"ISHIP" INTERNATIONAL STUDENT HEALTH INSURANCE PLAN

PPO + Vision/Dental

LifeWise
Assurance Company

INTRODUCTION

Welcome

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

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

Some words have special meanings under this plan. 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, student.lifewiseac.com/uw/ship (for Seattle campus) and student.lifewiseac.com/uw/bt (for Bothell and Tacoma campuses), 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.

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

Group Name:	University of Washington
Effective Date:	September 1, 2022
Plan:	LifeWise ISHIP PPO + Vision/Dental
Certificate Form Number:	UWISHIP (09-2022)

LifeWise Assurance Company

Discrimination is Against the Law

LifeWise Assurance Company (LifeWise) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-971-1491 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-971-1491（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-971-1491 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-971-1491 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-971-1491 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-971-1491 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-971-1491 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-971-1491 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-971-1491（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-971-1491 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-971-1491 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-971-1491 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-971-1491 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-971-1491 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-971-1491 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-971-1491 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-971-1491 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-971-1491 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-971-1491 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-971-1491 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-971-1491 (TTY: 711) تماس بگیرید.

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, copays, coinsurance, coinsurance maximums, out-of-pocket maximums and allowed amounts
- **How Providers Affect Your Costs** – How using an in-network provider affects your benefits and lowers your out-of-pocket costs
- **Prior Authorization**– Describes our prior authorization provision
- **Clinical Review** – Describes our clinical review provision
- **Personal Health Support Programs** – Describes our health support programs
- **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
- **How Do I File A Claim** – Instructions on how to send in a claim
- **Complaints and Appeals** – What to do if you want to file a complaint or submit an appeal
- **Eligibility and Enrollment** – Describes who can be covered.
- **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 10
Plan Year Deductible 10
Copays 10
Coinsurance 10
Out-Of-Pocket Maximum.....10
Allowed Amount 11
HOW PROVIDERS AFFECT YOUR COSTS 12
Medical Services 12
Pediatric Dental Services 13
CARE MANAGEMENT 14
Prior Authorization and Emergency Admission Notification.....14
Clinical Review 16
Health Support Programs.....16
Continuity of Care 16
COVERED SERVICES.....17
Common Medical Services 18
Other Covered Services.....38
EXCLUSIONS 46
OTHER COVERAGE.....50
Coordinating Benefits With Other Plans 50
Third Party Liability (Subrogation).....53
HOW DO I FILE A CLAIM.....53
COMPLAINTS AND APPEALS 55
ELIGIBILITY AND ENROLLMENT 58
Eligibility For Students (Subscribers).....58
Family Members You May Cover (Dependents).....59
Premiums 61
When Coverage Begins And Ends 61
OTHER PLAN INFORMATION 62
DEFINITIONS 68

SUMMARY OF YOUR COSTS

Campus Clinics

Your Provider Network is: LifeWise Assurance Co.

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

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

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

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

- The allowed amount. 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. Copays apply to the out-of-pocket maximum unless stated otherwise in the summary.
- The deductible. The costs shown below are what you pay after the deductible is met. Sometimes the deductible is waived. This is also shown below. The deductible is waived at Campus Clinics.

	Campus Clinic Providers	In-Network Providers	Out-of-Network Providers
Individual Deductible Deductible waived at Campus Clinics	None	$100 per quarter/ $400 per plan year	
Family Deductible (embedded) Deductible waived at Campus Clinics	None	$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 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 facility fees billed by the hospital. See ***Hospital Services*** for these costs.

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

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

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
COMMON MEDICAL SERVICES		
Office and Clinic Visits (including virtual care providers) You may have additional costs for other services such as x-rays lab, therapeutic injections and hospital facility charges. See those covered services for details. See ***Preventive Care*** for preventive services.		
• Office visits, including virtual care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Office visit for women's health	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Non-hospital urgent care centers	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• All other office and clinic visits (including non-preventive nutritional therapy and consultations with a pharmacist) See ***Mental Health, Behavioral Health and Substance Abuse*** section for these benefits	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Preventive Care Benefits for preventive care that meet the federal guidelines are not subject to cost sharing when care is provided by an in-network provider.		
• Exams, screenings and immunizations (including seasonal immunizations in a provider's office) are limited in how often you can get them based on your age and gender	0% coinsurance, deductible waived	Not covered
• Seasonal and travel immunizations (pharmacy, mass immunizer, travel clinic and county health department)	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• Health education, preventive nutritional therapy for diseases such as diabetes, and nicotine dependency treatment	0% coinsurance, deductible waived	Not covered
Contraception Management and Sterilization (See ***Surgery Services*** for male sterilization.)	0% coinsurance, deductible waived	Deductible then 40% coinsurance
Diagnostic X-ray, Lab and Imaging		
• Preventive care screening and tests	0% coinsurance, deductible waived	Deductible then 40% coinsurance
• Basic diagnostic lab, x-ray, lab and imaging	25% coinsurance, deductible waived	Deductible then 40% coinsurance
• Major diagnostic x-ray and imaging	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Pediatric Care (members under age 19)		
Pediatric Vision Services		
• Routine exams limited to one per plan year	Deductible then 25% coinsurance	Deductible then 40% coinsurance

