two main types of at-home care:

- Home health care (which is occasional and short-term)
- Skilled hourly nursing (which is intensive and continual care)

Home Health Care

Home health care is occasional visits by a medical professional employed by a home health agency that is state-licensed or Medicare-certified. This short-term care is designed to help a patient prevent or recover from an illness, injury, or hospital stay.

Home health care provided by licensed home health, hospice and home care agencies may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is medically necessary and home health care:

- Can be provided at equal or lesser cost;
- Is the most appropriate and cost-effective setting; and
- Is substituted with the consent of the member and upon the recommendation of the member's doctor or licensed provider which will adequately meet the member's needs.

The decision to substitute less expensive or less intensive services shall be made based on the medical needs of the member. We may require a written treatment plan that has been approved by the member's doctor or licensed provider. Substituted home health care benefits available for hospital care or other inpatient care services are covered as stated in the ***Summary of Your Costs***.

- Some services require prior approval. See ***Prior Authorization*** for details.
- See ***Prescription Drugs*** related to medications.

The following are covered under the Home Health Care benefit:

- Home medical equipment, supplies, and devices billed as part of the home visit.
- Prescription drugs given by the home health agency.
- Physical, occupational, or speech therapy to help regain function.

When provided by a home health agency, the following are covered:

- A registered nurse
- A licensed practical nurse
- A licensed physical or occupational therapist
- A certified speech therapist
- A certified respiratory therapist
- A home health aide directly supervised by one of the above listed providers
- A licensed social worker

Skilled Hourly Nursing

Skilled hourly nursing is continuous, daily care for homebound patients with oversight by a home health agency. This longer-term care is designed to help patients with a chronic illness, injury, or disability.

- This benefit is only covered when it's an alternative to hospitalization.
- Prior authorization is required.
- A written plan of care from your provider is required.

Benefits are provided by a registered nurse or licensed practitioner when:

- The patient is homebound,
- Services are medically necessary, and
- Such care is prescribed by a physician.

The Home Health Care and Skilled Hourly Nursing benefits do not cover:

- Over-the-counter drugs, solutions, nutritional supplements
- Non-medical services, like housekeeping
- Services that bring you food, such as Meals on Wheels, or advice about food
- The independent hiring of a nurse by a family or member to provide care without oversight by a home health agency.
- Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family or member to provide care without oversight by a home health agency. The care may be skilled, supportive or respite in nature.

Hospice Care

A hospice care program must be provided in a hospice facility or in your home by a hospice care agency or program. Hospice care benefits may be provided, with your consent, when medically appropriate as an alternative to inpatient or institutional care.

This benefit covers:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a medical social worker who is working under the direction of a physician; this may include counseling for the purpose of helping you and your caregivers to adjust to the approaching death
- Services provided by a qualified provider associated with the hospice program
- Short term inpatient care provided in a hospice inpatient unit or other designated hospice bed in a hospital or skilled nursing facility; this care may be for the purpose of occasional respite for your caregivers, or for pain control and symptom management
- Home medical equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness
- Home health aide services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services provided by family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Non-medical services, such as spiritual, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services

Rehabilitation and Neurodevelopmental (Habilitation)Therapy

This plan covers rehabilitation and neurodevelopmental (habilitation) therapy. Services must be provided by a licensed physical therapist, occupational therapist, speech language pathologist or any other licensed practicing within the scope of their license. Services must be prescribed in writing by your provider. The prescription must include site, type of therapy, how long and how often you should get the treatment.

Rehabilitation therapy is therapy that helps a person restore or improve a skill needed to perform an activity of daily living that was lost because of an accidental injury, illness or surgery.

Neurodevelopmental (habilitation) therapy is therapy that helps a person acquire, improve, or maintain age-appropriate skills that have not yet developed. Examples are therapy for a child who isn't walking or talking at the

expected age. These services may include physical and occupational therapy, speech-language pathology, aural (hearing) therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings, including school-based settings.

See ***Mental Health Care, Behavioral Health, and Substance Use Disorder*** for therapies provided for mental health conditions such as autism.

Day limits listed in the ***Summary of Your Costs*** and prior authorization requirements stated below under outpatient care do not apply to cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or disease.

Inpatient Care

You can get inpatient care in a specialized rehabilitative unit of a hospital. If you are already inpatient, this benefit will start when your care becomes mainly rehabilitative.

You must get prior authorization from us before you get inpatient treatment. See ***Prior Authorization*** for details.

This plan covers inpatient rehabilitative therapy only when it meets these conditions:

- You cannot get these services in a less intensive setting
- Services must be prescribed in writing by your provider

Outpatient Care

This plan covers rehabilitative and habilitative therapy received in an outpatient setting. Certain therapies require prior authorization for services beyond the first six visits per episode of care. An “episode of care” is treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous ninety days and is not currently undergoing any active treatment. Initial evaluations do not count toward the six-visit limit.

This benefit covers:

- Physical, speech, hearing and occupational therapies
- Chronic pain care
- Cardiac and pulmonary therapy
- Cochlear implants
- Home medical equipment, medical supplies and devices

This benefit does not cover:

- Recreational, vocational or educational therapy
- Exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that the ill, injured or impaired member does not actively take part in
- Gym or swim therapy
- Custodial care

Skilled Nursing Facility and Care

This plan covers skilled nursing facility services. Covered services include room and board for a semi-private room, plus services, supplies and drugs you get while confined in a skilled nursing facility. Sometimes a member goes from acute nursing care to skilled nursing care without leaving the hospital. When that happens, this benefit starts on the day that the care becomes primarily skilled nursing care.

Skilled nursing care is covered only during certain stages of recovery. It must be a time when inpatient hospital care is no longer medically necessary, but care in a skilled nursing care facility is medically necessary. Your doctor must actively supervise your care while you are in the skilled nursing facility.

We cover skilled nursing care provided following hospitalization at the long-term care facility where you were residing immediately prior to your hospitalization when your primary care provider determines that the medical care you need can be provided at that facility, and that facility satisfies our standards, terms and conditions for long-term care facilities, accepts our rates, and has all applicable licenses and certifications.

You must get prior authorization from us before you get treatment. See ***Prior Authorization*** and ***Definitions*** for details.

Home Medical Equipment (HME) Supplies, Devices, Prosthetics and Orthotics

Services must be prescribed by your provider. Not all supplies, devices or HME are a covered service and are subject to the terms and conditions as described in this plan. Documentation must be provided which includes; the prescription stating the diagnosis, the reason the service is required and an estimate of the duration of its need. For this benefit, this includes services such as prosthetic and orthotic devices, oxygen and oxygen supplies, diabetic supplies, wheelchairs and treatment of inborn errors of metabolism.

Prior Authorization is required for some medical supplies/devices, home medical equipment, prosthetics and orthotics. See ***Prior Authorization***.

Home Medical Equipment (HME)

This plan covers rental of medical and respiratory equipment (including fitting expenses), not to exceed the purchase price, when medically necessary and prescribed by a provider for therapeutic use in direct treatment of a covered illness or injury. Benefits may also be provided for the initial purchase of equipment, in lieu of rental. In cases where an alternative type of equipment is less costly and serves the same medical purpose. We will provide benefits only up to the lesser amount. Repair or replacement of medical or respiratory equipment medically necessary due to normal use or growth of a child is covered.

Medical and respiratory equipment includes, but is not limited to, wheelchairs, hospital-type beds, traction equipment, ventilators and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps and insulin infusion devices (including any sales tax).

Medical Supplies

Medical supplies include, but are not limited to dressings, braces, splints, rib belts and crutches, as well as related fitting expenses. Covered Services also include only the following diabetic care supplies such as blood glucose monitor, insulin pump (including accessories), and insulin infusion devices.

Medical Vision Hardware

This plan covers medical vision hardware including eyeglasses, contact lenses and other corneal lenses for members age 19 and older when such devices are required for the following:

- Aniridia
- Aniseikonia
- Anisometropia
- Aphakia
- Bullous keratopathy
- Congenital cataract
- Corneal ulcer, abrasion, or recurrent erosion
- Irregular astigmatism
- Keratoconus
- Pathological myopia
- Post-traumatic disorders
- Progressive high (degenerative) myopia
- Sjogren’s disease
- Tear film insufficiency

Medical vision hardware for members under age 19 is covered for all medically necessary diagnoses. See ***Pediatric Vision Services***.

Prosthetics and Orthotic Devices

Benefits for external prosthetic devices (including fitting expenses) are covered when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device cannot be repaired. Replacement devices must be prescribed by a provider because of a change in your physical condition.

Shoe Inserts and Orthopedic Shoes

Benefits are provided for medically necessary shoes, inserts or orthopedic shoes. Covered services also include training and fitting. Benefits are provided as shown in ***Summary of Your Costs***.

This benefit does not cover:

- Hypodermic needles, lancets, test strips, testing agents and alcohol swabs. These services are covered under ***Prescription Drugs.***
- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Over bed tables, elevators, vision aids and telephone alert systems
- Over the counter orthotic braces and or cranial banding
- Non-wearable defibrillator, trusses and ultrasonic nebulizers
- Blood pressure cuff/monitor (even if prescribed by a provider)
- Bed-wetting (enuresis) alarm
- Compression stockings which do not require a prescription
- Structural modifications to your home and/or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation of a sport, recreation or similar activity
- Penile prostheses
- Hair prostheses, such as wigs or hair weaves, transplants and implants
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under ***Surgery***. Items provided and billed by a hospital are covered under ***Hospital*** for inpatient and outpatient care.

OTHER COVERED SERVICES

The services listed in this section are covered as shown in ***Summary of Your Costs***.

Acupuncture

The technique of inserting thin needles through the skin at specific points on the body to help control pain and other symptoms. Services must be provided by certified or licensed acupuncturist.

This benefit covers acupuncture to:

- Relieve pain
- Provide anesthesia for surgery
- Treat a covered illness, injury, or condition.

Allergy Testing and Treatment

Skin and blood tests used to diagnose what substances a person is allergic to, and treatment for allergies. Services must be provided by a certified or licensed allergy specialist.

This benefit covers:

- Testing

- Allergy shots
- Serums

Artificial Insemination

This benefit covers in vivo fertilization, a form of artificial insemination which facilitates the fusion of sperm and egg within the body.

