



BOTHELL "ISHIP" INTERNATIONAL STUDENT HEALTH INSURANCE PLAN

Gold + Vision/Dental



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. Please 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 at student.lifewiseac.com/uw/bt 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 student.lifewiseac.com/uw/bt.

This plan will comply with the federal health care reform law, called the Affordable Care Act (see **Definitions**), including any applicable requirements for distribution of any medical loss ratio rebates and actuarial value requirements. If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, including changes which become effective on the beginning of the calendar year, this plan will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

Translation Services

If you need an interpreter to help with oral translation services, please call us. Customer Service will be able to guide you through the service.

Group Name: University of Washington

Effective Date: September 1, 2015

Group Number: 9000035

Plan: LifeWise ISHIP PPO + Vision/Dental

Certificate Form Number: ISHIP UW B (09-2015)

HOW TO USE THIS BENEFIT BOOKLET

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, copayments, 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
- **Health Support Programs** – Describes our health support programs
- **Disease Management** – Describes our disease management provision
- **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** – 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
- **Sending us a Claim** –Instructions on how to send in a claim
- **Complaints and Appeals** – What to do if you want to share ideas, ask questions, file a complaint, or submit an appeal
- **Eligibility and Enrollment** – Describes who can be covered.
- **Termination of Coverage** – 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

TABLE OF CONTENTS

| | |
|---|-----------|
| HOW TO CONTACT US.....(SEE BACK COVER OF THIS BOOKLET) | |
| SUMMARY OF YOUR COSTS | 1 |
| IMPORTANT PLAN INFORMATION | 7 |
| Calendar Year Deductible | 7 |
| Copayments | 7 |
| Coinsurance | 7 |
| Out-of-Pocket Maximum | 7 |
| Allowed Amount | 7 |
| HOW PROVIDERS AFFECT YOUR COSTS | 8 |
| Pediatric Dental Services | 9 |
| CARE MANAGEMENT | 9 |
| Prior Authorization and Emergency Admission Notification..... | 9 |
| Clinical Review..... | 10 |
| Health Support Programs..... | 10 |
| Disease Management | 10 |
| Continuity of Care | 11 |
| COVERED SERVICES..... | 11 |
| Common Medical Services | 12 |
| Other Covered Services..... | 26 |
| EXCLUSIONS | 31 |
| OTHER COVERAGE..... | 34 |
| Excess Provision..... | 34 |
| Third Party Liability (Subrogation)..... | 34 |
| SENDING US A CLAIM | 35 |
| COMPLAINTS AND APPEALS | 36 |
| ELIGIBILITY AND ENROLLMENT | 39 |
| OTHER PLAN INFORMATION..... | 42 |
| DEFINITIONS | 44 |

SUMMARY OF YOUR COSTS

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

- The allowed amount. This is the most this plan allows 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.
- 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. When services are subject to in-network benefit level or cost shares, the in-network deductible applies.

| | Campus Clinic Providers | In-Network Providers | Out-of-Network Providers |
|--|-------------------------|---|--------------------------|
| Individual Deductible Deductible waived at Campus Clinic | None | \$100 per quarter/ \$400 per plan year | |
| Family deductible Deductible waived at Campus Clinic | Not Available | \$200 per quarter/ \$800 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 by us in writing before you get them, in order to be eligible for benefits. 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 to facility fees billed by the hospital. See **Hospital Services** for these costs.

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

Note: Not all services are provided at Campus Clinic.

| | YOUR COSTS OF THE ALLOWED AMOUNT | |
|---|---|---|
| | CAMPUS CLINIC AND IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |
| COMMON MEDICAL SERVICES | | |
| Office and Clinic Visits You may have additional costs for other services such as x-rays lab, therapeutic injections and hospital facility charges. See those covered services for details. See Preventive Care for preventive services. | | |
| <ul style="list-style-type: none"> • Office visits • Telehealth services. See Telehealth Virtual Care Services. • Office visit for women's health • Non-hospital urgent care centers • All other office and clinic visits | 25% coinsurance 25% coinsurance 25% coinsurance 25% coinsurance 25% coinsurance | 40% coinsurance 40% coinsurance 40% coinsurance 40% coinsurance 40% coinsurance |

| YOUR COSTS OF THE ALLOWED AMOUNT | |
|--|--------------------------|
| CAMPUS CLINIC AND IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |

| | | |
|--|--|--|
| <p>Preventive Care Benefits for preventive care that meet the federal guidelines are not subject to cost sharing when care is provided by Hall Health or an in-network provider.</p> <ul style="list-style-type: none"> 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 Seasonal and travel immunizations (pharmacy, mass immunizer, travel clinic and county health department) Health education and nicotine dependency treatment | <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> | <p>Not covered</p> <p>0% coinsurance, deductible waived</p> <p>Not covered</p> |
| <p>Contraception Management and Sterilization</p> | <p>0% coinsurance, deductible waived</p> | <p>40% coinsurance</p> |
| <p>Diagnostic X-ray, Lab and Imaging</p> <ul style="list-style-type: none"> Preventive care screening and tests Basic diagnostic x-ray, lab and imaging Major diagnostic x-ray and imaging | <p>0% coinsurance, deductible waived</p> <p>25% coinsurance, deductible waived</p> <p>25% coinsurance</p> | <p>40% coinsurance</p> <p>40% coinsurance</p> <p>40% coinsurance</p> |
| <p>Pediatric Care (members under age 19)</p> <p>Pediatric Vision Services</p> <ul style="list-style-type: none"> Routine exams limited to one per plan year One pair of glasses (frames and lenses) per plan year. Lens features limited to polycarbonate lenses and scratch resistant coating. One pair of contacts per plan year in lieu of glasses, or a year supply of disposable contacts. Contact lenses and glasses required for medical reasons One comprehensive low vision evaluation and four follow up visits in a five plan year period Low vision devices, high powered spectacles, medical vision hardware, magnifiers and telescopes when medically necessary <p>Pediatric Dental Services</p> <ul style="list-style-type: none"> Class I Services Class II Services Class III Services Medically Necessary Orthodontia | <p>25% coinsurance</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>10% coinsurance</p> <p>20% coinsurance</p> <p>50% coinsurance</p> <p>50% coinsurance</p> | <p>40% coinsurance</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>30% coinsurance</p> <p>40% coinsurance</p> <p>50% coinsurance</p> <p>50% coinsurance</p> |

| | YOUR COSTS OF THE ALLOWED AMOUNT | |
|---|---|--|
| | CAMPUS CLINIC AND IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |
| Prescription Drugs– Retail Pharmacy Up to a 30-day supply. The quarterly deductible is waived. Maximum copay/coinsurance of up to \$150/prescription. - <ul style="list-style-type: none"> • Preventive drugs • Formulary generic drugs • Formulary brand-name drugs • Non-formulary drugs • Specialty drugs | 0% coinsurance, deductible waived \$20 copay \$30 copay \$45 copay 50% coinsurance, deductible waived | 50% coinsurance, deductible waived based on billed charge |
| Hospital and Surgery Services <ul style="list-style-type: none"> • Inpatient hospital • Outpatient hospital, ambulatory surgical center • Professional services | 25% coinsurance 25% coinsurance 25% coinsurance | 40% coinsurance 40% coinsurance 40% coinsurance |
| Emergency Room <ul style="list-style-type: none"> • Facility fees. The copay is waived if you are admitted as an inpatient through the emergency room. • Professional, diagnostic services, other services and supplies | \$100 copay, then deductible, 25% coinsurance 25% coinsurance | \$100 copay, then deductible, 25% coinsurance 25% coinsurance |
| Emergency Ambulance Services | 25% coinsurance | 25% coinsurance |
| Urgent Care Centers | 25% coinsurance | 40% coinsurance |
| Hospital Services <ul style="list-style-type: none"> • Inpatient Care • Outpatient Care | 25% coinsurance 25% coinsurance | 40% coinsurance 40% coinsurance |
| Mental Health, Behavioral Health and Substance Abuse <ul style="list-style-type: none"> • Office visits (there are no fees at the Counseling Center for registered students) • Inpatient and residential | 25% coinsurance 25% coinsurance | 40% coinsurance 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. <ul style="list-style-type: none"> • Hospital • Birthing center or short-stay facility • Diagnostic tests during pregnancy • Professional | 25% coinsurance 25% coinsurance 25% coinsurance 25% coinsurance | 40% coinsurance 40% coinsurance 40% coinsurance 40% coinsurance |
| Home Health Care Limited to 130 visits per plan year | 25% coinsurance | 40% coinsurance |

| | YOUR COSTS OF THE ALLOWED AMOUNT | |
|--|---|------------------------------------|
| | CAMPUS CLINIC AND IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |
| Hospice Care <ul style="list-style-type: none"> Home visits Respite care, inpatient or outpatient (limited to 14 days lifetime) | 25% coinsurance 25% coinsurance | 40% coinsurance 40% coinsurance |
| Habilitation Therapy Neuropsychological testing to diagnose is not subject to any maximum. Please see <i>Mental Health, Behavioral Health and Substance Abuse</i> for therapies provided for mental health conditions such as autism. <ul style="list-style-type: none"> Inpatient (limited to 30 days per plan year) Outpatient (limited to 25 visits per plan year) | 25% coinsurance 25% coinsurance | 40% coinsurance 40% coinsurance |
| Rehabilitation Therapy Please see <i>Mental Health, Behavioral Health and Substance Abuse</i> for therapies provided for mental health conditions such as autism. <ul style="list-style-type: none"> Inpatient (limited to 30 days per plan year) Outpatient (limited to 25 visits per plan year) | 25% coinsurance 25% coinsurance | 40% coinsurance 40% coinsurance |
| Skilled Nursing Facility and Care <ul style="list-style-type: none"> Skilled nursing facility care limited to 60 days per plan year Skilled nursing care in the long-term care facility care limited to 60 days per plan year | 25% coinsurance 25% coinsurance | 40% coinsurance 40% coinsurance |
| Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics Shoe inserts and orthopedic shoes limited to \$300 per plan year, except when diabetes-related. Sales tax, shipping and handling costs apply to any limit if billed and paid separately. | 25% coinsurance | 40% coinsurance |
| OTHER COVERED SERVICES | | |
| Acupuncture Limited to 12 visits per plan year. Unlimited for chemical dependency treatment | 25% coinsurance | 40% coinsurance |
| Allergy Testing and Treatment | 25% coinsurance | 40% coinsurance |
| Chemotherapy, Radiation Therapy and Kidney Dialysis | 25% coinsurance | 40% coinsurance |
| Clinical Trials | Covered as any other service | Covered as any other service |