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
• One pair of glasses (frames and lenses) per plan year. Lens features limited to polycarbonate lenses and scratch resistant coating.	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• One pair of contacts or a 12-month supply of contacts per plan year instead of glasses (lenses and frames).	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• Contact lenses and glasses required for medical reasons	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• One comprehensive low vision evaluation and four follow up visits in a five plan year period	0% coinsurance, deductible waived	0% coinsurance, deductible waived
• Low vision devices, high powered spectacles, medical vision hardware, magnifiers and telescopes when medically necessary	0% coinsurance, deductible waived	0% coinsurance, deductible waived
Pediatric Dental Services		
• Class I Services	Deductible then 10% coinsurance	Deductible then 30% coinsurance
• Class II Services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
• Class III Services	Deductible then 50% coinsurance	Deductible then 50% coinsurance
• Medically Necessary Orthodontia	Deductible then 50% coinsurance	Deductible then 50% coinsurance
	YOUR COSTS OF THE ALLOWED AMOUNT	
Note: Not all services are provided at Campus Clinics.	**IN-NETWORK PROVIDERS** Rubenstein Pharmacy, UMC/UWP and all In-Network Pharmacies	**OUT-OF-NETWORK PROVIDERS** Out-of-Network Pharmacies
Prescription Drugs– Retail Pharmacy		
Up to a 30-day supply. Up to a 12-month supply for contraceptive drugs and devices. The quarterly deductible is waived. Maximum copay/coinsurance of up to $150/prescription.		
• Preventive drugs required by federal health care reform. See ***Covered Services*** for details.	No charge	No charge
• Formulary preferred generic drugs	$20 copay, deductible waived	50% coinsurance, deductible waived (based on billed charge)
• Formulary preferred brand-name drugs	$30 copay, deductible waived	
• Formulary non-preferred drugs	$45 copay, deductible waived	
• Specialty drugs	50% coinsurance, deductible waived	

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
• Oral chemotherapy drugs **Your cost-shares for covered prescription insulin drugs will not exceed $100 per 30-day supply of the drug, and the deductible does not apply. Cost-shares for covered prescription insulin drugs apply towards the deductible.*	25% coinsurance, deductible waived	40% coinsurance, deductible waived

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**

Surgery Services		
• Inpatient hospital	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Outpatient hospital, ambulatory surgical center	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Professional services	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Male sterilization	0% coinsurance, deductible waived	Deductible then 40% coinsurance
Emergency Room		
• Facility fees. The copay is waived if you are admitted as an inpatient through the emergency room. The copay is waived if you are transferred and admitted to a different hospital directly from the emergency room.	$100 copay, then deductible and 25% coinsurance	$100 copay, then deductible and 25% coinsurance
• Professional, diagnostic services, other services and supplies	Deductible then 25% coinsurance	Deductible then 25% coinsurance
Emergency Ambulance Services	Deductible then 25% coinsurance	Deductible then 25% coinsurance
Urgent Care Centers	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Hospital Services		
• Inpatient Care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Outpatient Care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Mental Health, Behavioral Health and Substance Abuse		
• Office visits (including virtual care) and other outpatient services (there are no fees at the Counseling Center for registered students)	No charge	No cost-shares
• Inpatient and residential	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Maternity and Newborn Care Prenatal, postnatal, delivery, and inpatient care. See also ***Diagnostic X-ray, Lab and Imaging***. For specialty care see		