This benefit covers:

- Preliminary infertility evaluation and diagnosis
- Placement of sperm into the cervix or uterus to achieve a pregnancy
- Simple sperm preparation, such as sperm washing and isolation

This benefit does not cover:

- All services and supplies (other than in vivo fertilization) related to conception by artificial means.
- Prescription drugs related to such services
- Donor semen and donor eggs used for such services, such as, but not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfers.
- Donor sperm or eggs, or services related to procuring or storing these materials

For surgical procedures performed in a provider's office, surgical suite or other facility, see ***Surgery***. Lab tests or images may be billed separately, see ***Diagnostic X-ray, Lab, and Imaging***. Office visits are covered under ***Professional Visits and Services***.

Blood Products and Services

Blood components and services, like blood transfusion, which are provided by a certified or licensed health care provider.

This benefit covers:

- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury.
- Some services require prior approval. See ***Prior Authorization*** for details.
- See ***Prescription Drugs*** related to medications.

Virtual Care

On-demand virtual care that connects you to providers. Benefits are provided for services for low-level conditions using virtual methods like secure chat, text, voice or video chat. Virtual care select providers can be found at students.lifewiseac.com/find-care or contact LifeWise Customer Service for assistance.

Anticancer Medication, Radiation Therapy, and Dialysis

Treatment which uses anti-cancer drugs (e.g. chemotherapy) or high-energy beams (radiation) to shrink or kill cancer cells. Dialysis is a treatment that performs the functions of healthy kidneys. It is needed when your own kidneys can't take care of your body's needs.

Important things to know:

- Outpatient anticancer medication and radiation therapy services must be prescribed and approved by LifeWise to be covered. See ***Prior Authorization***.
- If you are prescribed oral anticancer medication, it is covered under Prescription Drugs.
- In the case of dialysis, we recommend calling customer service to find in-network providers.

This benefit covers:

- Outpatient anticancer medication and radiation therapy services
- Dialysis treatments in an outpatient facility or hospital setting or in your home

- Tooth extractions to prepare your jaw for radiation therapy
- Supplies, solutions and drugs used during an anticancer drug treatment or radiation visit
- See ***Prescription Drugs*** for medications for use after you leave the dialysis facility.
- See ***How Providers Affect Your Costs*** for information about when out-of-network providers are covered.
- See *Allowed Amount* in *Important Plan Information*.

Clinical Trials

This plan covers the routine costs of a qualified clinical trial. Routine costs are the medically necessary care that is normally covered under this plan for a member who is not enrolled in a clinical trial. The trial must be appropriate for your health condition and you must be enrolled in the trial at the time of treatment for which coverage is requested.

Benefits are based on the type of service you get. For example, benefits for an office visit are covered under ***Office and Clinic Visits*** and lab tests are covered under ***Diagnostic X-ray, Lab, and Imaging***.

A qualified clinical trial means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, diagnosis or treatment of cancer or other life-threatening disease or conditions, and it is either federally funded or approved, conducted under FDA investigational new drug application, or drug trial exempt from FDA investigational new drug application.
The study must be approved by an institutional review board that complies with federal standards for protecting human research subjects and one or more of the following:

- The US Department of Health and Human Services, National Institutes of Health, or its institutes or centers.
- The United States Food and Drug Administration (FDA).
- The US Departments of Veterans Affairs or Defense.
- An institutional review board in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the National Institutes of Health.
- A qualified research entity that meets the criteria for National Institutes of Health Center Support Grant eligibility.
- A National Institutes of Health (NIH) cooperative group or center that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

A “clinical trial” does not include expenses for:

- Costs for treatment outside patient care
- Travel, housing, and meal costs related to trial
- The drug, device or service being tested by the trial
- Services that are not consistent with established standards of care for a certain condition
- Services, supplies or pharmaceuticals that would not be charged to the member, if there were no coverage.
- Services provided to you in a clinical trial that are fully paid for by another source
- Services that are not routine costs normally covered under this plan

We encourage you or your provider to call Customer Service before you enroll in a clinical trial. We can help you verify that the clinical trial is a qualified clinical trial.

DENTAL INJURY AND FACILITY ANESTHESIA

This section will go over two types of dental care:

- Dental Care for medical injuries
- Anesthesia for routine dental care when medically necessary

Dental Injuries

This benefit covers exams and treatments of injuries to the gum, tooth, and jaw; and oral surgery when related to an accident/injury and is medically necessary.

This benefit covers:

- Exams
- Consultations
- Treatment of dental injuries to teeth, gum, and jaw
- Oral surgery

Services are covered when all of the following are true:

- Treatment of dental injuries are covered within 12 months of the injury. If more time is needed, ask your provider to contact Customer Service.
- Treatments for an injury can result in multiple charges for things like facility, exams, and tests used to diagnose your condition. You may receive separate bills for each charge.
- This benefit covers sound and natural teeth that:
  - Do not have decay
  - Do not have a large number of restorations, such as crowns or bridge work
  - Do not have gum disease or any condition that would make them weak
- Sound natural tooth means a tooth that:
  - Is organic and formed by the natural development of the body (not manufactured)
  - Hasn't been extensively restored
  - Hasn't become extensively decayed or involved in periodontal disease
  - Isn't more susceptible to injury than a whole natural tooth

Anesthesia for Routine Dental Care

Anesthesia for routine dental care is covered for any one of the following reasons when medically necessary:

- The member is under age 19 and failed patient management in the dental office.
- The member has a disability, medical, or mental health condition making it unsafe to have care in a dental office.
- The severity and extent of the dental care prevents care in a dental office.

This benefit covers:

- Hospital or other facility care
- General anesthesia provided by an anesthesia professional other than the dentist or the physician performing the dental care

This benefit does not cover:

- Routine dental care, including the professional charges of the dentist or services received in the dental office

Foot Care

This section will cover medically necessary foot care services that need care from a provider. Routine foot care is covered for some medical conditions, as indicated below.
Examples of medical conditions include:

- Diabetes
- Lymphedema
- Athlete's foot
- Bunions
- Fungus of the foot or toenails

- Ingrown toenails
- Warts
- Any other medical diagnosis or service in which foot care is deemed medically necessary

This benefit covers:

- Medically necessary foot care performed by a licensed provider
- A medical provider can cut or remove corns, calluses, and nails related to a certain medical condition.

This benefit does not cover:

- Routine foot care, such as trimming of nails and removing calluses, that can be done by the member or a caregiver and that do not require skills from a qualified provider
- Non-medically necessary foot care

Gender Affirming Care

Benefits for medically necessary services and care related to gender-affirming medical care or surgery are subject to the same cost-shares that you would pay for inpatient or outpatient treatment for other covered medical conditions, for all ages. Gender transition or affirmation is the process of changing the gender characteristics a person was born with to the gender characteristics with which a person identifies. To find the amounts you are responsible for, see ***Summary of Your Costs*** earlier in this booklet.

Benefits are provided for gender affirming care surgical services which meet the requirements of LifeWise's medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from Customer Service, or at students.lifewiseac.com/medical-policies-disclaimer. For more information, visit students.lifewiseac.com/lgbtq-health. If you can't find an in-network provider or need information about what services are covered under this plan, call Customer Service.

This benefit does not cover:

- Procedures that are not medically necessary for gender affirming surgery
- Surgery to change the appearance of prior gender change procedures, except when medically necessary
- For mental health services, see ***Mental Health Care***.
- Hormone treatments are covered under the ***Prescription Drugs*** benefit.
- For covered surgery benefits not part of gender affirming care, see ***Surgery***.

Infusion Therapy

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy in an office, home, or infusion clinic/center. Infusion therapy (also known as intravenous therapy) is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction
- Some services require prior approval. See ***Prior Authorization*** for details.
- See ***Prescription Drugs*** related to medications.

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements.

Medical Foods

Nutrients given orally or via feeding tube to provide complete nutrition when a person can't eat, swallow, or otherwise absorb foods, due to a specific medical condition, for example phenylketonuria (PKU). Medical foods must be prescribed and supervised by doctors or other health care providers.

This benefit covers dietary replacement to treat:

- Inborn errors of metabolism
- A severe allergy to most foods based on white blood cells in the stomach and intestine that cause inflammation (eosinophilic gastrointestinal associated disorder)
- Other severe conditions when your body can't take in nutrients from food in the small intestine
- Disorders where you can't swallow due to a blockage or muscular problem and need to be fed through a tube

This benefit does not cover:

- Food and nutritional supplements, and specialized infant formulas (other than those prescribed to treat the conditions listed above)
- Lactose-free or gluten-free foods

Mastectomy and Breast Reconstruction

Benefits are provided for mastectomy necessary due to disease, illness or injury.

This benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses (including bras)
- Physical complications of all stages of mastectomy, including lymphedemas

Chiropractic Adjustments

Benefits for spinal and other manipulations are provided as shown in ***Summary of Your Costs***.

Services must be medically necessary to treat a covered illness, injury or condition.

Rehabilitation therapy (such as massage or physical therapies) provided in conjunction with manipulative treatment will accrue toward the ***Rehabilitation and Neurodevelopmental (Habilitation)*** benefit maximums, even when provided during the same visit.

Orthognathic Surgery (Jaw Augmentation Or Reduction)

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic surgery) are provided.

This benefit covers:

- Exams and consultations
- Diagnostic services
- Orthognathic surgery
- Facility charges

See ***Prior Authorization*** for more information on getting prior approval for services.

This benefit does not cover:

- Procedures to lengthen or shorten the jaw for cosmetic purposes.

Temporomandibular Joint (TMJ) Disorders

Services for TMJ are provided as shown in ***Summary of Your Costs***. Services must be medically necessary to treat a covered illness, injury or condition.

"Medical Services" for the purpose of this TMJ benefit are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case
- Effective for the control or elimination of one or more of the following, caused by a disorder of the

temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food

- Recognized as effective, according to the professional standards of good medical practice
- Not experimental or investigational, according to the criteria stated under ***Definitions***, or primarily for cosmetic purposes

"Dental Services" for the purpose of this TMJ benefit are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food
- Recognized as effective, according to the professional standards of good dental practice
- Not experimental or investigational, according to the criteria stated under ***Definitions***, or primarily for cosmetic purposes

Injectable Drug Therapies

Injectable drug therapies are those given under the skin, into the muscle, in joints (or by another route into the body) as part of a course of treatment. They can be used to treat certain conditions or to help reduce swelling and relieve pain in an affected joint or muscle.