| | YOUR COSTS OF THE ALLOWED AMOUNT | |
|---|--|-----------------------------------|
| | CAMPUS CLINIC AND IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |
| Dental Accidents | Covered as any other service | Covered as any other service |
| Dental Anesthesia When medically necessary | 25% coinsurance | 40% coinsurance |
| Foot Care Routine care that is medically necessary for the treatment of diabetes | 25% coinsurance | 40% coinsurance |
| Infusion Therapy | 25% coinsurance | 40% coinsurance |
| Mastectomy and Breast Reconstruction | 25% coinsurance | 40% coinsurance |
| Medical Foods | 25% coinsurance | 40% coinsurance |
| Spinal or Other Manipulative Treatment Limited to 10 visits per plan year | 25% coinsurance | 40% coinsurance |
| Temporomandibular Joint (TMJ) Disorders | | |
| • Office visits | 25% coinsurance | 40% coinsurance |
| • Inpatient facility fees | 25% coinsurance | 40% coinsurance |
| • Other professional services | 25% coinsurance | 40% coinsurance |
| Therapeutic Injections | 25% coinsurance | 40% coinsurance |
| Transplants All approved transplant centers covered at in-network benefit level. | | |
| • Office visits | 25% coinsurance | Not covered |
| • Inpatient facility fees | 25% coinsurance | Not covered |
| • Other professional services | 25% coinsurance | Not covered |
| • Travel and lodging. \$5,000 limit per transplant. | 0% coinsurance | 0% coinsurance |
| Abortion | 25% coinsurance | 40% coinsurance |
| Transgender Surgery | 25% coinsurance | 40% coinsurance |
| 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 <i>Pediatric Vision Services</i> . | | |
| • Vision exams (limited to 1 per plan year up to maximum of \$150 per plan year) | 0% coinsurance, deductible waived | 0% coinsurance, deductible waived |
| • Vision hardware (maximum of \$150 per plan year) | 0% coinsurance, deductible waived | 0% coinsurance, deductible waived |

| | YOUR COSTS OF THE ALLOWED AMOUNT | |
|--|---|---|
| | CAMPUS CLINIC AND IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |
| <p>Dental for Adults (maximum of \$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 <i>Pediatric Dental Services</i>.</p> | | |
| <ul style="list-style-type: none"> Preventive Services (includes routine exams and cleanings). See the <i>Dental for Adults</i> for more detail. | Dental deductible, then 0% coinsurance | Dental deductible, then 0% coinsurance |
| <ul style="list-style-type: none"> 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 |
| <p>Emergency Medical Evacuation and Repatriation of Remains Services do not apply toward the out-of-pocket maximum shown above.</p> <ul style="list-style-type: none"> Emergency Medical Evacuation (\$100,000 lifetime maximum) Repatriation of Remains (\$25,000 maximum). | <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> | <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> |

IMPORTANT PLAN INFORMATION

This plan is a Preferred Provider Plan (PPO). Your plan provides you benefits for covered services from providers within the LifeWise 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. Please 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.

PLAN YEAR DEDUCTIBLE

A deductible is what you have to pay for covered services for each plan year 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 the ***Summary of Your Costs*** for your individual deductible amount.
Family Deductible

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

The **Plan Year Deductible** is subject to the following:

- There is no carry over provision. Amount credited to your deductible during the current plan year will not carry forward to the next plan year deductible
- Amounts credited to the deductible will not exceed the allowed amount
- Copayments are not applied to the deductible
- Amounts credited toward the deductible do not add to benefits with an annual 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 allowable charge
- Charges for excluded services

COPAYMENTS

A copayment is a dollar amount that you are responsible for paying to a healthcare provider for a covered service. A copayment is also called a copay.

COINSURANCE

Coinsurance is the percentage of the covered service that you are responsible to pay when you receive covered services.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is a limit on how much you pay each plan year. After you meet the out-of-pocket maximum this plan pays 100% of the allowed amount for the rest of the plan year. See the ***Summary of Your Costs*** for further detail.

Expenses that do not apply to 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 say they do not apply to the out-of-pocket maximum on the ***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.

Covered Medical Services Received in the Service Area

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. See the ***Summary of Your Costs*** for the name of your provider network.

Out-of-Network

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), if available
- The provider's billed charges

End Stage Renal Disease

In-Network Providers

The allowed amount is the fee that LifeWise has negotiated with its in-network providers for covered services.

Out-of-Network Providers

For dialysis due to End-Stage Renal Disease, the allowed amount will be no less than fee that LifeWise has negotiated with its in-network providers and no more than 90% of billed charges.

Pediatric 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 of provider fees in that geographic area.

Emergency Services

Consistent with the requirements of the Affordable Care Act the allowed amount will be the greater of the following:

- The median amount in-network providers have agreed to accept for the same services
- The amount Medicare would allow for the same services
- The amount calculated by the same method the plan uses to determine payment to out-of-network providers

In addition to your deductible, copayments and coinsurance, you will be responsible for charges received from out-of-network providers above the allowed amount.

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

HOW PROVIDERS AFFECT YOUR COSTS

MEDICAL SERVICES

This plan is a Preferred Provider plan (PPO). This means that your plan provides you benefits for covered services from providers of your choice. It also gives you access to the LifeWise provider network and to networks in other states with which we have arranged to provide covered services to you. Hospitals, physicians and other providers in these networks are called "in-network providers."

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 network before you receive services.

Our provider directory is available any time on our website at student.lifewiseac.com/uw/bt. 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 provide medical services for a negotiated fee. This fee is the allowed amount for in-network providers.

When you receive covered services from an in-network provider, your medical bills will be reimbursed at a higher percentage (the in-network provider benefit level). 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.

If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-network provider at the in-network benefit level. See **Prior Authorization** for details.

Out-of-Network Providers

Out-of-network providers are providers that are not part of your network. 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 **Sending Us a Claim** for details.

In-Network Benefits for Out-of-Network Providers

The following covered services and supplies provided by out-of-network providers will always be covered at the in-network level of benefits:

- Emergency care for a medical emergency. (Please see the "Definitions" section for definitions of these terms.) This plan provides worldwide coverage for emergency care.

The benefits of this plan will be provided for covered emergency care without the need for any prior authorization and without regard as to whether the health care provider furnishing the services is a network provider. Emergency care

furnished by an out-of-network provider will be reimbursed on the same basis as a network provider. As explained above, if you see an out-of-network provider, you may be responsible for amounts that exceed the allowable charge.

- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- 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 in Washington from a hospital that has a provider contract with us, if you were admitted to that hospital by an in-network provider who doesn't have admitting privileges at an in-network hospital.
- Covered services received from providers located outside the United States.

If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-network provider at the in-network benefit level. However, you 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. You have access to these network providers wherever you are in the United States.

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 the **Summary of Your Costs** for cost share amounts.

To locate an in-network provider wherever 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 **Sending Us a Claim** for details.

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 by us 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

Prior authorization is never required for emergency care.

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 the all 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.

Prior Authorization for Prescription Drugs

Certain prescription drugs you receive through a pharmacy must have prior authorization before you get them at a pharmacy, in order for us to provide benefits. Your provider can ask for a prior authorization by faxing a prior authorization form to us. This form is on the pharmacy section of our website at student.lifewiseac.com/uw/bt. See the specific list of prescription drugs requiring prior authorization on our website on student.lifewiseac.com/uw/bt. If your prescription drug is on this list and you do not get prior authorization, when you go to the pharmacy to fill your prescription, your pharmacy will tell you that it needs to be prior authorized. You or your pharmacy should call your provider to let them know. Your provider can fax us a prior authorization form for review.

You can 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 ***Sending Us a Claim*** for details.

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 service 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. In addition to the cost shares, you will be required to pay any amounts over the allowed amount if the provider does not have a contracting agreement with us.

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 student.lifewiseac.com/uw/bt. 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/investigational. A decision by LifeWise following this review may be appealed in the manner described in ***Complaints and Appeals***. When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

HEALTH SUPPORT PROGRAMS

Case management works cooperatively with you and your doctor to consider effective alternatives to hospitalization and other high cost care. Working together we can make more efficient use of your plan's benefits. Your participation in a treatment plan through case management is voluntary.

DISEASE MANAGEMENT

LifeWise's 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 doctor 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 health support programs is voluntary.

To learn more about the program contact Customer Service at the number listed on your LifeWise ID card.

CONTINUITY OF CARE

You may be able to continue to receive covered services from a provider for a limited period of time at the in-network benefit level after the provider ends his/her contract with LifeWise. To be eligible for continuity of care you must be covered under this plan, in an active treatment plan and receiving covered services from an in-network provider at the time the provider ends his/her contract with LifeWise. The treatment must be medically necessary and you and this provider agree that it is necessary for you to maintain continuity of care.

We will not provide continuity of care if your provider:

- Will not accept the reimbursement rate applicable at the time the provider contract terminates
- Retired
- Died
- No longer holds an active license
- Relocates out of the service area
- Goes on sabbatical
- Is prevented from continuing to care for patients because of other circumstances
- Terminates the contractual relationship in accordance with provisions of contract relating to quality of care and exhausts his/her contractual appeal rights

We will not provide continuity of care if you are no longer covered under this plan.

We will notify you no later than 10 days after your provider's LifeWise contract ends if we reasonably know that you are under an active treatment plan. If we learn that you are under an active treatment plan after your provider's contract termination date, we will notify you no later than the 10th day after we become aware of this fact.

You can call or send your request to receive continuity of care to Care Management at the address or fax number shown on the back cover.

Duration of Continuity of Care

If you are eligible 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 90th day after we notified you that your

provider's contract ended, or the date your request for continuity of care was received or approved by us, whichever is earlier

- The day after you complete the active course of treatment entitling you to continuity of care
- If you are pregnant, and become eligible for continuity of care after commencement of the second trimester of the pregnancy, you will receive continuity of care
- As long as you continue under an active course of treatment, but no later than the 90th day after we notified you that your provider's contract ended, or the date your request for continuity of care was received or approved by us, whichever is earlier.

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 subject to the allowed amount. Please refer to the **How Providers Affect Your Costs** for an illustration about benefit payments. If we deny your request for continuity of care, you may request an appeal of the denial. Please refer to **Complaints and Appeals** for information on how to submit a complaint review request.

COVERED SERVICES

This section describes the services this plan covers. Covered services means medically necessary services (see **Definitions**) and specified preventive care services you receive when you are covered for that benefit. This plan provides benefits for covered services only if all of the following are true when you receive the services:

- The reason for the services is to prevent, diagnose or treat a covered illness 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.
- The service is not excluded
- The provider is working within the scope of their license or certification

This plan may exclude or limit benefits for some services. See the specific benefits in this section and **Exclusions** for details.

Benefits for covered services are subject to the following:

- Copays
- Deductibles
- Coinsurance
- Benefit limits
- Prior Authorization. Some services must be authorized in writing by us before you get them.