This benefit covers:

- Shots given in the provider's office
- Supplies used during the visit, such as serums, needles, and syringes
- Three teaching doses per self-administered injectable drug per lifetime
- See ***Prescription Drugs*** for self-administered and specialty drugs.
- Some services require prior approval. See ***Prior Authorization*** for details.
- For immunization benefits, see ***Preventive Care***.
- For allergy shot benefits, see ***Allergy Testing and Treatment.***
- See ***Infusion Therapy*** for drug therapy and pain management benefit details.

Hearing Hardware

To receive your hearing hardware benefit, you must:

- Be examined by a licensed provider before obtaining hearing aids.
- Purchase a hearing aid device.

This benefit covers:

- Hearing aids (monaural or binaural) prescribed as a result of an exam
- Ear molds
- Fitting examinations for hearing hardware
- The hearing aid instruments, including bone conduction hearing devices and the initial assessment, adjustment and auditory training
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords and other necessary ancillary equipment
- A warranty, when provided by the manufacturer
- A follow-up consultation within 30 days following delivery of the hearing aids with the prescribing licensed provider
- Repairs, servicing, and alteration of hearing aid equipment purchased under this benefit

This benefit does not cover:

- Hearing aids purchased before your effective date of coverage under this plan
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss.
- Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended.
- Charges in excess of this benefit. These expenses are also not eligible for coverage under other benefits of this plan.

Transplants

This plan covers transplant services when they are provided at an Approved Transplant Center. An Approved Transplant Center is a hospital or other provider that has developed expertise in performing organ transplants or bone marrow or stem cell reinfusion.

The transplant center must also meet the other approval standards we use. We have agreements with Approved Transplant Centers in Washington. Whenever medically possible, we will direct you to an Approved Transplant Center that we've contracted with for transplant services. Please call Customer Service.

No waiting or exclusion periods apply for coverage of transplant services. Please call us as soon as you learn you need a transplant.

Covered Transplants

This plan covers only transplant procedures that are not considered experimental or investigative for your condition. Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet coverage criteria. We review the medical reasons for the transplant, how effective the procedure is and possible medical alternatives.

Artificial organ transplants are covered based on your doctor’s medical guidelines and the manufacturer recommendations.

These are the types of transplants and reinfusion procedures that meet our medical policy criteria for coverage:

- Heart
- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas
- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- Stem cell (autologous and allogeneic)

Under this benefit, transplant does not include cornea transplant or skin grafts. It also does not include transplants of blood or blood derivatives (except bone marrow or stem cells). These procedures are covered the same way as other covered surgical procedures.

Recipient Costs

Benefits are provided for services from an Approved Transplant Center and related professional services. This benefit also provides coverage for anti-rejection drugs given by the transplant center.

Covered services consist of all phases of treatment:

- Evaluation
- Pre transplant care

- Transplant
- Follow up treatment

Donor Costs

This benefit covers donor or procurement expenses for a covered transplant. Covered services include:

- Selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell
- Transportation of the donor organ, bone marrow or stem cells, including the surgical and harvesting teams
- Donor acquisition costs such as testing and typing expenses
- Storage costs for bone marrow and stem cells for up to 12 months

Transportation and Lodging

This benefit covers costs for transportation and lodging for the member getting the transplant (while not confined), not to exceed three (3) months. The member getting the transplant must live more than 50 miles from the facility, unless treatment protocols require them to remain closer to the transplant center.

Travel Allowances: Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll costs are reimbursed. Mileage reimbursement will be based on the current IRS medical mileage reimbursement. Please refer to the IRS website http://www.irs.gov for current rates.

Lodging Allowances: Expenses incurred by a transplant patient and companion for hotel lodging away from home is reimbursed based on current IRS guidelines.

Companions:

- Adult Patient – 1 companion is permitted.
- Child Patient – 2 parents or guardians are permitted

Non-Covered Expenses

- Alcohol/tobacco
- Car rental
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and their covered companion
- Meals
- Personal care items (e.g., shampoo, deodorant, etc.)
- Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
- Telephone calls

Vision for Adults

See ***Summary of Your Costs*** for cost-shares and benefit limits. For vision exams and hardware for a child under age 19, see ***Pediatric Vision Services***.

Vision Exams

Covered services for adult vision exams include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

For vision exams and testing related to medical conditions of the eye, see ***Office and Clinic Visits***.

Some clinics that are based in or owned by a hospital will charge a separate facility fee for all physician visits,

including routine vision exams. Benefits for these fees will be subject to your deductible and coinsurance, if any.

The Vision Exams benefit doesn't cover vision hardware or fitting examinations for contact lenses or eyeglasses.

Vision Hardware

Benefits for vision hardware for members 19 or older are provided when all of the requirements listed below are met:

- They must be prescribed and furnished by a licensed or certified vision care provider
- They must be named in this benefit as covered
- They must not be excluded from coverage under this plan

The benefit covers:

- Prescription eyeglass lenses (single vision, bifocal, trifocal, progressive), quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

Vision hardware benefits are based on the "allowed amount," see ***Important Plan Information*** for covered services and supplies. Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this plan.

This benefit will cover services and supplies (including hardware) received after your coverage under this benefit has ended when all of the following requirements are met:

- You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended
- You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended

This benefit does not cover:

- Services or supplies that aren't named above as covered or that are covered under other provisions of this plan. See the ***Medical Vision Hardware*** subsection of the ***Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies*** benefit for hardware coverage for certain conditions of the eye.
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses, or light-sensitive lenses, or smart glasses (such as augmented reality glasses), even if prescribed.

Dental for Adults (age 19 and older)

Coverage is available for a covered dental condition for members age 19 and older. For dental care for a child under age 19 see ***Pediatric Dental Services***. For accidental injury of teeth, gums or jaw, see ***Dental Injury and Facility Anesthesia***. Such services must meet all of the following requirements:

- They must be medically necessary. See ***Definitions***.
- They must be named in this plan as covered
- They must be furnished by a licensed dentist (DMD or DDS) or denturist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of their license or certification, as allowed by law.
- They must not be excluded from coverage under this benefit

Dental care coverage includes the following:

Preventive Services

Preventive services do not apply toward the $1,500 per plan year dental maximum. Benefits include the following routine exam and cleaning services:

- Routine oral examinations are limited to 2 visits per plan year. Comprehensive and periodic oral examinations count toward the limit for oral examinations. Oral hygiene instruction is covered as part of the routine exam.
- Emergency oral examinations are not limited. Services that are determined to be routine will be limited to 2 per plan year.
- Prophylaxis (cleaning, scaling, and polishing of teeth) is limited to 2 per plan year
- Covered dental x-rays include either a complete series or panoramic x-ray once every 36 months, but not both. Supplemental bitewing and periapical x-rays are covered.

Restorative Services

Services that restore the function of the tooth by replacing missing or damaged tooth structure. Restorative services include, but not limited to, extractions, fillings, root canals, crowns, and periodontal (gum) treatment.

This benefit does not cover:

- Behavior management.
- Caries susceptibility tests
- Charges above the allowed amount
- Charges for any services in excess of the percentage and maximums listed
- Charges for failure to keep scheduled appointments or for filling out claim forms
- Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements
- Charges that would not have been made, or that the member would have had no obligation to pay in the absence of this plan
- Cleaning of a prosthetic appliance
- Consultations
- Local anesthesia, sterilization, and supplies billed as separate charges. These services and items are included in the allowance for the procedure.
- Materials not approved by the American Dental Association
- Oral hygiene instruction not listed above, dietary instruction and home fluoride kits
- Plaque control program
- Prescription drugs, medications, or supplies provided by a dental office not related to covered dental care. For prescriptions dispensed by a pharmacy, see the medical prescription drug benefit
- Replacement of a space maintainer previously paid for by the plan
- Services to the extent that they are not recommended and approved by the licensed dentist attending the participant
- Charges for failure to keep scheduled appointments or for filling out claim forms
- Study and diagnostic models
- Orthodontia

Emergency Medical Evacuation and Repatriation of Remains

Benefits will be provided for you and your insured dependents (including insured international students on non-immigration visas and their eligible insured dependents).

Emergency Medical Evacuation

The plan will pay 100% of the actual expense up to a lifetime maximum of $150,000 to transport you to your home country or country of regular domicile. Evacuation must be recommended and approved by the attending

physician. Emergency Medical Evacuation means after being treated at a local Hospital, your medical condition warrants transportation to your home country to obtain further medical treatment to recover. Covered Expenses are Expenses up to the maximum for transportation, medical services and medical supplies necessarily incurred in connection with your Emergency Medical Evacuation. All transportation arrangements made for your evacuation must be:

- By the most direct and economical conveyance
- Approved in advance

Transportation for this benefit means any land, water or air conveyance required to transport you during an emergency evacuation. Expenses for special transportation (such as air ambulance, land ambulance and private motor vehicle) must be:

- Recommended by the attending physician.
- Required by standard regulations of the conveyance transporting you.

Repatriation of Remains

In the event of your death, the plan will pay the actual charges for preparing and transporting your remains to your home country up to a maximum of $25,000. This will be done in accord with all legal requirements in effect at the time your remains are to be returned to your home.

EXCLUSIONS AND LIMITATIONS

In addition to services listed as not covered under ***Covered Services***, this section of your booklet lists services that are either limited or not covered by this plan.

Amounts Over the Allowed Amount

Costs over the allowed amount as defined by this plan for a non-emergency service from a non-participating provider.

Benefits from other sources

Services that are covered by other types of insurance or coverages, such as:

- Motor vehicle medical or motor vehicle no-fault
- Any type of no-fault coverage, such as Personal Injury Protection (PIP), Medical Payment coverage or Medical Premises coverage.
- Any type of liability insurance, such as homeowners' coverage or commercial liability coverage
- Any type of excess coverage
- Boat coverage
- School or athletic coverage

Benefits that have been exhausted

Services in excess of benefit limitations or maximums of this plan.

Broken or missed appointments

Broken or missed appointments, including charges from providers for broken or missed appointments.

Caffeine Dependency

Charges for records or reports

Charges from providers for supplying records or reports that aren’t requested by LifeWise for utilization review.

Complications of a non-covered service

Includes follow-up services or effects of those services.

Cosmetic Services

Drugs, services or supplies for cosmetic services that are not medically necessary. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. This also includes drugs, services, or supplies to improve or alter the appearance of your skin or hair. This does not apply to services that are determined to be medically necessary for ***Gender Affirming Care***.

Counseling, Education And Training

Counseling education or training in the absence of illness or injury, including but not limited to:

- Job-help and outreach
- Social or fitness counseling
- Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff.
- Private school or boarding school tuition
- Community wellness or safety programs

Court-Ordered Services

Services that you must get to avoid being tried, sentenced, or losing the right to drive when they are not medically necessary.

Custodial Care

Custodial services that are not covered hospice care services.

Dental Care

Dental care or supplies, that is not covered under any dental benefits.

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental or Investigational Services

Experimental or investigational services or supplies, including any complications or effects of such services. This does not apply to certain services that are part of an approved clinical trial.

Family Members or Volunteers

Services or supplies that you provide to yourself. It also does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or their spouse
- A volunteer

Government Facilities

Services provided by a state or federal facility that are not emergency services or required by law or regulation.

Hair Analysis

Hair Loss

- Drugs, supplies, equipment, or procedures to replace hair, slow hair loss or stimulate hair growth
- Hair protheses, such as wigs or hair weaves, transplants and implants

Hearing Exams

Hearing exams and testing used to prescribe or fit hearing aids and any associated service or supply.

Illegal Acts, Illegal Services, and Terrorism

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any service that is illegal under state or federal law.

Low-level laser Therapy

Military Service and War

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country, including any related civilian forces or units.

Non-Covered Services

Services or supplies directly related to any non-covered condition.

- Ordered when this plan is not in effect or when the person is not covered under this plan
- Provided to someone other than the ill or injured member
- That are not listed as covered under this plan
- Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay
- Non-treatment charges, including charges for provider time
- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping.
- Doing housework or chores for the member or helping the member do housework or chores

Non-Treatment Facilities, Institutions or Programs

- Institutional care
- Housing
- Incarceration
- Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered services.

Examples are prisons, nursing homes, juvenile detention facilities.

Personal comfort or convenience items

- Personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting
- Normal living needs, such as food, clothes, housekeeping, and transport. This doesn’t apply to chores done by a home health aide as prescribed in your treatment plan.
- Dietary assistance, including “Meals on Wheels”

Provider's Licensing or Certification

Services that are outside the scope of the provider's license or certification or any unlicensed or uncertified providers.

Recreational, Camp and Activity Programs

Recreational, camp and activity-based programs. These programs are not medically necessary and include:

- Gym, swim and other sports programs, camps and training
- Creative art, play and sensory movement and dance therapy
- Recreational programs and camps
- Boot camp programs, outward bound programs and tall-ship programs
- Equine programs and other animal-assisted programs and camps
- Exercise and maintenance-level programs.
- Hiking and other adventure programs and camps

Serious Adverse Events and Never Events

Serious Adverse Events are hospital injury(ies) caused by medical management that prolonged the hospitalization, and/or produces a disability at the time of discharge.

Never Events are events that should never occur, such as a surgery on the wrong patient, surgery on the wrong body part or a wrong surgery.

Members and this plan are not responsible for payment of services provided by providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. Providers may not bill members for these services and members are held harmless.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us or on the Center for Medicare and Medicaid Services (CMS) website.

Services or Supplies Not Medically Necessary

Services or supplies that are not medically necessary even if they are court ordered. This also includes places of service, such as inpatient hospital care or stays.

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause, surgical, medical or psychological treatment of impotence or hypoactive sexual desire disorder, including drugs, medications, or penile or other implants.

Vision Therapy

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics treatment or surgeries to improve the refractive character of the cornea, or results of these treatments.

Voluntary Support Groups

Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics Anonymous.

Weight Loss Surgery or Drugs

Surgery, drugs or supplements for weight loss or weight control. GLP-1 medications are covered only to treat conditions other than overweight and obesity that have been approved by the U.S. Food and Drug Administration.

Work-Related Illness or Injury

Any illness, condition, or injury for which you get benefits under:

- Separate coverage for illness or injury on the job
- Workers compensation laws
- Any other law that would repay you for an illness or injury you get on the job

OTHER COVERAGE

Note: If you participate in a health savings account (HSA) and are enrolled in this plan (have other healthcare coverage that is not a high deductible health plan as defined by IRS regulations), the tax deductibility of the health savings account contributions may not be allowed. Contact your tax advisor or HSA plan administrator for more information.

COORDINATING BENEFITS WITH OTHER PLANS

When you have more than one health plan, "coordination of benefits (COB)" makes sure that the combined payments of all your plans don't exceed your covered health costs. You or your provider should file your claims with your primary plan first. If you have Medicare, Medicare may submit your claims to your secondary plan. See ***COB's Effect on Benefits*** for details on primary and secondary plans.

If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan(s) to determine which is primary and will let you know within 30 calendar days.

Caution: All health plans have timely filing requirements. If you or your provider fails to submit your claim to your secondary health plan within that plan’s claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan, you should promptly report to your providers and plans any changes in your coverage.

DEFINITIONS

For the purposes of COB:

- A **Plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB doesn't apply is treated as a separate plan.
  - "Plan" means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law.
  - "Plan" **doesn't mean**: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law.
- **This plan** means your plan's health care benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to

coordinate other benefits. All the benefits of your LifeWise plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.

- **Primary plan** is a plan that provides benefits as if you had no other coverage.
- **Secondary Plan** is a plan that is allowed to reduce its benefits in accordance with COB rules. See ***COB's Effect on Benefits*** for rules on secondary plan benefits.
- **Allowable Expense** is a healthcare expense, including deductibles, coinsurance and copays, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that is not covered by any of your plans is not an allowable expense.

The allowable expense for the secondary plan is the amount it allows for the service or supply in the absence of other coverage that is primary. This is true regardless of what method the secondary plan uses to set allowable expenses.

The exceptions to this rule are when a Medicare, a Medicare Advantage plan, or a Medicare Prescription Drug plan (Part D) is primary to your other coverage. In those cases, the allowable expense set by the Medicare plan will also be the allowable expense amount used by the secondary plan.

- **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the plan year, excluding any temporary visitation.
- **Gatekeeper Requirements** Any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. Examples are restrictions of coverage to providers in a network, prior authorization, or primary care provider referrals.

PRIMARY AND SECONDARY RULES

Certain governmental plans, like Medicaid, are always secondary by law. Except as required by law, Medicare supplement plans and other plans that don't coordinate benefits at all must pay as if they were primary.

A plan that doesn't have a coordination of benefits provision that complies with this plan's rules is primary to this plan unless the rules of both plans make this plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan.

The first of the rules below to apply decides which plan is primary. If you have more than one secondary plan, the rules below also decide the order of the secondary plans to each other.

Non-dependent or dependent The plan that doesn't cover you as a dependent is primary to a plan that does. However, if you have Medicare, and federal law makes Medicare secondary to your dependent coverage and primary to the plan that doesn't cover you as a dependent, then the order is reversed.

Dependent children Unless a court decree states otherwise, the rules below apply:

- **Birthday Rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
  - If a court decree makes one parent responsible for the child's healthcare expenses or coverage, that plan is primary. This rule applies to plan years starting after the plan is given notice of the court decree.
  - If a court decree assigns one parent primary financial responsibility for the child but does not mention responsibility for healthcare expenses, the plan of the parent with financial responsibility is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, then that plan is the primary plan.
  - If a court decree makes both parents responsible for the child's healthcare expenses or coverage, the birthday rule determines which plan is primary.
  - If a court decree requires joint custody without making one parent responsible for the child's healthcare expenses or coverage, the birthday rule determines which plan is primary.
- If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
  - The plan covering the custodial parent, first

- The plan covering the spouse of the custodial parent, second
- The plan covering the non-custodial parent, third
- The plan covering the spouse of the non-custodial parent, last

- If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

Retired or Laid-off Employee The plan that covers you as an active employee (an employee who is neither laid off nor retired) is primary to a plan covering you as a retired or laid-off employee. The same is true if you are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.

Continuation Coverage If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that is not through COBRA or other continuation law.

Note: The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.

Length of Coverage The plan that covered you longer is primary to the plan that didn't cover you as long.

If none of the rules above apply, the plans must share the allowable expenses equally.

COB's Effect on Benefits

The primary plan provides its benefits as if you had no other coverage.

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a plan year are not more than the total allowable expenses incurred in that year. **When paying a claim, the total amount paid by the secondary plan in combination with what is paid by the primary plan is never required to be more than one hundred percent of the highest total allowable expense of either plan plus any savings accrued from prior claims incurred in the same calendar year.**

The secondary plan must credit to its deductible any amounts it would have credited if it had been primary. It must also calculate savings for each claim by subtracting its secondary benefits from the amount it would have provided as primary. It must use these savings to pay any allowable expenses incurred during that plan year, whether or not they are normally covered.

If this plan is secondary to a plan with gatekeeper requirements, and the member has met the primary plan's gatekeeper requirements for a particular service, this plan's gatekeeper requirements will be waived for that service. This rule will not apply if an alternative procedure is agreed upon between both plans and the member. See ***COB Definitions***.

Certain facts about your other healthcare coverage are needed to apply the COB rules. We may get the facts we need for COB from, or give them to, other plans, organizations or persons. We don't need to tell or get the consent of anyone to do this. State regulations require each of your other plans and each person claiming benefits under this plan to give us any facts we need for COB. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the primary plan fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim to the secondary plan to make payment as if the secondary plan was primary. In such situations, the secondary plan is required to pay claims within 30 calendar days of receiving your claim and notice that your primary plan has not paid. However, the secondary plan may recover from the primary plan any excess amount paid under ***Right of Recovery/Facility of Payment***.

Note: When this plan is secondary prior authorization requirements are waived.

Right of Recovery/Facility of Payment

The plan has the right to recover any payments that are greater than those required by the coordination of benefits provisions from one or more of the following:

- The persons the plan paid or for whom the plan has paid.
- Providers of service

- Insurance companies
- Service plans or other organizations

If a payment that should have been made under this plan was made by another plan, the plan also has the right to pay directly to another plan any amount that the plan should have paid. Such payment will be considered a benefit under this plan and will meet the plan's obligations to the extent of that payment. This plan has the right to appoint a third party to act on its behalf in recovery efforts.

Questions about COB? Contact our Customer Service Department or the Washington Insurance Department.