These services are identified in this section. For more information see **Prior Authorization**.

- Medical and payment policies. The plan has policies used to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigational status for specific procedure, drugs, biologic agents, devices, level of care or services. Payment policies define our 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). Our policies are available to you and your provider at student.lifewiseac.com/uw/bt or by calling Customer Service.

If you have any questions regarding your benefits and how to use them, call Customer Service at the number listed.

COMMON MEDICAL SERVICES

The services listed in this section are covered as shown on the **Summary of Your Costs**. Please 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. 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, therapeutic injections and office surgeries.

Some outpatient services you get from a specialist must be prior authorized. 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

This plan covers preventive care as described below. "Preventive care" is a specific set of evidence-based services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies.

Preventive services have limits on how often you should get them. These limits are based on your age and gender. Some of the services you get as part of

a routine exam may not meet preventive guidelines and would be covered as part of medical benefits.

The plan covers the following as preventive services:

- Covered preventive services include those with an "A" or "B" rating by the United States Preventive Task Force (USPTF); immunizations recommended by the Centers for Disease Control and Prevention and as required by state law; and preventive care and screening recommended by the Health Resources and Services Administration (HRSA).
- Routine exams and well-baby care. Includes exams for school, sports and employment
- Women's preventive exams. Includes pelvic exams, pap smears and clinical breast exams.
- Screening mammograms. See **Diagnostic Lab, X-ray and Imaging** for mammograms needed because of a medical condition.
- Pregnant women's services such as breast feeding counseling before and after delivery, maternity diagnostic screening and diabetic supplies
- Electric breast pumps and supplies. Includes the purchase of a non-hospital grade breast pump or rental of a hospital grade breast pump. The cost of the rental cannot be more than the purchase price. For electric breast pumps and supplies purchased at a retail location you will need to pay out of pocket and submit a claim for reimbursement. See **Sending Us a Claim** for instructions.
- Prostate cancer screening. Includes digital rectal exams and prostate-specific antigen (PSA) tests.
- Colon cancer screening. Includes exams, colonoscopy, sigmoidoscopy and fecal occult blood tests. Covered colonoscopy/sigmoidoscopy services include medically necessary sedation. Removal of polyps during a screening colonoscopy procedure will be included as part of the preventive screening.
- Outpatient lab and radiology for preventive screening and tests
- Medical diabetes management
- Routine immunizations and vaccinations as recommended by your physician. You can also get flu shots, flu mist, and immunizations for shingles, pneumonia and pertussis at a pharmacy or other center. If you use an out-of-network provider you may need to pay out of pocket and submit a claim for reimbursement. See **Sending Us a Claim** for instructions.
- Contraceptive management. Includes exams, treatment, and supplies you get at your provider's office, including all FDA approved contraceptives.

FDA approved contraceptives include but are not limited to, emergency contraceptives, and contraceptive devices (insertion and removal). Tubal ligation and vasectomy are also covered. See **Prescription Drugs** for prescribed oral contraceptives and devices.

- Health education and training for covered conditions such as diabetes, high cholesterol and obesity. Includes outpatient self-management programs, training, classes and instruction.
- Nutritional therapy. Includes outpatient visits with a physician, nurse, pharmacist or registered dietitians. The purpose of the therapy must be to manage a chronic disease or condition such as diabetes, high cholesterol and obesity.
- Preventive drugs required by federal law. See **Prescription Drugs**.
- Approved tobacco use cessation programs recommended by your physician. After you have completed the program, please provide us with proof of payment and a completed reimbursement form. You can get a reimbursement form on our website at student.lifewiseac.com/uw/bt. See **Prescription Drugs** for covered drug benefits.

You can get a complete list of the preventive care services with these limits on our website at student.lifewiseac.com/uw/bt or call us for a list. This list may be changed as required by state and federal preventive guidelines change. The list will include website addresses where you can see current federal preventive guidelines.

This benefit does not cover:

- Charges for services that don't meet preventive guidelines, even when provided during a scheduled preventive care visit or recommended by your doctor. This includes services provided more often than the guidelines allow.
- 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.
- Prescription contraceptives, including over-the-counter items, dispensed and billed by your provider or a hospital. See **Prescription Drugs** for prescribed contraceptives.
- Gym memberships or exercise classes and programs
- Inpatient newborn exams while the child is in the hospital following birth. See **Maternity and Newborns** for those covered services.
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations

Diagnostic X-ray, Lab and Imaging

This plan covers diagnostic medical tests that help find or identify diseases. Covered services include interpreting these tests for covered medical conditions. Some diagnostic tests, such as MRA, MRI, CT and echocardiograms require prior authorization. See **Prior Authorization** for details.

Preventive Care Screening and Tests

Preventive care screening and tests are covered in full when provided by an in-network provider. "Preventive care" is a specific set of evidence-based services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies. For more information about what services are covered as preventive see **Preventive Care**.

Basic Diagnostic X-ray, Lab and Imaging

Basic diagnostic x-ray, lab and imaging services that do not meet the preventive guidelines include but are not limited to:

- Barium enema
- Blood and blood services (storage and procurement, including blood banks), when medically necessary
- Bone density screening for osteoporosis
- Cardiac testing, including pulmonary function studies
- Diagnostic imaging like x-rays and echocardiograms
- Lab services
- Mammograms for a medical condition
- Neurological and neuromuscular tests
- Pathology tests

Major Diagnostic X-ray and Imaging

Major diagnostic x-ray and imaging services include:

- Computed Tomography (CT) scan
- High technology ultrasounds
- Nuclear cardiology
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) scan

The diagnostic x-ray, lab and imaging benefit does not cover:

- Diagnostic services from an inpatient facility, an outpatient facility, or emergency room that are billed with other hospital or emergency room services. These services are covered under inpatient, outpatient or emergency room benefits.
- Allergy tests. These services are covered under

the **Allergy Testing and Treatment** benefit.

Pediatric Care

This plan covers vision and dental services for covered children. A child under age 19 (who has not reached their 19th birthday) is eligible for these services as stated on the **Summary of Your Costs**, unless otherwise stated below.

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

Pediatric Dental Services

Coverage is available for a covered dental condition. 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 (D.M.D. or D.D.S.) 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 his or her 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. These materials will be requested directly from your dental care provider. If we're unable to obtain necessary materials, we'll provide benefits only for those dental services we can verify as covered.

You can ask for an **Estimate of Benefits**. An **Estimate of Benefits** verifies, for the dental care provider and yourself, your eligibility and benefits. It may also clarify, before services are rendered,

treatment that isn't covered in whole or in part. This can protect you from unexpected out-of-pocket expenses.

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

Our **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 services are rendered. Please see the back cover for the address and fax for an **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

Benefits include the following services:

- Routine oral examinations are limited to 2 visits per plan year. Comprehensive and periodic oral examinations count toward the limit for oral examinations.
- Prophylaxis (cleaning, scaling, and polishing of teeth) is limited to 2 per plan year
- Fluoride treatment (including fluoride varnishes) is limited to 3 treatments 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.
- Sealants are covered up to age 19 for permanent teeth and primary (baby) molars, once every three plan years
- Space maintainers are only covered when designed to preserve space for permanent teeth. Replacement of space maintainers will be covered only when medically necessary.

- Oral hygiene instruction two times per plan year for ages 8 and under if not billed on the same day as exams.

Class II Services

Benefits include the following services:

- Non-routine x-rays, including occlusal intraoral x-rays when medically necessary are limited to once every 24 months
- Oral and facial photographic images subject to review for medical necessity on a case by case basis
- Full mouth debridement
- Simple extractions
- Emergency, limited problem focused and other non-routine oral exams are limited to 1 per plan year
- Behavior management (behavior guidance techniques used by dental provider)
- Fillings, consisting of silver amalgam or tooth colored composite. Limited to once every 24 months for the same restoration. Resin based composite fillings performed on second and third molars are considered cosmetic and will be reduced to the amalgam allowance.
- Metal and porcelain prefabricated stainless steel crowns once every 36 months for primary and permanent teeth.
- Periodontal (non-surgical) maintenance is limited to 1 per plan year.
- Recementing of crowns, inlays, bridgework and dentures. Recementing of permanent crowns is limited to ages 12 up to age19.
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- Repair of crowns, bridgework & dentures is limited to once every 3 plan years (if performed 6 months from seating date).
- Limited occlusal adjustment (reshaping of a limited number of teeth to attain proper bite) are limited to once every 12 months as medically necessary.
- Pulp vitality test
- Extended care facility or nursing home calls is limited to 2 per facility per day, when medically necessary

Class III Services

Benefits include the following services:

- Surgical Extractions
- Therapeutic injections and therapeutic drugs administered in a dental office when medically necessary

- Diagnostic casts, study models and cephalometric film when medically necessary are included in conjunction with another covered dental procedure
- Oral and Maxillofacial surgery which includes:
 - Alveoplasty and Vestibuloplasty
 - Cancer treatment
 - Care of abscesses
 - Cleft palate treatment
 - Cyst removal
 - Excision of lesion
 - Frenulectomy or Frenuloplasty (limited to ages 6 and under)
 - Post-surgical complications
 - Surgical biopsy
 - Treatment of fractures
- Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns for decayed or fractured teeth when amalgam or composite resin fillings wouldn't adequately restore the teeth. Crowns, inlays, and onlays consisting of porcelain, ceramic, or resin, performed on second or third molars will be limited to the allowed amount that we would have paid for a metal crown, inlay or onlay. An Estimate of Benefits is suggested.
- Replacement inlays, onlays, laboratory-processed labial veneers and crowns, but only when:
 - The existing restoration was seated at least 5 plan years before replacement; or
 - The service is a result of an injury as described under "Dental Care Services For Injuries"
- Partial dentures and fixed bridges are covered. Replacement of partial dentures and fixed bridges is limited to once per 3 plan years. A replacement is covered three years from original seat date.
- Complete denture (upper and lower) is covered. Replacement of complete denture (upper and lower) is limited to 1 per lifetime. Replacement of complete denture must be 5 years after the seat date
- Repreparation of the natural tooth structure under the existing bridgework if required as a result of an injury to that structure, and such repair is performed within 12 months of the injury as described under "Dental Care Services For Injuries"
- The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement
- Relining, rebasing and adjustments of dentures when performed 6 or more months after denture installation.

- Tooth cast and core or prefabricated post and core limited to permanent teeth
- General, regional blocks, oral or parenteral sedation and deep sedation in a dental care provider's office when medically necessary and provided with a covered service. This includes members who are under the age of 9 or are disabled physically or developmentally. An Estimate of Benefits is suggested.
 - This benefit also covers drugs and medications used for parenteral conscious sedation, deep sedation and general anesthesia when medically necessary.
 - Local anesthesia in conjunction with operative or surgical procedures would be combined in allowance for the primary procedure
- Osseous and mucogingival surgery (surgical periodontal treatment) is covered in the same quadrant once every 3 plan years. Surgical periodontal services also covers post-operative gingivectomy and gingivoplasty. This benefit covers post-surgical complications.
- Endodontic (root canal) therapy and pulpal therapy (restorable filling) is limited to once per tooth per lifetime
 - Retreatment of a root canal when services are performed at least 12 months after the original procedure
 - Benefits for root canals performed in conjunction with overdentures are limited to 2 per arch
 - Open and drain (open and broach) (open and medicate) procedures may be limited to a combined allowance based on our review of the services rendered
 - Other than the initial diagnostic x-ray, additional x-rays done in conjunction with a root canal are included in the fee for root canals
 - Apexification for apical closures
 - Apicoectomy and retrograde filling
- Orthodontic services are covered when medically necessary. Orthodontic services must be prior authorized before services are received. To request a prior authorization, please contact our Customer Service Department. This benefit includes braces and orthodontic retainer for specific malocclusions associated with:
 - Cleft lip and palate, cleft palate, or cleft lip with alveolar
 - Craniofacial anomalies (hemifacial microsomia, craniosynostosis syndromes, arthrogryposis and Marfan syndrome)
- Periodontal scaling and root planning services are covered for age 13 up to age 19. Services are

limited to once per quadrant every 24 months

- Periodontal surgery, including post-surgical complications
- Occlusal guard (nightguard) is covered for bruxism and other occlusal factors when medically necessary. This benefit is limited to one every 36 months for members age 12 up to age 19.
- Hospital call including emergency care limited to 1 per day, when medically necessary.

Medically Necessary Orthodontia

- Orthodontic services are covered when medically necessary. Orthodontic services must be prior authorized before services are received. To request a prior authorization, please contact our Customer Service Department. This benefit includes braces and orthodontic retainer for specific malocclusions associated with:
 - Cleft lip and palate, cleft palate, or cleft lip with alveolar
 - Craniofacial anomalies (hemifacial microsomia, craniosynostosis syndromes, arthrogryposis and Marfan syndrome)

The pediatric dental benefit does not cover:

- Cleaning of appliances
- Complete occlusal adjustment
- Cosmetic services:
 - Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and aftereffects thereof
 - Cosmetic orthodontia
- Crowns and copings in conjunction with an overdenture
- Dental services received from a:
 - Dental or medical department maintained for employees by or on behalf of an employer
 - Mutual benefit association, labor union, trustee, or similar person or group
- Duplicate appliances
- Extra dentures or other duplicate appliances, including replacements due to loss or theft
- Facility charges (hospital and ambulatory surgical center) for dental procedures
- Home use products. Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.
- Implants. Dental implants and implant related services.
- Increase of vertical dimension. Any service to increase or alter the vertical dimension.
- Non-standard techniques. Techniques other than standard techniques used in the making of

restorations or prosthetic appliances, such as personalized restorations.

- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting
- Plaque control programs (dietary instruction and home fluoride kits)
- Precision attachments and personalization of appliances
- Services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends)

Except for major services and root canals that were started after your effective date and before the date your coverage ended under this plan, and were completed within 30 days after the date your coverage ended under this plan.

The following are deemed service start dates:

- For root canals, it's the date the canal is opened
- For onlays, crowns, and bridges, it's the preparation date
- For partial and complete dentures, it's the impression date

The following are deemed service completion dates:

- For root canals, it's the date the canal is filled
- For onlays, crowns, and bridges, it's the seat date
- For partial and complete dentures, it's the seat or delivery date
- Testing and treatment for mercury sensitivity or that are allergy-related

Prescription Drugs

This plan uses the prescription drug formulary shown on the **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 U.S. 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.

Prescription Drug Formulary

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

The formulary includes both generic and brand name drugs. Consult the Pharmacy Benefit Guide or RX Search tool listed on our web page, or contact Customer Service for a complete list of your plan's covered prescription drugs.

Your provider may request that you get a non-formulary drug or a dose that is not on the drug list. Under some circumstances, 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

You must also provide medical records to support

your request. We will review your request and let you know 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. If your request is not approved, the drug will not be covered.

If you disagree with our decision you may ask for an appeal. See **Complaints and Appeals** for details.

Covered Prescription Drugs

- FDA approved formulary prescription drugs. Federal law requires a prescription for these drugs. They are known as “legend drugs.”
- Compound drugs when the main drug ingredient is a covered prescription drug
- Oral drugs for controlling blood sugar levels, insulin and insulin pens
- Throw-away diabetic test supplies such as test strips, testing agents and lancets
- Drugs for shots you give yourself
- Needles, syringes and alcohol swabs you use for shots
- Glucagon emergency kits
- Inhalers, supplies and peak flow meters
- Drugs for nicotine dependency
- Human growth hormone drugs when medically necessary
- All FDA approved oral contraceptive drugs and devices such as diaphragms and cervical caps are covered in full when provided by an in-network pharmacy, see **Preventive Drugs** in the **Summary of Your Costs**
- Oral chemotherapy drugs
- Drugs associated with an emergency medical condition (including drugs from a foreign country)

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 specialists or a specific provider
- Step therapy, meaning you must try a generic drug or a specified brand name drug first

These limitations are based on medical criteria, the drug maker’s recommendations, and the circumstances of the individual case. They are also based on U.S. 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 the **Summary of Your Costs**.

Specialty drugs are high-cost often self-administered injectable 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). We contract with specific specialty pharmacies that specialize in these drugs. You and your provider must work with these specialty pharmacies to get these drugs in order for you to receive coverage.

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

Dispensing Limits

Benefits are limited to a certain number of days’ supply as shown in the **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. You must pay a copayment for each limited days’ supply.

Preventive Drugs

Benefits for certain preventive care prescription drugs will be as shown in the **Summary of Your Costs** when received from network pharmacies. Contact Customer Service or visit our web site 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 web page at student.lifewiseac.com/uw/bt.

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, copayment or coinsurance as shown in the **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 **Sending Us a Claim** for instructions.

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 the **Summary of Your Costs**.

Specialty drugs are high-cost often self-administered injectable 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). We contract with specific specialty pharmacies that specialize in these drugs.

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

Diabetic Injectable Supplies

Whether injectable diabetic drug needles and syringes are purchased along with injectable diabetic drugs or 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 and lancets.

Oral Chemotherapy

This benefit covers self-administered oral drugs when the medication is dispensed by a pharmacy. These drugs are covered at as shown in the **Summary of Your Costs**.

Tablet Splitting Program

The Tablet Splitting Program allows members to have reduced copays on certain prescription medications.

Participation in the program is voluntary. When you participate, selected drugs are dispensed at double strength. The individual tablets are then split by the member into half-tablets for each use. We will provide you with a tablet splitter. The drugs eligible for the program have been selected because they are safe to split without jeopardizing quality or effectiveness.

If you participate in the program, you will pay one-half the copays specified above for retail or mail order drugs included in the program. If your plan requires coinsurance rather than copays, the coinsurance percentage will remain the same, but you will have lower out-of-pocket costs because the double strength tablets are less expensive than the single-strength medication.

Because the drugs are dispensed at double strength and will be split, they will be dispensed at one-half the normal dispensing limits listed above.

Contact Customer Service to find out which drugs are eligible for the Tablet Splitting Program and to request a tablet splitter.

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 from out-of-network specialty pharmacies
- Drugs for cosmetic use such as for wrinkles
- Drugs to promote or stimulate hair growth
- Biological, blood or blood derivatives
- 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 drug
- Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and injectable medications. Exceptions to this exclusion are injectable drugs for self-administration such as insulin and glucagon and growth hormones. See **Infusion Therapy** for covered infusion therapy services.
- Drugs dispensed for use in a healthcare facility or provider's office or take-home medications. Exceptions to this exclusion are injectable drugs for self-administration such as insulin and glucagon and growth hormones.
- Immunizations. See **Preventive Care**.
- Drugs to treat infertility, to enhance fertility or to treat sexual dysfunction
- Weight management drugs or drugs for the treatment of obesity
- Therapeutic devices or appliances. See **Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics**.

Prescription Drug Volume Discount Program

Your prescription drug benefit program includes per-claim rebates that LifeWise receives from its pharmacy benefit manager. We consider these rebates when we set the premium charges, or we credit them to administrative charges that we would otherwise pay. These rebates are not reflected in your cost share. The allowed amount for prescription drugs is higher than the price we pay our pharmacy benefit manager for those prescription drugs. LifeWise does one of two things with this difference:

- We keep the difference and apply it to the cost of our operations and the prescription drug benefit program
- We credit the difference to subscription rates for the next benefit year

If your prescription drug benefit includes a copayment, coinsurance calculated as a percentage, or a deductible, the amount you pay and your account calculations are based on the allowed amount.

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 1-800-562-6900. 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 drug list. (This is sometimes referred to as a "formulary.") We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the prescription drug formulary. This plan doesn't cover certain categories of drugs. These are listed above under "What's Not Covered." Non-formulary medications may be covered only on an exception basis for members meeting medical necessity criteria.

Certain formulary drugs are subject to pre-dispensing medical necessity review. As part of this review, some prescriptions may require additional medical information from the prescribing provider, or substitution of equivalent medication.

See **Prior Authorization** for details.

2. When can my plan change the prescription

drug formulary? If a change occurs, will I have to pay more to use a drug I had been using?

The formulary is updated frequently throughout the year. See "Prescription Drug Formulary" above. If changes are made to the drug list prior to the quarterly update, you will receive a letter advising you of the change that may affect your cost share.

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. Please see **Complaints and Appeals**, or call our Customer Service department 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, mail-order 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. Also, specialty drugs are only covered when dispensed by our designated specialty pharmacies. See "Specialty Pharmacy Program" earlier in this benefit.

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 and through the mail-order pharmacy benefit are described in the "Dispensing Limit" provision above.

Benefits for refills will be provided only when the member has used 75% of a supply of a

single medication. The 75% 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

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 Services

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

Covered services include:

- Anesthesia or sedation and postoperative care, as medically necessary
- Cornea transplants and skin grafts
- Cochlear implants
- Blood transfusion, including blood derivatives
- Biopsies and scope insertion procedures such as endoscopies
- Colonoscopy and sigmoidoscopy services that do not meet the preventive guidelines. For more information about what services are covered as preventive see **Preventive Care**.
- Facility fees
- Surgical supplies
- Termination of pregnancy
- Reconstructive surgery that is needed because of an injury, infection or other illness
- The repair of a congenital anomaly
- Cosmetic surgery for correction of functional disorders.