THIRD PARTY LIABILITY (SUBROGATION)

If we make claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, we will be subrogated to any rights that you may have to recover compensation or damages from that liable party related to the injury or illness, and we would be entitled to be repaid for payments we made on your behalf out of any recovery that you obtain from that liable party after you have been fully compensated for your loss. The liable party is also known as the "third party" because it is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tort feasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties or from proceeds of your recovery from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party and you have been fully compensated for your loss.
- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts you have received on your claim after you have been fully compensated for your loss.
- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses from any responsible third-party once you have been fully compensated for your loss.

To the fullest extent permitted by law, we are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of payments we have made on your behalf after you have been fully compensated for your loss. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. In recovering payments made on your behalf, we may at our election hire our own attorney to prosecute a subrogation claim for recovery of payments we have made on your behalf directly from third-parties, or be represented by your attorney prosecuting a claim on your behalf. Our right to prosecute a subrogation claim against third-parties is not contingent upon whether or not you pursue the party at fault for any recovery. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. Notwithstanding such right, if you recover from a third party and we share in the recovery, we may pay our share of the legal expenses. Our share is that percentage of the legal expenses necessary to secure a recovery against the liable party that the amount we actually recover bears to the total recovery.

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. In the event of a trial or arbitration, you must make a claim against, or otherwise pursue recovery from third-parties payments we have made on your behalf, and give us reasonable notice in advance of the trial or arbitration proceeding. See ***Notice***. You must also cooperate fully with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery. If you fail to cooperate fully with us in the recovery of the payments we have paid on your behalf, you are responsible for reimbursing us for payments we have made on your behalf.

You agree, if requested, to hold in trust and execute a trust agreement in the full amount of payments we made on your behalf from any recovery you obtain from any third-party until such time as we have reached a final determination or settlement regarding the amount of your recovery that fully compensates you for your loss.

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

We have the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM)

policy, personal injury protection (PIP) or similar type of insurance or contract.

HOW DO I FILE A CLAIM

Many providers will send claims to us directly. When you need to send a claim to us, follow these simple steps:

Step 1

Complete a claim form. Use a separate claim form for each patient and each provider. You can get claim forms by calling Customer Service or you can print them from our website.

Step 2

Attach the bill that lists the services you received. Your claim must show all of the following information:

- Name of the member who received the services.
- Name, address, and IRS tax identification number of the provider.
- Diagnosis (ICD) code. You must get this from your provider.
- Procedure codes (CPT or HCPCS). You must get these from your provider.
- Date of service and charges for each service.

Step 3

If you are also covered by Medicare, attach a copy of the Explanation of Medicare Benefits.

Step 4

Check to make sure that all the information from Steps 1, 2, and 3 is complete. Your claim will be returned if all of this information is not included.

Step 5

Sign the claim form.

Step 6

Mail your claims to the address listed on the back cover.

Prescription Claims

For retail pharmacy purchases, you do not have to send us a claim form. Just show your LifeWise ID card to the pharmacist, who will bill us directly. If you do not show Your LifeWise ID card, you will have to pay the full cost of the prescription. Send your pharmacy receipts attached to a completed Prescription Drug Claim form for reimbursement. If you need a Prescription Drug Claim Form contact Customer Service at the number listed on your ID card. Send the prescription claim information to the address listed on the back cover.

It is very important that you use your LifeWise ID card at the time you receive services from an in-network pharmacy. Not using your LifeWise ID card may increase your out-of-pocket costs.

Coordination of Prescription Claims

If this plan is the secondary plan as described under ***Other Coverage***, you must submit your pharmacy receipts attached to a completed claim form for reimbursement. Please send the information to the address listed under Secondary Prescription Claims included on the drug claim form.

Timely Payment of Claim

You should submit all claims within 365 days of the date you received services. No payments will be made by us for claims received more than 365 days after the date of service. Exceptions will be made if we receive documentation of your legal incapacitation or when required by law or regulation. Payment of all claims will be made within the time limits required.

Notice Required for Reimbursement and Payment of Claims

At our option and in accordance with federal and state law, we may pay the benefits of this plan to the eligible member, provider, other carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such payment will discharge our obligation to the extent of the amount paid so that we will not be liable to anyone aggrieved by our choice of payee.

If all you have to pay is a copay for a covered service or supply, your payment of the copay to your provider is not considered a claim for benefits. You can call Customer Service to get a paper copy of an explanation of benefits for the service or supply.

COMPLAINTS AND APPEALS

If at any time you have questions regarding your healthcare, you may contact Customer Service for assistance. They are here to serve you and answer questions.

If you disagree with a decision we made or feel dissatisfied, and would like us to formally review your concerns, you can file a complaint or appeal with LifeWise.

WHAT IS A COMPLAINT?

Other than denial of payment for medical services for nonprovision of medical services, a complaint is when you are not satisfied with Customer Service, quality, or access to medical service, and you want to share it with LifeWise.

How to file a complaint:	**Send the details in writing to:**
Call Customer Service at 800-971-1491	LifeWise Assurance Company
Send a fax to 866-903-9899	PO Box 91102
	Seattle WA 91102-9202

For complaints received in writing, we will send a written response within 30 days.

WHAT IS AN APPEAL?

An appeal is a request to review a specific decision or an adverse benefit determination LifeWise has made.

An adverse-benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage.
- A limitation on otherwise covered benefits.
- A clinical review decision.
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective.

WHAT YOU CAN APPEAL

Claims and prior authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials.
Enrollment canceled or not issued	No Coverage	You are not eligible to enroll or stay in the plan.

APPEAL LEVELS

You have the right to two levels of appeals.

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. LifeWise will review your appeal.	180 days from the date you were notified of our decision.
External	If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. **OR** You can ask for an IRO review if LifeWise has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	180 days from the date you were notified of our Level 1 appeal decision. **OR** 180 days from the date of the response to your Level 1 appeal, if you did not get a response or it was late.

HOW TO SUBMIT AN APPEAL IN WRITING

Step 1. Get the form	• Complete the Member Appeal Form**,** you can find it on students.lifewiseac.com or call Customer Service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call Customer Service.
Step 2. Collect supporting documents	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your provider. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a Member Appeal Form with authorization; you can find it on our website. We can't release your information without this form.
Step 3. Send in my appeal	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** LifeWise Assurance Company PO Box 91102 Seattle, WA 91102-9202 Fax to 866-903-9899

Note: You may also call Customer Service to verbally submit an appeal.

If you would like to review the information used for your appeal, send us a request in writing to:

LifeWise Assurance Company
PO Box 91102
Seattle, WA 91102-9202

APPEAL RESPONSE TIME LIMITS

We'll review your appeal and send a decision in writing within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, LifeWise representatives who have not reviewed the case before will review and make a decision. Medical review denials will be reviewed by a medical specialist.

Type of Appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing
Pre-service appeals (a decision made by us before you received services)	Within 14 days
Appeals of experimental and/or investigative denials	Within 20 days
All other Level 1 appeals	14-30 days
External appeals	• Urgent appeals within 72 hours • Other IRO appeals within 15 days after the IRO gets the information or 20 days from the date the IRO gets your request

IF WE NEED MORE TIME

Except for urgent appeals, we can extend the time limits. We will notify you, if for good cause, more time is needed. An extension cannot delay the decision beyond 30 days without your informed written consent.

WHAT IF YOU HAVE ONGOING CARE?

Ongoing care is continuous treatment you are currently receiving, such as residential care, care for a chronic condition, inpatient care and rehabilitation.

If you appeal a decision that affects ongoing care because we've determined the care is no longer medically necessary, we will continue to cover your care during the appeal period. This continued coverage during the appeal period does not mean that the care is approved. If our decision is upheld, you must repay all amounts we paid for ongoing care during the appeal review.

WHAT HAPPENS IF IT'S URGENT?

If your condition is urgent, you will get our response sooner. Urgent appeals are only available for services you are currently receiving or have not yet received.

Examples of urgent situations are:

- Your life or health is in serious danger, or a delay in treatment would cause you to be in severe pain that you cannot bear, as determined by our medical professional or your treating physician.
- You are requesting coverage for inpatient or emergency services that you are currently receiving.

If your situation is urgent, you may ask for an expedited external appeal at the same time you request an expedited internal appeal.

HOW TO ASK FOR AN EXTERNAL REVIEW

External reviews will be done by an Independent Review Organization (IRO).

Step 1. Get the form	We'll tell you about your right to an external review with the written decision of your internal appeal. • Complete the Independent Review Organization (IRO) Request form, you can find it on students.lifewiseac.com or call Customer

	Service to request a copy. You may also write to us directly to ask for an external appeal.
Step 2. Collect supporting documents	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.
Step 3. Send in my external review request	To help process your external review, be sure to complete the form and return with any supporting documents. **Send your documents to:** LifeWise Assurance Company PO Box 91102 Seattle, WA 98111-9202 Fax to 866-903-9899

External appeals are available for decisions related to LifeWise's compliance with protections against balance billing in accordance with federal and state law.

ONCE THE IRO DECIDES

For urgent appeals, the IRO will inform you and LifeWise immediately. LifeWise will accept the IRO decision.

If the IRO:

- Reverses our decision, we will apply their decision quickly.
- Stands by our decision, there is no further appeal. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about understanding a denial of a claim or your appeal rights, you may call Customer Service at the number listed on your LifeWise ID card. Contact the Washington Consumer Assistance Program at any time during this process if you have any concerns or need help filing an appeal.

Washington Consumer Assistance Program

5000 Capitol Blvd.

Tumwater, WA 98501

800-562-6900

E-mail: cap@oic.wa.gov

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY FOR STUDENTS (SUBSCRIBERS)

You are eligible to enroll if you are an international or practical training student of the policyholder who meets all of the following criteria:

1. Are admitted to the university by the appropriate UW Principal Designated School Official (PDSO) in accordance with applicable United States law;
2. Are temporarily outside your home country or country of regular domicile as a non-resident alien, or a non-domiciled United States citizen with dual citizenship, in the United States;
3. Have a current passport and a current F-1 or J-1 student visa status which allows you to enroll in a course of

study (non-domiciled United States citizen – passport only);

4. Meet the criteria established, published, and updated from time to time by the Student and Exchange Visitor Program administered by the Department of US Immigration and Customs Enforcement.