This benefit does not cover:

- 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 **Transplant** for details.

Emergency Room

This plan covers services you get in a hospital emergency room for an emergency medical condition. An emergency medical condition includes things such as heart attack, stroke, serious burn, chest pain, severe pain or bleeding that does not stop. You should call 911 or the emergency number for your local area. You can go to the nearest hospital emergency room that can take care of you. If it is possible, call your physician first and follow their instructions.

You do not need prior authorization for emergency room services. However, you must let us know if you are admitted to the hospital from the emergency room as soon as reasonably possible.

Covered services include the following:

- The emergency room and the emergency room doctor
- Services used for emergency medical exams and for stabilizing a medical condition
- Outpatient tests billed by the emergency room and that you get with other emergency room services

Benefits are covered at the in-network cost share up to the allowed amount from any hospital emergency room. You pay any amounts over the allowed amount when you get services from out-of-network providers even if the hospital emergency room is in an in-network hospital. If you pay out of pocket for prescription medications associated with an emergency medical need, submit a claim to us for reimbursement. See **Sending Us a Claim** for instructions.

This benefit does not cover the inappropriate (non-emergency) use of an emergency room. This means services that could be delayed until you can be seen in your doctor's office. This could be for things like minor illnesses such as a cold, check-ups, follow-up visits and prescription drug requests.

Emergency 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.

This plan covers 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.

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, therapeutic injections 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 deductible and coinsurance for related to facility fees charged by the hospital.

Hospital Services

This plan covers services you get in a hospital. At an in-network hospital, you may get services from doctors or other providers who are not in your network. When you get covered services from non-out-of-network providers, you pay any amounts over the allowed amount.

Inpatient Care

Covered services include:

- Room and board, general duty nursing and special diets
- Doctor services and visits
- Use of an intensive care or special care units
- Operating rooms, surgical supplies, anesthesia, drugs, blood, dressing, equipment and oxygen
- X-ray, lab and testing

Outpatient Care

Covered services include:

- Operating rooms, procedure rooms and recovery rooms
- Doctor services
- Anesthesia
- Services, medical supplies and drugs that the hospital provides for your use in the hospital
- Lab and testing services billed by the hospital and done with other hospital services

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

Mental Health, Behavioral Health and Substance Abuse

This plan covers mental health care and treatment for alcohol and drug dependence. This plan will also cover alcohol and drug services from a state-approved treatment program. You must also get these services in the lowest cost type of setting that can give you the care you need. This plan will comply with federal mental health parity requirements.

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

Mental Health Care

This plan covers all of the following services:

- Inpatient, residential treatment and outpatient care to manage or reduce the effects of the mental condition
- Individual or group therapy
- Family therapy as required by law
- 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.

Alcohol and Drug Dependence (Also called "Chemical Dependency" or "Substance Abuse")

This plan covers all of the following services:

- Inpatient and residential treatment and outpatient 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

This benefit does not cover:

- Prescription drugs. These are covered under **Prescription Drugs**.
- Treatment of sexual dysfunctions, such as impotence
- Institutional care, except that services are covered when provided for an illness or injury treated in an acute care hospital
- EEG biofeedback or neurofeedback
- Family and marriage counseling or therapy, except when it is medically necessary to treat your

mental condition

- Therapeutic or group homes, foster homes, nursing homes boarding homes or schools and child welfare facilities
- Correctional services
- Outward bound, wilderness, camping or tall ship programs or activities
- Phone services, unless they are done in a crisis or when the member cannot get out of bed for medical reasons.
- Mental health tests that are not used to assess a covered mental condition or plan treatment. This plan does not cover tests to decide legal competence or for school or job placement.
- Support groups, such as Al-Anon or Alcoholics Anonymous.
- Services that are not medically necessary. This is true even if a court orders them or you must get them to avoid being tried, sentenced or losing the right to drive.
- Sober living homes, such as halfway houses
- Caffeine dependence

Maternity and Newborn Care

This plan covers health care providers and facility charges for prenatal care, delivery and postnatal care for all covered female members. 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 prior authorized. See **Prior Authorization** for details.

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

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

This benefit covers:

- Prenatal and postnatal care and screenings (including in utero care)
- Home birth services, including associated supplies, provided by a licensed women's 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

This benefit does not cover:

- Outpatient x-ray, lab and imaging. These services are covered under **Diagnostic Lab, X-ray and**

Imaging.

- Home birth services provided by family members or volunteers

Home Health Care

Home health care services must be part of a home health care plan. These services are covered when a qualified provider certifies that the services are provided or coordinated by a state-licensed or Medicare-certified home health agency or certified rehabilitation agency.

Covered services provided and billed by a home health agency include:

- Home visits and acute nursing (short-term nursing care for illness or injury)
- Home medical equipment, medical supplies and devices.
- Prescription drugs and insulin provided by and billed by a home health care provider or home health agency
- Therapeutic services such as respiratory therapy and phototherapy

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 or providers not in the written plan of care or not named as covered in this benefit
- Custodial care
- Nonmedical services, such as housekeeping
- Services that provide food, such as Meals on Wheels or advice about food

Hospice Care

A hospice care program must be provided in a hospice facility or in your home by a hospice care agency or program.

Covered services include:

- 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 or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Nonmedical services, such as housekeeping, dietary assistance or spiritual bereavement, legal or financial counseling
- Services that provide food, such as Meals on Wheels or advice about food

Rehabilitation and Habilitation Therapy

This plan covers rehabilitation and habilitation therapy. Benefits must be provided by a licensed physical therapist, occupational therapist, speech language pathologist or a licensed qualified provider. 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.

Rehabilitative therapy is therapy that helps get a part of the body back to normal health or function. It includes therapy to restore or improve a function that was lost because of an accidental injury, illness or surgery.

Habilitation therapy is therapy that helps a person keep, learn or improve skills and functioning for daily living. 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 and Behavioral Health and Substance Abuse*** for therapies provided for mental health conditions such as autism.

Day limits listed in the ***Summary of Your Costs*** 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 an 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
- The care is part of a written plan of treatment prescribed doctor

Outpatient Care

This plan covers the following types of outpatient therapy:

- 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 patient 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 (see **Definitions**) 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** for details.

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

Services must be prescribed by your physician. 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. Please see **Prior Authorization** for additional information.

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 physician 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:

- Corneal ulcer
- Bullous keratopathy
- Recurrent erosion of cornea
- Tear film insufficiency
- Aphakia
- Sjogren's disease
- Congenital cataract
- Corneal abrasion
- Keratoconus.

Medical vision hardware for members under age 19 is covered for all medically necessary diagnosis. 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 physician 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 the **Summary of Your Cost Shares**.

This benefit does not cover:

- Hypodermic needles, lancets, test strips, testing agents and alcohol swabs. These services are covered under the **Prescription Drugs**.
- Supplies or equipment not primarily intended for medical use

- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths and massage devices
- 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 physician)
- 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
- Routine eye care services including eye glasses and contact lenses
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under **Surgery Services**. Items provided and billed by a hospital are covered under the **Hospital** benefit for inpatient and outpatient care.

OTHER COVERED SERVICES

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

Acupuncture

Benefits are provided for acupuncture services that are medically necessary to relieve pain, to help with anesthesia for surgery, or to treat a covered illness, injury, or condition.

Allergy Testing and Treatment

This plan covers allergy tests and treatments. Covered services include testing, shots given at the doctor's office, serums, needles and syringes.

Chemotherapy, Radiation Therapy and Kidney Dialysis

This plan covers the following services:

- Outpatient chemotherapy and radiation therapy services
- Outpatient or home kidney dialysis
- Extraction of teeth to prepare the jaw for treatment of neoplastic disease

- Supplies, solutions and drugs (See **Prescription Drugs** for oral chemotherapy drugs)

You may need prior authorization from us before you get treatment. See the detailed list at student.lifewiseac.com/uw/bt.

Clinical Trials

This plan covers the routine costs of a qualified clinical trial. Routine costs mean medically necessary care that is normally covered under this plan outside the clinical trial. Benefits are based on the type of service you get. For example, benefits of an office visit are covered under **Office and Clinic Visits**, and lab tests are covered under **Diagnostic Lab, X-ray and Imaging**.

A qualified clinical trial is a trial that is funded and supported by the National Institutes of Health, the Center for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs.

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. You may also be assigned a nurse case manager to work with you and your provider. See **Health Support Programs** for details.

Dental Accidents

This plan covers accidental injuries to teeth, gums or jaw. Covered services include exams, consultations, dental treatment, and oral surgery when repair is performed within 12 months of the injury. To request an extension, please have your provider contact Customer Service. In order for us to review an extension request, we will ask the provider to send additional information that would show the necessity for the extension; such as, the severity of the accident or other circumstances.

Services are covered when all of the following are true:

- Treatment is needed because of an accidental injury
- Treatment is done on the natural tooth structure and the teeth were free from decay and functionally sound when the injury happened. Functionally sound means that the teeth do not have:
 - Extensive restoration, veneers, crowns or splints
 - Periodontal (gum) disease or any other condition that would make them weak

This plan does not cover damage from biting or chewing, even when caused by a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the injury date. To request an extension, please have your provider contact Customer Service. In order for us to review an extension request, we will ask the provider to send additional information that would show the necessity for the extension; such as, the severity of the accident or other circumstances.

Emergency services are covered the same as any other emergency service.

Dental Anesthesia

In some cases, this plan covers general anesthesia, professional services and facility charges for dental procedures. These services can be in a hospital or an ambulatory surgical facility. They are covered only when medically necessary for one of these reasons:

- The member is under age 9 years old, or has a disability and it would not be safe and effective to treat them in a dental office
- You have a medical condition (besides the dental condition) that makes it unsafe to do the dental treatment outside a hospital or ambulatory surgical center

This benefit does not cover the dental procedure. See **Pediatric Care** for covered dental services.

Foot Care

This plan covers routine foot care for the treatment of diabetes. Covered services include treatment for corns, calluses, toenail conditions other than infection and hypertrophy or hyperplasia of the skin of the feet.

Infusion Therapy

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. 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

This benefit doesn't cover over-the-counter drugs, solutions and nutritional supplements.

Medical Foods

This plan covers medically necessary medical foods for supplementation or dietary replacement for the treatment of inborn errors of metabolism. An example is phenylketonuria (PKU). Benefits include medically necessary enteral formula prescribed by a physician or other health care provider for the treatment of eosinophilic gastrointestinal associated disorder or other severe malabsorption disorder. Benefits are provided for all delivery methods or formula.

Medical foods are foods that are formulated to be consumed or administered enterally under strict medical supervision. Medical foods generally provide most of a person's nutrition. Medical foods are designed to treat a specific problem that can be diagnosed using medical tests.

This benefit does not cover:

Other oral nutrition or supplements not used to treat inborn errors of metabolism, even if prescribed by a physician. Includes but is not limited to specialized infant formulas and lactose-free foods.

Mastectomy and Breast Reconstruction Services

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

Spinal and Other Manipulative Treatment

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

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 Habilitation** annual maximums, even when provided during the same visit.

Telehealth Virtual Care Services

Your plan covers access to care via online and telephonic methods when medically appropriate. Coverage for psychiatric conditions is medically appropriate for crisis/emergency evaluations or when the member is temporarily confined to bed for medical reasons.

Services delivered via telehealth methods are subject to standard office visit cost-shares and other provisions as stated in this booklet.

Temporomandibular Joint (TMJ) Disorders

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

Therapeutic Injections

This plan covers therapeutic injections given at the doctor's office, including serums, needles and syringes. Your provider may administer three teaching doses per drug, per lifetime, of self-injectable specialty drugs in an office or clinic setting. However, all other self-injectable specialty drugs are covered under the **Specialty Pharmacy Programs**. For more information on how self-injectable specialty drugs are covered, see **Prescription Drugs**.

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 LifeWise has approved for organ transplants or bone marrow or stem cell reinfusion. 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 Investigational 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 and any donor covered services
- 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) and one companion, 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.

Transgender Surgery

The plan covers charges for transgender medical treatment including but not limited to medically necessary office visits, laboratory tests, and gender reassignment surgeries. The plan covers these charges the same as covered medical expenses for

any other condition.

Transgender Surgical Services Criteria

Surgical gender reassignment services will be considered medically necessary if the criteria listed under Surgical Procedures, Breast Surgery or Genital Surgery are met.

Surgical Procedures

For all surgical procedures approved in the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH), transgender benefits are available if you are at least 18 years old and diagnosed as having gender identity disorder or gender dysphoria.

Breast Surgery

For breast surgery you must be at least 18 years old and diagnosed as having gender identity disorder or gender dysphoria. You must also have one letter of recommendation for surgery from a mental health professional.

Genital Surgery

For genital surgery all the following criteria must be met:

- You are at least 18 years old and diagnosed as having gender identity disorder or gender dysphoria
- You have successfully lived and worked within the desired gender role full time for at least 12 months
- You have received recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. One Master's degree level professional is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist.
- The surgery is recognized as medically necessary within the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

Prior Authorization

Inpatient surgeries and some other services and supplies require prior authorization. Please see **Prior Authorization** for additional information.

To be advised if you meet the surgical criteria outlined above, information should be submitted by the physician who is most knowledgeable about your history and should include:

- The surgical procedure(s) for which coverage is being requested
- The date the surgery will be performed
- Information supporting that criteria listed above has been met, based on the surgery being requested.

Vision for Adults

See the **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, please see **Office and Clinic Visits**.

Vision Hardware

Vision hardware for adults 19 and older is covered up to the Vision for Adults plan year dollar limit. This includes all prescription eyeglass lenses and frames, contact lenses, fittings, special features and supplies.

Please see the **Medical Equipment and Supplies** benefit for hardware coverage for certain conditions of the eye.

The Vision for Adults benefit doesn't cover:

- Services or supplies that aren't named above as covered, or that are covered under other provisions of this plan. Please see the Medical Equipment and Supplies benefit for hardware coverage for certain conditions of the eye.
- Other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except 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

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 Accidents**. 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 (D.M.D. or D.D.S.) or dentist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of his or her 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

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.
- Emergency oral examinations are not limited, subject to the annual maximum benefit. However, 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.

The dental benefit for adults (age 19 and older) does not cover:

- Behavior management.
- Caries susceptibility tests.
- Charges above the allowable charge as determined by us.
- Charges by any person other than a licensed dentist (D.M.D or D.D.S), or licensed dentist, except for a licensed hygienist under the supervision of a licensed dentist, or other

individual performing within the scope of their license or certification, as allowed by law

- Charges for any services in excess of the percentage and maximums listed
- Charges for failure to keep scheduled appointments or for filling out claim form.
- Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements
- Charges that would not have been made, or that the participant 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 (except as 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 please 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 \$100,000 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 by us.

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

This section lists the services that are either limited or not covered by this plan. They are in addition to the services listed as not covered under **Covered Services**.

Amounts Over the Allowed Amount

This plan does not cover amounts over the allowed amount as defined in this plan. If you get services from an out-of-network provider, you will have to pay charges over the allowed amount.

Benefits from Other Sources

This plan does not cover services that are covered by:

- 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 home owners' coverage or commercial liability coverage
- Any type of excess coverage
- Boat coverage
- School or athletic coverage

Benefits That Have Been Used Up

Biofeedback

This plan does not cover:

- Biofeedback for mental conditions other than

generalized anxiety disorder

- EEG biofeedback and neurofeedback services

Broken Appointments

Caffeine Dependence

Charges for Records or Reports

Separate charges from providers for supplying records or reports, except those we request for care management.

Comfort or Convenience

This plan does not cover:

- Items that are mainly for your convenience or that of your family. For instance, this plan does not cover personal services or items like meals for guests, long-distance phone, radio or TV and personal grooming. Please see the **Transplants** for **Transportation and Lodging Expenses** exception.
- Normal living needs, such as food, clothes, housekeeping and transport. This does not apply to chores done by a home health aide as prescribed in your treatment plan.
- Help with meals, diets and nutrition. This includes Meals on Wheels.

Cosmetic Services

This plan does not cover services to restore, improve, correct, or change the look or shape of a body part. Any direct or indirect complications and aftereffects are also not covered.

The only exceptions to this exclusion are:

- Repair of a defect that is the direct result of an injury, see **Surgery Services**
- Repair of a dependent child's congenital anomaly, see **Surgery Services**
- Reconstructive breast surgery in connection with a mastectomy, except as stated under **Mastectomy and Breast Reconstruction Services**
- Correction of functional disorders, see **Surgery Services**
- Services covered under the **Transgender Surgery** benefit.

Counseling, Education or Training

This plan does not cover counseling or training in the absence of illness, job help and outreach, social or fitness counseling or training.

Court-Ordered Services

This plan does not cover services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically necessary.

Custodial Care

This plan does not cover custodial services, except when it is part of covered hospice care. See **Hospice Care**.

Dental Care

This plan does not cover dental services except as stated in **Pediatric Dental Services** and **Dental for Adults (age 19 and older)**.

Drugs and Food Supplements

This plan does not cover the following:

- Over-the-counter drugs, solutions, supplies, vitamins, food, or nutritional supplements, except as required by law
- Herbal, naturopathic, or homeopathic medicines or devices

Environmental Therapy

This plan does not cover therapy to provide a changed or controlled environment.

Experimental and Investigative Services

This plan does not cover any service that is experimental or investigative, see **Definitions**. This plan also does not cover any complications or effects of such services. This exclusion does not apply to certain services provided as part of a covered clinical trial. See **Covered Services**.

Family Members or Volunteers

This plan does not cover services that you give 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 the spouse of one of these people
- A volunteer, except as described in **Home Health and Hospice Care**

Foot Care

This plan does not cover routine foot care. It also does not cover services to ease foot pain or other symptoms. Examples are:

- Care to keep feet clean and healthy
- Care for fallen arches or flat feet
- Care of corns, bunions, calluses, or toenails. This does not apply to surgery on foot bones or ingrown toenails.
- Other foot problems that cause pain or other symptoms but have no exact cause or cure

The only exception is for foot care you need if you have diabetes.

Government Facilities

This plan does not cover services provided by a state or federal hospital which is not a participating facility, except for emergency services or other covered services as required by law or regulation.

Growth Hormone

This plan does not cover growth hormones for the following:

- To stimulate growth, except when it meets medical standards
- Treatment of idiopathic short stature without growth-hormone deficiency

Hair Loss

This plan does not cover:

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

Hospital Admission Limitations

This plan does not cover hospital stays solely for diagnostic studies, physical examinations, checkups, medical evaluations, or observations, unless:

- The services cannot be provided without the use of a hospital
- There is a medical condition that makes hospital care medically necessary

Illegal Acts and Terrorism

This plan does not cover illness or injuries resulting from a member's commission of:

- A felony (does not apply to a victim of domestic violence)
- An act of terrorism
- An act of riot or revolt

Infertility and Assisted Reproduction

This plan does not cover:

- Services for infertility or fertility problems
- Assisted reproduction methods, such as artificial insemination or in-vitro fertilization
- Services to make you more fertile or for multiple births
- Undoing of sterilization surgery
- Complications of these services

The only exception is for diagnosing infertility.

Laser Therapy

Benefits are not provided for low-level laser therapy for any diagnosis, including vitiligo.

Military-Related Disabilities

This plan does not cover services to which you are legally entitled for a military service-connected disability and for which facilities are reasonably available.

Military Service and War

This plan does not cover 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. This includes the air force, army, coast guard, marines, national guard or navy. It also includes any related civilian forces or units.

Not Eligible for Coverage

The plan does not cover services that are:

- Received or ordered when this plan is not in force
- Not charged for or would not be charged for if this plan were not in force
- You are not required to pay for, other than services covered by a pre-paid plan, such as an HMO or services that the law requires the plan to cover
- Connected or directly related to any service that is not covered by this plan
- Received or ordered when you are not covered under this plan
- Given to someone other than an ill or injured member, except as stated in **Preventive Care**.

No Charge or You Do Not Have to Pay

Services and supplies for which 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.

However, this exclusion does not apply to covered services and supplies which are prepaid through participation under any health care service contract or health maintenance agreement.

Non-Treatment Facilities, Institutions or Programs

Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions from licensed providers. Examples are prisons, nursing homes, juvenile detention facilities, and group homes. Benefits are provided for medically

necessary medical or behavioral health treatment received in these locations.

Not Medically Necessary

Services and places of service that are not medically necessary, even if they are court-ordered.

Obesity or Weight Loss (Surgery or Drugs)

This plan does not cover surgery, drugs or supplements for obesity, weight loss or weight control. It also does not cover any complications, follow-up services, or effects of those treatments, except services defined as **Emergency Services**. This is true even if you have an illness or injury that might be helped by obesity or weight loss surgery or drugs. This plan does not cover removal of extra skin or fat that came about as a result of obesity or weight loss surgery or drugs.

Orthognathic Surgery

This plan does not cover procedures to make the jaw longer or shorter, except orthognathic surgery and supplies for the treatment of Temporomandibular Joint (TMJ) Disorders, Sleep Apnea or Congenital Anomalies.

Preventive Care

This plan does not cover preventive care in excess of the preventive care benefits, including services that exceed the frequency, age and gender guidelines. You can get a complete list of the preventive care services with these limits on our website at student.lifewiseac.com/uw/bt or call us for a list. This list may be changed as required by state and federal preventive guidelines change. The list will include website addresses where you can see current federal preventive guidelines.