For purposes of Item 1. above, eligible students taking a term or semester break (herein referred to as "term break"), annually, in accordance with school policy and while keeping coverage in force are considered Eligible Students engaged in full-time educational activities. For schools with a two-semester term system, summer break is the designated term break. For schools with a trimester or quarter term system, any trimester or quarter can be taken as the term break, provided only one trimester or quarter is taken per academic plan year.

Your classes must be on one of the University of Washington Seattle, Bothell or Tacoma campuses.

Who's Not Eligible

Some students are not eligible to enroll:

- International students who have been approved for permanent residency in the US in accordance with federal law in effect at the time of enrollment, are not Eligible Students.
- Students who are not international students.
- UW and other state employees attending classes under the Employee Tuition Exemption Program.

FAMILY MEMBERS YOU MAY COVER (DEPENDENTS)

You may also enroll your eligible dependents in the same plan:

- Your children under age 26

  The term "child" includes an insured student's biological children, step-children, children for whom responsibility was assumed through domestic partnership, foster children, adopted children from the date of placement in the insured student's home and who depend on the insured student for their support, children which the insured student has been granted legal custody, and children which the insured student has legal obligation to provide coverage due to a court order.
- When a court ordered guardianship or foster care terminates or expires, the child is no longer an eligible child. Court ordered guardianship and foster care expires at the child's age of majority.
- The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both: 1) Incapable of self-sustaining employment by reason of developmental or physical disability; and, 2) Chiefly dependent upon the insured person for support and maintenance.
- The lawful spouse of the subscriber. For purposes of the rights and benefits of this plan, the term "spouse" also means the domestic partner of the subscriber.
- All rights and benefits afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage"; the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."

Deadline for Adding a New Spouse or Domestic Partner to Your Coverage

You must enroll a newly acquired spouse or registered domestic partner **within 60 days** of the marriage or registration.

Deadlines for Adding a New Child to Your Coverage

A child born to or adopted by you, your enrolled spouse or domestic partner, while you are enrolled in ISHIP will receive the same benefits as you for the first three weeks after birth

If you want continuing coverage for your child after this, you must enroll your child in the timeframes listed below:

- An enrollment application isn't required for natural newborn children when premiums being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for natural newborn children on the date of birth.
- When premiums being paid don't already include coverage for dependent children, you must submit a

completed enrollment application and any required premium to the Student Insurance Office within 60 days of birth.

- For adoptions, an enrollment application isn't required for adopted children when premiums being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for adopted children on the date of placement. When premiums being paid don't already include coverage for dependent children you must submit a completed enrollment application and any required premium the Student Insurance Office within 60 days of adoption. We cover adopted children from the date the child is placed for adoption only if you send us a written request to add the child no more than 60 days after the child is placed and include any additional premium.

You must enroll eligible children acquired through marriage or domestic partner registration within 60 days of marriage or registration.

HOW TO ENROLL

You are automatically enrolled for student, quarterly coverage under this plan when you register for classes on the Personal Services section of MyUW.

You may change your coverage period and add a spouse or dependents during the enrollment period. You may also enroll in person at Student Fiscal Services in 129 Schmitz Hall, (206) 543-4694.

Once you enroll, you must also pay the premium.

Your Enrollment Decisions

- Choose to sign up for a whole academic year (also called the "plan year") or for one quarter.
  - **Whole year (annual) option**—The "annual" option is also offered at the beginning of each subsequent quarter for the rest of the plan year. For example, if you sign up for annual coverage beginning in Winter quarter, you'll be enrolling for the remaining three quarters of that academic year: winter, spring and summer. In all academic terms, annual coverage only runs through August 31, 2026.
  - **Quarterly option**—you may enroll on a quarterly basis. You must be registered for school during the quarter in which you enroll. To be covered during a quarter when you will not be registered, sign up and pay for the annual option at the beginning of a quarter when you are registered. If you enroll on a quarterly basis, benefits are paid during that quarter term only. You must renew the plan for coverage to continue in the next quarter.
- If you enroll for annual coverage, you will remain covered during Summer quarter even if you are not registered for classes.
- Choose **who** you want to cover: just you, or you and your eligible family members.
- If you enroll in the plan during pre-registration, the premium will be included on your tuition statement sent after the quarter begins. If you enroll in the plan after the quarter begins, you may not receive an adjusted bill. You will not be enrolled in the plan by just sending in the premium.
- Limited waivers are available from the International Student Services (ISS) office and must be requested no later than the 5th calendar day of the academic term.

Making Changes

If You Withdraw From Classes

If you withdraw from all your classes before the seventh calendar day of the quarter, your insurance will be cancelled. If you withdraw after the seventh calendar day, your insurance coverage will not be affected.

You do not have to be registered for classes in Summer quarter in order to be covered, as long as you signed up for annual coverage (or Spring and Summer coverage).

Cancellation

Unless you cancel by the third Friday of the quarter (the same as the tuition due date), you may not cancel coverage unless you, your spouse, or your domestic partner enters the military service on full-time active duty.

Annual enrollment in the plan cannot be cancelled in subsequent quarters except if you become eligible for the Graduate Appointee Insurance Plan (GAIP) policy or you or your spouse/domestic partner enter full-time military duty. Otherwise, it can only be cancelled up to the third Friday of the quarter (the same as the tuition due date) in which it is initially purchased. If you become eligible for GAIP, you may not re-enroll in the ISHIP annual coverage during the same plan year. If you subsequently lose eligibility under GAIP, you can continue coverage under the GAIP using the Self-Pay Option.

Adding New Dependents

You may add new dependents during the quarter by contacting the university's Student Insurance Office. You will be required to pay a pro-rata premium based on when your new dependent is enrolled.

Note: You must enroll your new dependent within 60 days of marriage or domestic partner registration or 60 days of birth or placement for adoption.

Domestic Partners

If you wish to enroll yourself and your domestic partner and/or your domestic partner's child(ren), your domestic partnership must be registered in the applicable jurisdiction where domestic partner registration is offered.

Adding A New Child

A child born to or adopted by you or your spouse or domestic partner while you are enrolled will receive the same benefits as you for the first three weeks after birth or adoption only. If you want continuing coverage for your child after this, you must enroll your child in the timeframes (60 days for a child born to you or your spouse/domestic partner, or 60 days from placement for adopted children) listed in ***Deadlines for Adding a New Child to Your Coverage***.

PREMIUMS

The cost of your coverage—your premium—is due by the tuition due date, which is usually the third Friday of the quarter. If you enroll during pre-registration, the premium will be included on your billing statement for tuition, sent after the quarter begins. If you enroll after the quarter begins, you may not receive an adjusted tuition bill. Non-payment of the premium by the tuition due date will not cancel your coverage and you'll still be required to pay your premium. You may receive additional billing statements.

PREMIUM RATES

The following rates apply per person for each eligible international student and each eligible dependent. Premium rates for dependent children 0-20 years old are capped at premium for three (3) children per family.

1 Qtr	$550
Annual Autumn (4 Qtrs)	$2,200
Annual Winter (3 Qtrs)	$1,650
Annual Spring (2 Qtrs)	$1,100

An International student can purchase Summer coverage on a monthly basis for the summer prior to the school year in which they are enrolled.

WHEN COVERAGE BEGINS AND ENDS

ISHIP is a one-year plan that begins on September 1, 2026 and ends on August 31, 2027. The benefits described in this booklet are applicable during this term only.

2026-2027 Dates of Coverage	
Autumn Qtr	September 1, 2026–January 3, 2027
Winter Qtr	January 4, 2027–March 28, 2027
Spring Qtr	March 29, 2027–June 20, 2027
Summer Qtr	June 21, 2027–August 31, 2027

When Coverage Begins

If you purchase quarterly coverage, you are covered for the dates in the quarters in which you purchase coverage, as shown in the chart.

If you purchase annual coverage, you will be covered from the date listed above for the quarter in which you purchase the annual coverage and continuing until August 31, 2027.

If You're in the Hospital When Coverage Would Otherwise Begin

If you or your covered family member is in the hospital or other facility at the time coverage would otherwise begin, coverage will not begin until after discharge, except for newborn and adoptive children as described in ***Who's Eligible***.

When Coverage Ends

Benefits expire at the end of the plan year or quarter for which you purchased it, whichever is earlier. See the table above for the termination dates for each quarter.

Coverage under this contract will terminate when any of the events specified below occurs.

- Violation of published policies of LifeWise that have been approved by the Washington State Insurance Commissioner
- A member commits fraudulent acts as to LifeWise
- A member materially breaches the contract which includes, but is not limited to, failure to continue to meet the provisions stated under ***Eligibility and Enrollment***
- The contract between the policyholder (The University of Washington) and LifeWise ends
- Change or implementation of federal or state laws that no longer permit the continued offering of this contract
- We discontinue this contract to all those covered under this contract as allowed by law. In such instance you will be given at least a 90-day notification of the discontinuation.

There is no extension of coverage beyond the date for which you purchased coverage, unless you continue to qualify as a student, in which case you would need to re-enroll in a timely manner. See ***How to Enroll***.

If you are eligible for the graduate appointee coverage after having international student coverage, and there's a coverage gap between the plans, the International Student Health Insurance Plan will cover any eligible claims during the gap period up to a period of 11 days.

OTHER PLAN INFORMATION

This section tells you about how your Group's contract with us and this plan are administered. It also includes information about federal and state requirements we must follow and other information we must provide to you. You also have the right to ask for any documents, instruments or other information that this contract refers to. If you have any questions about your plan or want to request additional information or forms, please call Customer Service or go to students.lifewiseac.com. Information about your plan is provided to you free of charge.

Benefit Modification

From time to time, we may change the terms of this contract. You will receive prior written notice of any changes,

and 30 days prior written notice of changes to premiums. See ***Notice***.

If the terms of this contract change, those changes will not affect benefits to a member during confinement in a facility. Benefit changes will take effect when you leave the facility, or from any other facility you are transferred to, as long as you are still covered under this plan.

No producer or agent of LifeWise or any other person, is authorized to make any changes, additions, or deletions to this contract or to waive any provision of this contract. Changes, alterations, additions, or exclusions can only be done with the signature of an officer of LifeWise.

Benefits Not Transferable

No person other than you is entitled to receive the benefits of this contract. Such right to these benefits is not transferable. Fraudulent use of such benefits will result in cancellation of your eligibility under this contract and appropriate legal action.