Private Duty Nursing

Benefits are not provided for private duty or 24-hour nursing care. See **Home Health Care** for home nursing care benefits.

Provider's License or Certification

This plan does not cover services that the provider's license or certification does not allow him or her perform. It also does not cover a provider that does not have the license or certification that the state requires.

Records and Reports

This plan does not cover separate charges from providers for supplying records or reports, except those we request for clinical review.

Serious Adverse Events and Never Events

This plan does not cover serious adverse events or

never events. These are serious medical errors that the U.S. government has identified and published. A "serious adverse event" is an injury that is caused by treatment in the hospital and not by a disease. Such events make the hospital stay longer or cause another health problem. A "never event" should never happen in a hospital. A never event is when the wrong surgery is done, or a procedure is done on the wrong person or body part.

You do not have to pay for services of in-network providers for these events and their follow-up care. In-network providers may not bill you or this plan for these services.

Not all medical errors are serious adverse events or never events. These events are very rare. You can ask us for more details. You can also get more details from the U.S. government. You will find them at www.cms.hhs.gov.

Sexual Problems

This plan does not cover problems with your sexual function or response. It does not matter what the cause is. Drugs, implants or any complications or aftereffects are not covered.

Voluntary Support Groups

Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics anonymous

Work-Related Illness or Injury

This plan does not cover any illness or injury for which you can 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

Please 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.

EXCESS PROVISION

No benefit under this plan is payable for any covered expense which is paid or payable by other valid and collectible insurance. Covered medical expenses exclude amounts not covered by the primary carrier due to penalties imposed on the participant for failing to comply with contract provisions or requirements.

This plan pays secondary when you also have other

valid and collectible insurance that are:

- Group, individual, or blanket insurance contracts and subscriber contracts
- Group and individual coverage through closed panel plans.

This plan pays primary when your other coverage is:

- Hospital indemnity coverage benefits or other fixed indemnity coverage
- Accident-only coverage
- Specified disease or specified accident coverage
- Limited benefit health coverage
- School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a "to and from school" basis
- Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services
- Medicare supplement policies
- A state plan under Medicaid
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan
- Automobile insurance policies required by statute to provide medical benefits
- Benefits provided as part of a direct agreement with a patient-provider primary care practice as defined by state law (section 3, chapter 267, Laws of 2007).

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 tortfeasor 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.

SENDING US 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. Please send the information to the address listed on the drug claim form.

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. 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.

COMPLAINTS AND APPEALS

As a LifeWise member, you have the right to offer your ideas, ask questions, voice complaints and request a formal appeal to reconsider decisions we have made. Our goal is to listen to your concerns and improve our service to you.

If you need an interpreter to help with oral translation, please call us. Customer Service will be able to guide you through the service.

WHEN YOU HAVE IDEAS

We would like to hear from you. If you have an idea, suggestion, or opinion, please let us know. You can contact us at the addresses and telephone numbers found on the back cover.

WHEN YOU HAVE QUESTIONS

Please call us when you have questions about a benefit or coverage decision, our services, or the quality or availability of a healthcare service, or our service. We can quickly and informally correct errors, clarify benefits, or take steps to improve our service.

We suggest that you call your provider of care when you have questions about the healthcare they provide.

WHEN YOU HAVE A COMPLAINT

You can call or write to us when you have a complaint about a benefit or coverage decision, Customer Service, or the quality or availability of a health care service. We recommend, but don't require, that you take advantage of this process when you have a concern about a benefit or coverage decision. There may be times when Customer Service will ask you to submit your complaint for review through the formal internal appeals process outlined below.

We will review your complaint and notify you of the outcome and the reasons for our decision as soon as possible, but no later than 30 days from the date we received your complaint.

WHEN YOU DO NOT AGREE WITH A PAYMENT OR BENEFIT DECISION

If we declined to provide payment or benefits in whole or in part, and you disagree with that decision, you have the right to request that we review that adverse benefit determination through a formal, internal appeals process.

This plan's appeals process will comply with any new requirements as necessary under state and federal laws and regulations.

What is an 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, investigational, not medically necessary or

appropriate, or not effective.

WHEN YOU HAVE AN APPEAL

After you find out about an adverse benefit decision, you can ask for an internal appeal. Your plan has two levels of internal appeals. Your Level I internal appeal will be reviewed by people who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be done by a provider. They will review all of the information about your appeal and will give you a written decision. If you are not satisfied with the decision, you may request a Level II appeal.

Your Level II internal appeal will be reviewed by a panel of people who were not involved in the Level I appeal. If the adverse benefit determination involved medical judgment, a provider will be on the panel. You may take part in the Level II panel meeting in person or by phone. Please contact us for more details about this process.

Once the Level II review is done, we will give you a written decision.

If you are not satisfied with the outcome of an internal appeal (Level I or Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigational, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an IRO. An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

Who may file an internal appeal?

You may file an appeal for yourself. You can also appoint someone to do it for you. This can be your doctor or provider. To appoint a representative, you must sign an authorization form and send it to us. The address and fax number are listed on the back cover. This release gives us your approval for this person to appeal on your behalf and allows our release of information, if any, to them. If you appoint someone else to act for you, that person can do any of the tasks listed below that you would need to do.

Please call us for an Authorization For Release form. You can also get a copy of this form on our website at student.lifewiseac.com/uw/bt.

How do I file an internal appeal?

You may file an appeal by calling Customer Service or by writing to us at the address listed on the back cover of this booklet. We must receive your appeal request as follows:

- For a Level I internal appeal, within 180 calendar

days of the date you were notified of the adverse benefit determination.

- For a Level II internal appeal, within 60 calendar days of the date you were notified of the Level I determination. If you are in the hospital or away from home, or for other reasonable cause beyond your control, we will extend this time limit up to 180 calendar days to allow you to get medical records or other documents you want us to look at.

You may send your written appeal request to the address or fax number on the back cover of this booklet.

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed on the back cover of this benefit booklet. You can also get a description of the appeals process by visiting our website at student.lifewiseac.com/uw/bt.

We will confirm in writing that we have your request within 72 hours.

What if my situation is clinically urgent?

If your provider believes that your situation is urgent under law, we will expedite your appeal; for example:

- Your doctor thinks a delay may put your life or health in serious jeopardy or would subject you to pain that you cannot tolerate
- The appeal is related to inpatient or emergency services and you are still in the emergency room or in the ambulance

We will not expedite your appeal if you have already received the services you are appealing, or if you do not meet the above requirements. Please call Customer Service if you want to expedite your appeal. The number is listed on the back cover of this booklet.

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

Can I provide more information for my appeal?

You may give us more information to support your appeal either at the time you file an appeal or at a later date. Mail or fax the information to the address and fax number listed on the back cover of this booklet. Please give us this information as soon as you can.

Can I get copies of information relevant to my appeal?

We will also send you any new or additional information we considered, relied upon or generated in connection to your appeal. We will send it as soon

as possible and free of charge. You will have the chance to review it and respond to us before we make our decision.

What happens next?

We will review your appeal and give you a written decision within the time limits below:

- For expedited appeals, as soon as possible, but no later than 72 hours after we got your request. We will call, fax or email and then follow up in writing.
- For appeals for benefit decisions made before you received the services, within 14 days of the date we got your request.
- For all other appeals, including experimental and investigational appeals, within 14 days of the date we got your request. If we need more time to review your request, we may extend the review to no more than 30 days, unless we ask for and receive your agreement for more time after the 30 days.

We will send you a notice (see **Notice**) of our decision and the reasons for it. If we uphold our initial decision, we will tell you about your right to a Level II internal appeal or to an external review at the end of the internal appeals process. You can also go to the next appeal step if we do not comply with the rules above when we handle your appeal.

Appeals about ongoing care

If you appeal a decision to change, reduce or end coverage of ongoing care because the service is no longer medically necessary or appropriate, we will suspend our denial of benefits during the appeal period. Our provision of benefits for services received during the internal appeal period does not, and should not be assumed to, reverse our denial. If our decision is upheld, you must repay us all amounts that we paid for such services. You will also be responsible for any difference between our allowed amount and the provider's billed charge if the provider is non-contracting.

WHEN AM I ELIGIBLE FOR EXTERNAL REVIEW?

If you are not satisfied with the outcome of an internal appeal (Level I or Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigational, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an IRO. An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

We will send you an External Review Request form at the end of the internal appeal process to tell you about your rights to an external review. We must receive your written request for an external review within 180 days of the date you got our Level II appeal response. Your request must include a signed waiver granting the IRO access to medical records and other materials that are relevant to your request.

You can ask us to expedite the external review when your provider believes that your situation is clinically urgent under law. Please call Customer Service at the number listed on the back cover of this booklet to ask us to expedite your external review.

We will tell the IRO that you asked for an external review. The IRO will let you, your authorized representative and/or your attending physician know where more information may be sent directly to the IRO and when the information must be sent. We will forward your medical records and other relevant materials to the IRO. We will also give the IRO any other information they ask for that is reasonably available to us.

When the IRO completes the external review

Once the external review is done, the IRO will let you and us know their decision within the time limits below:

- For expedited external reviews, as soon as possible, but no later than 72 hours after receiving the request. The IRO will notify you and us immediately by phone, e-mail or fax and will follow up with a written decision by mail.

All other reviews, within 15 days after the IRO gets all the information they need or 20 days from the date the IRO gets your request, whichever comes first.

What Happens Next?

LifeWise is bound by the IRO's decision. If the IRO overturned our decision, we will implement their decision in a timely manner.

If the IRO upheld our decision, there is no further review available under this plan's appeal process. 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 contact LifeWise Customer Service at the number listed on the back cover. If you want to make a complaint or need help filing an appeal, you can also contact the Washington Consumer Assistance Program at any time during this process.

Washington Consumer Assistance Program
5000 Capitol Blvd.

Tumwater, WA 98501

1-800-562-6900

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 enrolled and actively engaged in a program of study approved 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. Meets the criteria established, published, and updated from time to time by the Student and Exchange Visitor Program administered by the Department of U.S. 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 the University of Washington Bothell campus

Who's Not Eligible

Some students are not eligible to enroll:

- International students who have been approved for permanent residency in the U.S. 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 disability or physical handicap; and, 2) Chiefly dependent upon the insured person for support and maintenance.

- The lawful spouse of the subscriber
- 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.” To establish a domestic partnership, the subscriber and the domestic partner must be state registered; **or**
 - Be at least 18 years of age, and
 - Currently share the same regular and permanent residence, and
 - Have a close personal relationship, such that each is responsible for the other's welfare, and
 - Are jointly responsible for basic living expenses including the cost of basic food, shelter and any other expenses of a domestic partner. They need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost, and
 - Are not married to anyone, and
 - Are not related by blood closer than would bar marriage in the State of Washington, and

- Were mentally competent to consent to contract when the domestic partnership began, and
- Are each other's sole domestic partner.

You will be asked to submit a copy of your marriage certificate, the Washington State registration certificate or certificate from other jurisdiction where domestic partner registration is offered, or the Domestic Partner Affidavit form. If you are unable to provide this documentation, your spouse or domestic partner will be deemed ineligible and their claims will be denied.

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:

- You must enroll a newborn child and pay any additional premium to the Student Insurance Office **within 60 days** of birth
- For adoptions, notify the Student Insurance Office of adoptions in writing, and pay any additional premium 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. . However, you are not enrolled in the plan by just sending in 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, 2016.
- **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. If you enroll for quarterly coverage and are covered during Spring quarter, you may sign up for Summer quarter coverage even if you are not taking 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 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 Newly Acquired Dependents

You may add newly acquired 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 newly acquired dependent is enrolled.

Please Note: You must enroll your newly acquired 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), you 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 or 60 days, depending on the situation) listed in the section called 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 | \$282 |
| Annual Autumn (4 Qtrs) | \$1,128 |
| Annual Winter (3 Qtrs) | \$846 |
| Annual Spring (2 Qtrs) | \$564 |

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, 2015 and ends on August 31, 2016. The benefits described in this booklet are applicable during this term only.

| 2015-2016 Dates of Coverage | |
|------------------------------------|-----------------------------------|
| Autumn Qtr | September 1, 2015–January 4, 2016 |
| Winter Qtr | January 4, 2016–March 27, 2016 |
| Spring Qtr | March 28, 2016–June 21, 2016 |
| Summer Qtr | June 22, 2016–August 31, 2016 |

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, 2016.

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 the Who's Eligible section.

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.

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 the Who's Eligible and How to Enroll sections.

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.

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.

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.

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. Please see **Right of Recovery** later in this section.

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.

Please 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.

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.

Newborn's and Mother's 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).

Notice

Any notice we're required to submit to the Group or subscriber will be considered to be delivered if it's mailed to the Group or subscriber at the most recent address appearing on our records. We'll use the date of postmark 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 our Customer Service department 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 his or her 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.

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. Please see ***Covered Services***.

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 "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.

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 Facility

A healthcare facility where people get surgery without staying overnight. An ambulatory surgical facility must be licensed or certified by the state it is in. It also must meet all of these criteria:

- It has an organized staff of doctors
- It is a permanent facility that is equipped and run mainly for doing surgical procedures
- It does not provide Inpatient services or rooms

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

Provider location where UW Bothell students can receive care with the highest level of insurance benefits.

Off campus location: HealthPoint – Bothell Medical Clinic and Pharmacy, 10414 Beardslee Blvd. Suite 100, Bothell, WA 98011, phone: (425) 486-0658

Chemical Dependency (Also called “Substance Abuse”)

Dependent on or addicted to drugs or alcohol. It is an illness in which a person is dependent on alcohol and/or a controlled substance regulated by state or federal law. It can be a physiological (physical) dependency or a psychological (mental) dependency or both. People with Chemical Dependency usually use drugs or alcohol in a frequent or intense pattern that leads to:

- Losing control over the amount and circumstances of use
- Developing a tolerance of the substance, or having withdrawal symptoms if they reduce or stop the use
- Making their health worse or putting it in serious danger
- Not being able to function well socially or on the job

Chemical Dependency includes drug psychoses and drug dependence syndromes.

Claim

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

Coinsurance

The amount you pay for covered services after you meet your deductible. Coinsurance is always a percentage of the allowed amount. Coinsurance amounts are listed in the **Summary of Your Costs**.

Community Mental Health Agency

An agency that’s licensed as such by the state of Washington to provide mental health treatment under the supervision of a physician or psychologist.

Complications of Pregnancy

A medical condition related to pregnancy or childbirth that falls into one of these three categories:

- A condition of the fetus that needs surgery while still in the womb (in utero)
- A disease the mother has that is not caused by the pregnancy but is made worse by the pregnancy
- A condition the mother has that is caused by the

pregnancy and is more difficult to treat because of the pregnancy. These conditions include, but are not limited to:

- Eclampsia and pre-eclampsia
- Ectopic pregnancy
- Hydatidiform mole/molar pregnancy
- Incompetent cervix that requires treatment
- Complications of administration of anesthesia or sedation during labor or delivery
- Obstetrical trauma uterine rupture before onset or during labor
- Hemorrhage before or after delivery that requires medical/surgical treatment
- Placental conditions that require surgical intervention
- Preterm labor and monitoring
- Toxemia
- Gestational diabetes
- Hyperemesis gravidarum
- Spontaneous miscarriage or miss abortion

A complication of pregnancy requires covered services that are beyond or greater than the usual maternity services. This includes care before, during, and after birth (normal or cesarean).

Congenital Anomaly

A body part that is clearly different from the normal structure at the time of birth.

Copay

A copay is a set dollar amount you must pay your provider. You pay a copay at the time you get care.

Cosmetic Services

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

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 mainly to:

- Maintain your health over time, and not to treat specific illness or injury
- Help you with activities of daily living. Examples are help in walking, bathing, dressing, eating, and preparing special food. This also includes supervising the self-administration of medication when it does not need the constant attention of trained medical providers.

Deductible

The amount of the allowed amounts incurred for covered services for which you are responsible before we provide benefits. Amounts in excess of the allowed amount do not accrue toward the deductible.

Dependent

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

Detoxification

Detoxification is active medical management of substance intoxication or substance withdrawal. Active medical management means repeated physical examination appropriate to the substance ingested, 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 (M.D.)
- Doctor of Osteopathy (D.O.).

In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a doctor as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist
- Nurse (R.N.) licensed in Washington State

Effective Date

The date your coverage under this plan begins.

Emergency Medical Condition

A medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

- Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy

- Result in serious impairment to bodily functions
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the women or the unborn child

Emergency Services

- Services and supplies including ancillary services given in an emergency department
- 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 treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant woman in active labor, to perform the delivery.

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 care, hospitalization, maternity and newborn care, mental health and chemical dependency 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/Investigational Services

Services that meet one or more of the following:

- A drug or device which cannot be lawfully marketed without the approval of the U.S. 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 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.

Facility (Medical Facility)

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

Home Medical Equipment (HME)

Equipment ordered by a provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches.

Home Health Agency

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

Hospice

A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.

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 doctors 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 chemical dependency or tuberculosis

Illness

A sickness, disease, medical condition, or pregnancy.

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.

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.

Medically Necessary and Medical Necessity

Services a physician, 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

Any person covered under this plan.

Mental 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 treatments for chemical dependency.

Off-Label Prescription Drugs

Off-label use of prescription drugs is when a drug is prescribed for a different condition than the one for which it was approved by the FDA.

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

A person who gets healthcare services without an overnight stay in a healthcare facility. This word also describes the services you get while you are an outpatient.

Plan

The benefits, terms, and limitations stated in the contract between us and the University of Washington. This booklet is a part of the contract.

Plan Year (Year)

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

Prescription Drug

Drugs and medications that by law require a prescription. This includes biologicals used in chemotherapy to treat cancer. It also includes biologicals used to treat people with HIV or AIDS. According to the Federal Food, Drug and Cosmetic Act, as amended, the label on a prescription drug must have the statement on it: "Caution: Federal law prohibits dispensing without a prescription."

Prior Authorization

Planned services that must be reviewed for medical necessity and approved by us before you receive them in order to be covered.

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 his or her 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 (L.Ac.) (In Washington also called East Asian Medicine Practitioners (E.A.M.P.))
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dental Hygienists (under the supervision of a D.D.S. or D.M.D.)
- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (P.A.) (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists (Ph.D.)
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- 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 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***. The defined terms below are how we show a provider's network status.

For providers of dental care, we use two terms:

- **In-Network Providers** are contracted providers that are in your provider network. You receive the highest benefit level when you use an in-network provider. In-network providers will not bill you for the amount above the allowed amount for a covered service. See the ***Summary of Your Costs***.
- **Out-Of-Network Providers** are providers that are not in your provider network. You receive lower benefit coverage for services provided by out-of-network providers, or the service may not be covered. An out-of-network dental provider will bill you the amount over the allowed amount for a covered service. See the ***Summary of Your Costs***.

For providers of medical care, we use these terms.

- **In-Network Providers** are contracted providers that are in your provider network. You receive the highest benefit level when you use an in-network provider. In-network providers will not bill you for the amount above the allowed amount for a covered service. See the ***Summary of Your Costs***.
- **Out-Of-Network Providers** are providers that are not in your provider network. You receive lower benefit coverage for services provided by out-of-

network providers, or the service may not be covered. The provider will bill you the amount over the allowed amount for a covered service. See the ***Summary of Your Costs***.

Reconstructive Surgery

Reconstructive Surgery is surgery:

- That restores features damaged as a result of injury or illness
- To correct a congenital deformity or anomaly.

Service Area

The service area for this plan is the states of Washington, Oregon and Alaska.

Services

Services are procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies or places of service.

Skilled 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

Sound natural tooth means 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

Spouse

Spouse means:

- An individual who is legally married to the subscriber
- An individual who is a state registered domestic partner of the subscriber or who meets the requirements for domestic partner coverage under this plan.

Subscription Charge

The monthly rates we establish as consideration for the benefits offered under this contract.

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.

We, Us and Our

LifeWise Assurance Company.

You and Your

A member enrolled in this plan.

Where To Send Claims

MAIL YOUR CLAIMS TO

LifeWise Assurance Company
P.O. Box 91059
Seattle, WA 98111-9159

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
P.O. Box 747000
Cincinnati, OH 45274-7000

Contact the Pharmacy Benefit Administrator At

1-800-391-9701
www.express-scripts.com

Customer Service

Mailing Address

LifeWise Assurance Company
P.O. Box 91059
Seattle, WA 98111-9159

Phone Numbers

Local and toll-free number:
1-800-971-1491

Physical Address

7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

Local and toll-free TDD number
for the hearing impaired:
1-800-842-5357

Student Insurance Office

459 Schmitz Hall
(206) 543-6202
stdins@uw.edu

Care Management

Prior Authorization

LifeWise Assurance Company
P.O. Box 91059
Seattle, WA 98111-9159

Local and toll-free number:
1-800-971-1491
Fax 1-800-843-1114

Pediatric Dental Estimate of Benefits

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

Fax 425-918-5956

Complaints and Appeals

LifeWise Assurance Company
Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202

Website

Visit our website student.lifewiseac.com/uw/bt for information and secure online access to claims information