Conformity with the Law

This Contract is issued and delivered in the State of Washington and is governed by the laws of the State of Washington, except to the extent pre-empted by federal law. If any provision of the Contract or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the Contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Entire Contract

The entire contract between the University of Washington and us consists of all of the following:

- The policy (the contract between the policyholder and us)
- The application (the policyholder's application to us)
- This booklet(s) (also referred to as the plan)
- All attachments, endorsements, and riders included or issued hereafter

No representative of LifeWise or any other entity is authorized to make any changes, additions or deletions to the Contract or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done over the signature of an officer of LifeWise.

If there is a language conflict in the contract, the benefit booklet (as amended by any attachments, endorsements or riders) will govern.

Evidence of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before we provide benefits under this plan. This proof may be submitted by you, or on your behalf by your healthcare providers. No benefits will be available if the proof isn't provided or acceptable to us.

ID Card

If you lose your card, or if it gets destroyed, you can get a new one by calling our Customer Service or by visiting our website at students.lifewiseac.com. If coverage under the contract terminates, your ID card will no longer be valid.

The University of Washington and You

The University of Washington is your representative for all purposes under this plan and not the representative of LifeWise. Any action taken by the University of Washington will be binding on you.

When you get care outside Washington

LifeWise members have access to a nationwide network of providers when outside the service area. Dependents that are outside the service area (such as a student attending school) can also access these providers. When you seek care from these providers, covered services are provided at the preferred provider benefit level. These providers will not charge you for amounts over our maximum allowable amount, and they will submit claims directly to us.

Providers who are located outside Washington State and are not contracted with the nationwide network are paid at the out-of-network benefit level.
The only exceptions are:

- Treatment of a medical emergency. See ***Definitions***.
- Treatment of an accidental injury, limited to services received on the day of or within two days following the date of the accidental injury.

When you receive services from providers located outside Washington State, the provider may bill you for charges above the allowed amount if the provider is not contracted. See ***Balance Billing Protection*** for more information.

LifeWise has contracting agreements with a network of providers outside of the service area for this plan. Services from these providers will be paid at the preferred (in-network) benefit level. These providers will also not bill you for any amounts over our allowable charge.

To verify that an individual provider, office location or provider group is a preferred provider before obtaining services, please contact us at the number listed on the back cover. You can also locate the nearest provider in the network by visiting our website at students.lifewiseac.com/iship.

Health Care Providers – Independent Contractors

All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this contract are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors.

Intentionally False or Misleading Statements

If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, we'll be entitled to recover these amounts. See ***Right of Recovery***.

And, if a member commits fraud or makes any intentionally false or misleading statements on any application or enrollment form that affects the member's acceptability for coverage, we may, at our option:

- Deny the member's claim
- Reduce the amount of benefits provided for the member's claim
- Void the member's coverage under this plan (void means to cancel coverage back to its effective date, as if it had never existed at all)

Finally, statements that are fraudulent, intentionally false or misleading on any group form required by us, that affect the acceptability of the Group or the risks to be assumed by us, may cause the Group Contract for this plan to be voided.

Note: We cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Limitations of Liability

We are not legally responsible for any of the following:

- Epidemics, disasters, or other situations that prevent members from getting the care they need
- The quality of services or supplies that members get from providers, or the amounts charged by providers
- Providing any type of hospital, medical, dental, vision, or similar care
- Harm that comes to a member while in a provider's care
- Amounts in excess of the actual cost of services and supplies
- Amounts in excess of this plan's maximums. This includes recovery under any claim of breach
- General or special damages including, without limitation, alleged pain, suffering, mental anguish or consequential damages

Member Cooperation

You're under a duty to cooperate with us in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us in the event of a lawsuit.

Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the 48 hours (or 96 hours).

Nonwaiver

No delay or failure when exercising or enforcing any right under this contract shall constitute a waiver or relinquishment of that right and no waiver or any default under this contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this contract shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

Notice

Any notice we're required to submit to the Group or subscriber will be considered to be delivered if it's mailed or emailed to the Group or subscriber at the most recent mailing or email address appearing on our records. We'll use the date of postmark or email in determining the date of our notification. If you or your Group are required to submit notice to us, it will be considered delivered 3 days after the postmark date, or if not postmarked, the date we receive it.

Notice of Information Use and Disclosure

We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for underwriting or enrollment purposes.)
- Coordinating benefits with other healthcare plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the Group contract

This information may also be collected, used or disclosed as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you, or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact Customer Service and ask a representative to mail a request form to you.

Notice of Other Coverage

As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which we provide benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
- Personal injury protection (PIP)
- Underinsured motorist coverage
- Uninsured motorist coverage
- Any other insurance under which you are or may be entitled to recover compensation
- The name of any other group or individual insurance plans that cover you.

Rights of Assignment

Notwithstanding any other provision in this contract, and subject to any limitations of state or federal law, in the event that we merge or consolidate with another corporation or entity, or do business with another entity under another name, or transfer this contract to another corporation or entity, this contract shall remain in full force and effect, and bind the subscriber and the successor corporation or other entity.

We agree to guarantee that all transferred obligations will be performed by the successor corporation or entity according to the terms and conditions of this contract. In consideration for this guarantee, the subscriber consents to the transfer of this contract to such corporation or entity.

Right of Recovery

We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of their dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

In addition, if this contract is voided as described in ***Intentionally False or Misleading Statements***, we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

Right to and Payment of Benefits

Benefits of this plan are available only to members. Except as required by law, we won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan.

At our option only and in accordance with the law, we may pay the benefits of this plan to:

- The subscriber
- A provider
- Another health insurance carrier
- The member
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies our obligation as to payment of benefits.

Severability

Invalidation of any term or provision herin by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

Venue

All suits or legal proceedings brought against us by you or anyone claiming any right under this plan must be filed:

- Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable
- In the state of Washington or the state where you reside or are employed

All suits or legal or arbitration proceedings brought by us will be filed within the appropriate statutory period of limitation, and you agree that venue, at our option, will be in King County, the state of Washington.

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. See ***Covered Services***.

DISCLOSURES REQUIRED BY THE STATE OF WASHINGTON

Misstatement of Age or Sex

If the age or sex of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age or sex.

- The amount of any underpayments which may have been made on account of any such misstatement under a disability income policy shall be paid the insured along with the current payment and the amount of any overpayment may be charged against the current or succeeding payments to be made by the insurer.
- Interest may be applied to such underpayments or overpayments as specified in the insurance policy form but not exceeding six percent per annum.

Time Limit on Certain Defenses

After two years from the date of issue of this policy no misstatements except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.

Incontestable

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it must become incontestable as to the statements contained in the application.

Reinstatement

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any insurance producer duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, must reinstate the policy: PROVIDED, HOWEVER, that if the insurer or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which

premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

Notice of Claim

Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at the claims address listed on the back cover, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, they shall at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

You should submit all claims within 365 days of the date you received services. No payments will be made by us for claims received more than 365 days after the date of service. Exceptions will be made if we receive documentation of your legal incapacitation or when required by law or regulation. Payment of all claims will be made within the time limits required.

Claim Forms

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid weekly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

Physical Examination and Autopsy

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Grace Period

The grace period for this policy is the 31 consecutive days which begin on the due date of any premium payment for the policyholder.

If, before any premium due date except the first, the policyholder has not given written notice to us of its intention to terminate the policy, a grace period of 31 days will be given in which to pay the premium then due. The policy will stay in effect during that time. If the premium due is not paid by the end of the grace period, the policy will automatically terminate on the last day for which premium was paid and any claims incurred after the premium due date will not be covered by the policy; except that if the policyholder has given written notice in advance of an earlier date of termination, the policy will terminate as of the earlier date.

Right to Return This Contract within Ten Days

If you are not satisfied with this contract after you read it, for any reason, you may return it. You have 10 days after the delivery date for a full refund. Delivery date means 5 days after the postmark date. We will refund your payment no more than 30 days after we receive the returned contract. If your refund takes longer than 30 days, we will add 10 percent to the refund amount.

If you return this contract within the 10-day period, we will treat it as if it was never in effect. However, we have the right to recover any benefits we paid before you returned the contract. We may deduct that amount from your refund.

DEFINITIONS

The information here will help you understand what these words mean. We have the responsibility and authority to use our expertise and judgment to reasonably construe the terms of this contract as they apply to specific eligibility and claims determinations. For example, we use the medical judgment and expertise of Medical Directors to determine whether claims for benefits meet the definitions below of ***Medically Necessary and Medical Necessity*** or ***Experimental/Investigative Services***. We also have medical experts who determine whether care is custodial care or skilled care and reasonably interpret the level of care covered for your medical condition. This does not prevent you from exercising your rights you may have under applicable law to appeal, have independent review or bring a civil challenge to any eligibility or claims determinations.

Accidental Injury

Physical harm caused by a sudden, unexpected event at a certain time and place.

Accidental injury does not mean any of the following:

- An illness, except for infection of a cut or wound
- Dental injuries caused by biting or chewing
- Over-exertion or muscle strains

Adverse Benefit Determination

An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits

- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Ambulatory Surgical Center

A healthcare facility that's licensed or certified as required by the state it operates in and meets all of the following:

- It has an organized staff of physicians.
- It has permanent facilities that are equipped and operated mainly for the purpose of performing surgical procedures.
- It does not provide inpatient services or accommodations.

Applied Behavioral Analysis (ABA)

The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.

Autism Spectrum Disorders

Pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the current Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, as amended or reissued from time to time.

Benefit

What this plan provides for a covered service. The benefits you get are subject to this plan's cost-shares.

Benefit Booklet

Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.

Campus Clinic

Your provider network is: LifeWise Assurance Co.

Provider locations where the highest level of insurance benefits is provided:

- On *University of Washington Seattle* campus for students and covered family members: Husky Health Center, 4060 NE. Stevens Way E, Seattle, WA 98195. Phone: 206-685-1011; or UW Neighborhood Ravenna Clinic, 4915 25th Ave. NE, Suite 300-W, Seattle, WA 98105. Phone: 206-525-7777
- Off campus care *University of Washington Bothell* for students and covered family members: HealthPoint – Bothell Medical Clinic and Pharmacy, 10414 Beardslee Blvd. Suite 100, Bothell, WA 98011. Phone: 425-486-0658
- Off campus care *University of Washington Tacoma* for students and covered family members: Community Healthcare Medical Building at St. Joseph, 1608 S. J St., Third Floor, Tacoma, WA, 98405. Phone: 253-274-7503

Claim

A request for payment from us according to the terms of this plan.

Clinical Trials

An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by the following:

- An institutional review board that complies with federal standards for protecting human research subjects; and
- The United States Department of health and Human Services, National Institutes of Health, or its institutes or centers
- The United States Food and Drug Administration (FDA)
- The United States Department of Defense
- The United States Department of Veterans' Affairs
- A nongovernmental research entity abiding by current National Institute of Health guidelines

Comprehensive Oral Evaluation

Comprehensive oral evaluations include complete dental/medical history and general health assessment, complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; the evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screenings.

Congenital Anomaly

A marked difference from the normal structure of an infant's body part that's present from birth.

Contract

Contract describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan.

Cosmetic Services

Services that are performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.

Cost Share

The part of healthcare costs that you have to pay. These are deductibles, coinsurance, and copayments.

Covered Service

A service, supply or drug that is eligible for benefits under the terms of this Plan.

Custodial Care

Any part of a service, procedure, or supply that is provided primarily:

- For ongoing maintenance of the member's health and not for it its therapeutic value in the treatment of an illness or injury
- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Dental Emergency

A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected injury,

acute infection or similar occurrence.

Dentally Necessary and Dental Necessity

Those covered services which are determined to meet all of the following requirements:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan
- Appropriate and consistent with authoritative dental or scientific literature
- Not primarily for the convenience of the member, the member's family, the member's dental care provider or another provider

Dependent

The subscriber's spouse or domestic partner and any children who are on this plan.

Detoxification

Active medical management of substance intoxication or substance withdrawal. Active medical management means repeated physical examination appropriate to the substance taken, repeated vital sign monitoring, and use of medication to manage intoxication or withdrawal.

Observation without active medical management, or any service that is claimed to be detoxification but does not include active medical management, is not detoxification.

Doctor (also called "Physician")

A state-licensed:

- Doctor of Medicine and Surgery (MD)
- Doctor of Osteopathy (DO)

Effective Date

The date your coverage under this plan begins.

Emergency Medical Condition (also called "Emergency")

A medical condition, mental health, or substance use disorder condition which manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the member's health or the unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Examples of an emergency medical condition are severe pain, suspected heart attacks and fractures. Examples of a non-emergency medical condition are minor cuts and scrapes.

Emergency Services

- A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary services given in an emergency department. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health.
- Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical, mental health, or substance use disorder treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant member in active labor, to perform the delivery.
- Ambulance transport, as needed, in support of the services above.

Endorsement

A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.

Essential Health Benefits

Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

Experimental/Investigative Services

A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the US Food and Drug Administration and does not have approval on the date the service is provided
- It is subject to oversight by an Institutional Review Board
- There is no reliable evidence showing that the service or drug is effective in clinical diagnosis, evaluation, management or treatment of the condition
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies

Reliable evidence means only published reports and articles in authoritative medical and scientific literature, and assessments.

Explanation of Benefits

An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.

Facility (Medical Facility)

A hospital, skilled nursing facility, approved treatment facility for substance use disorder, state-approved institution for treatment of mental or psychiatric conditions, or hospice. Not all health care facilities are covered under this contract.

Full Premium

The full premium/cost of coverage is the amount of premium for the period of time (quarterly or annual coverage) and family coverage (subscriber only, subscriber/spouse, etc.) offered under this contract.

Health Care Benefit Managers

Health Care Benefit Managers (HCBM): A person or entity that specializes in managing certain services for a health carrier or employee benefits programs. An HCBM may also make determinations for utilization of benefits and prior authorization for health care services, drugs, and supplies. These include pharmacy, radiology, laboratory, and mental health benefit managers.

Home Health Agency

An organization that provides covered home health services to a member.

Home Medical Equipment (HME)

Equipment ordered by a healthcare provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches. This is also sometimes known as “Durable Medical Equipment” or “DME.”

Hospice

A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill. Care is focused on comfort and not intended to cure or improve the medical or functional outcome of a patient’s condition or to prepare the patient for outpatient care settings.

Hospital

A healthcare facility that meets all of these criteria:

- It operates legally as a hospital in the state where it is located
- It has facilities for the diagnosis, treatment and acute care of injured and ill persons as inpatients
- It has a staff of providers that provides or supervises the care
- It has 24-hour nursing services provided by or supervised by registered nurses

A facility is not considered a hospital if it operates mainly for any of the purposes below:

- As a rest home, nursing home, or convalescent home
- As a residential treatment center or health resort
- To provide hospice care for terminally ill patients
- To care for the elderly
- To treat substance use disorder or tuberculosis

Illness

A sickness, disease, or medical condition.

Injury

Physical harm caused by a sudden event at a specific time and place. It is independent of illness, except for infection of a cut or wound.

Inpatient

Confined in a medical facility or as an overnight bed patient.

Lifetime Maximum

The maximum amount that LifeWise Assurance Company will provide during your lifetime.

Limited Oral Evaluation – Problem Focused

A limited oral evaluation – problem focused is an evaluation limited to a specific oral health problem or complaint and may include evaluation of a specific dental problem or oral health complaint, dental emergency and referral for other treatment.

Long-term Care Facility

A nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.023, or assisted living facility licensed under chapter 18.20 RCW.

Maternity Care

Health services you get during pregnancy (before, during, and after birth) or for any condition caused by pregnancy. This includes the entire time you are pregnant and up to 45 days after birth.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury.

Medically Necessary and Medical Necessity

Services a provider, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must:

- Agree with generally accepted standards of medical practice
- Be clinically appropriate in type, frequency, extent, site and duration., They must also be considered effective for the patient's illness, injury or disease
- Not be mostly for the convenience of the patient, physician, or other healthcare provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member (also called "You" or "Your")

A person covered under this plan as a subscriber or dependent.

Mental Health Conditions

A condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatments for substance use disorder.

Non-Contracted Provider

A provider that does not have a contract with us or with any of the other networks used by this plan.

Non-Participating Provider

A provider that is not in one of the provider networks stated in ***How Providers Affect Your Costs*** or does not have a contract with us.

Observation

Monitoring and evaluation at a Hospital or other facility in order to determine whether an inpatient stay is required.

Orthodontia

The branch of dentistry which specializes in tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Outpatient

Treatment received in a setting other than as inpatient in a medical facility.

Outpatient Surgical Center

A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians.

- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures.
- It doesn't provide inpatient services or accommodations.

Pharmacy Benefit Manager

An entity that contracts with us to administer the ***Prescription Drugs*** benefit under this plan.

Plan

The benefits, terms, and limitations stated in this contract between us and the University of Washington.

Plan Year (Year)

A 12-month period beginning and ending on the effective dates of the plan.

Prescription Drugs

Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription." Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

One of the following standard reference compendia:

- The American Hospital Formulary Service-Drug Information
- The American Medical Association Drug Evaluation
- The United States Pharmacopoeia-Drug Information
- Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner

If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts)

"Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling. Benefits aren't available for any drug when the US Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Prior Authorization

Prior authorization is a process that requires you or a provider to follow to determine if a service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care or effectiveness. You must ask for prior authorization before the service is delivered. See ***Prior Authorization*** for details.

Provider

A person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care-related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of their employment.

Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the State of Washington and other such facilities are included as required by state and federal law.

Covered categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

The providers are:

- Acupuncturists (LAc) (In Washington also called “East Asian Medicine Practitioners” (EAMP)
- Audiologists
- Chiropractors (DC)
- Counselors
- Dental Hygienists (under the supervision of a DDS or DMD)
- Dentists (DDS or DMD)
- Denturists
- Dietitians and Nutritionists (D or CD, or CN)
- Gynecologists
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (LMP)
- Midwives
- Naturopathic Physicians (ND)
- Nurses (RN, LPN, ARNP, or NP)
- Nursing Homes
- Obstetricians
- Occupational Therapists (OTA)
- Ocularists
- Opticians (Dispensing)
- Optometrists (OD)
- Osteopathic Physician Assistants (OPA) (under the supervision of a DO)
- Osteopathic Physicians (DO)
- Pharmacists (RPh)
- Physical Therapists (LPT)
- Physician Assistants (PA) (under the supervision of an MD)
- Physicians (MD)
- Podiatric Physicians (DPM)
- Psychologists (PhD)
- Radiologic Technologists (CRT, CRTT, CRDT, CNMT)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

The following healthcare facilities and other providers will also be considered providers for the purposes of this plan when they meet the requirements above.

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks

- Board Certified Behavior Analyst (BCBA), certified by the Behavior Analyst Certification Board, and state-licensed in states that have specific licensure for behavior analysts
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

In states other than Washington, "provider" means healthcare practitioners and facilities that are licensed or certified consistent with the laws and regulations of the state in which they operate.

This plan makes use of provider networks as explained in ***How Providers Affect Your Costs***.

Psychiatric Condition

A condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatment for substance use disorder.

Reconstructive Surgery

Is surgery:

- That restores features damaged as a result of injury or illness.
- To correct a congenital deformity or anomaly.

Rehabilitation Therapy

Rehabilitation therapy or devices are medical services or devices provided when medically necessary for restoration of bodily or cognitive functions lost due to a medical condition.

Rehabilitation therapy includes physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope of their license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.

Service Area

The service area for this plan is the states of Washington, Oregon and Alaska.

Services

Procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies or places of service.

Skilled Nursing Care

Medical care ordered by a physician and requiring the knowledge and training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility licensed by the state to provide nursing services that require the direction of a physician and nursing supervised by a registered nurse, and that is approved by Medicare or would qualify for Medicare approval if so requested.

Sound Natural Tooth

A tooth that:

- Is organic and formed by the natural development of the body (not manufactured)

- Has not been extensively restored
- Has not become extensively decayed or involved in periodontal disease
- Is not more susceptible to injury than a whole natural tooth

Specialist

A provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse

- An individual who is legally married to the subscriber.
- An individual who is a domestic partner of the subscriber.

Subscriber

The person in whose name the plan is issued.

Substance Use Disorder Conditions

Substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance use disorder is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance use disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

Urgent Care

Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours.

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused.

Originating site: Hospital, rural health clinic, federally qualified health center, physician’s or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center.

Visit

A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.

Visual Oral Screenings or Assessments

Performed by a licensed dentist or dental hygienist under the supervision of a licensed dentist to determine the need for sealants, fluoride treatment, and/or when triage services are provided in settings other than dental offices or dental clinics.

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