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
also ***Office and Clinic Visits***.		
• Hospital	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Birthing center or short-stay facility	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Diagnostic tests during pregnancy	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Professional	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Home Health Care Limited to 130 visits per plan year	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Hospice Care		
• Home visits (not subject to the Home Health Care visit limit)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Respite care, inpatient or outpatient (limited to 14 days lifetime)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Habilitation Therapy Neuropsychological testing to diagnose is not subject to any maximum. Please see ***Mental Health, Behavioral Health and Substance Abuse*** for therapies provided for mental health conditions such as autism.		
• Inpatient (limited to 30 days per plan year)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Outpatient (limited to 25 visits per plan year)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Rehabilitation Therapy Please see ***Mental Health, Behavioral Health and Substance Abuse*** for therapies provided for mental health conditions such as autism.		
• Inpatient (limited to 30 days per plan year)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Outpatient (limited to 25 visits per plan year)	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Skilled Nursing Facility and Care		
• Skilled nursing facility care limited to 60 days per plan year	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Skilled nursing care in the long-term care facility care limited to 60 days per plan year	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics Shoe inserts and orthopedic shoes limited to $300 per plan year, unless it is diabetes-related. Sales tax, shipping and handling costs apply to any limit if billed and paid separately.	Deductible then 25% coinsurance	Deductible then 40% coinsurance
OTHER COVERED SERVICES		
Acupuncture Treatments	Deductible then 25% coinsurance	Deductible then 40% coinsurance

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
Limited to 12 treatments per plan year.		
Allergy Testing and Treatment	Deductible then 25% coinsurance	Deductible then 40% coinsurance
App-based Care App-based care select providers • General Medical Services • Mental Health • Substance Abuse App-based care select providers can be found at https://student.lifewiseac.com/uw/ship/find-a-doctor.aspx or contact Customer Service for assistance See ***Office and Clinic Visits, Mental Health, Behavioral Health and Substance Abuse*** for virtual care benefits	 Deductible then 25% coinsurance No charge No charge	 Not covered
Chemotherapy, Radiation Therapy and Kidney Dialysis	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Clinical Trials You may have additional costs for other services such as x-rays, lab, prescription drugs, and hospital facility charges. See those covered services for details.	Covered as any other service	Covered as any other service
Dental Injuries You may have additional costs for other services such as x-rays, lab, and hospital facility charges. See those covered services for details.	Covered as any other service	Covered as any other service
Dental Anesthesia When medically necessary	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Foot Care Routine care that is medically necessary	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Gender Affirming Care	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Infusion Therapy	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Mastectomy and Breast Reconstruction	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Medical Foods	Deductible then 25% coinsurance	Deductible then 40% coinsurance

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
Spinal or Other Manipulative Treatment Limited to 10 visits per plan year	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Temporomandibular Joint (TMJ) Disorders		
• Office visits	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Inpatient facility fees	Deductible then 25% coinsurance	Deductible then 40% coinsurance
• Other professional services	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Therapeutic Injections	Deductible then 25% coinsurance	Deductible then 40% coinsurance
Transplants All approved transplant centers covered at in-network benefit level.		
• Office visits	Deductible then 25% coinsurance	Not covered
• Inpatient facility fees	Deductible then 25% coinsurance	Not covered
• Other professional services	Deductible then 25% coinsurance	Not covered
• Travel and lodging. $5,000 limit per transplant	Deductible then 0% coinsurance	Deductible then 0% coinsurance
Abortion	Deductible then 25% coinsurance	Deductible then 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 ***Pediatric Vision Services***.		
• 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
Dental for Adults (maximum of $1,500 per plan year, $25 individual/ $75 family deductible per plan year). The services below do not apply toward the overall deductible and out-of-pocket maximum amounts shown above. For dental care for a child under age 19 see ***Pediatric Dental Services***.		
• Preventive Services (includes routine exams, cleanings and x-rays). See the ***Dental for Adults*** for more detail.	Dental deductible, then 0% coinsurance	Dental deductible, then 0% coinsurance
• Restorative Services. Services that restore the function of the tooth by replacing missing or damaged tooth structure. Restorative services include, but not limited to, extractions, fillings, root canals, crowns, and periodontal (gum) treatment.	Dental deductible, then 0% coinsurance	Dental deductible, then 0% coinsurance
Emergency Medical Evacuation and Repatriation of Remains Services do not apply toward the out-of-pocket maximum shown above.		
• Emergency Medical Evacuation ($150,000	0% coinsurance, deductible waived	0% coinsurance, deductible

Note: Not all services are provided at Campus Clinics.	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Deductible waived at Campus Clinics	**OUT-OF-NETWORK PROVIDERS**
lifetime maximum)		waived
• Repatriation of Remains ($25,000 maximum)	0% coinsurance, deductible waived	0% coinsurance, deductible waived

IMPORTANT PLAN INFORMATION

This plan is a Preferred Provider Plan (PPO). Your Provider Network is: LifeWise Assurance Co. Your plan provides you benefits for covered services from providers within the LifeWise Assurance Co. network without referrals. You have access to one of the many providers included in your network of providers for covered services included in your plan. 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. **IMPORTANT NOTE**: Certain services received from out-of-network providers are not covered under this plan. See ***Summary of Your Costs***.

PLAN YEAR DEDUCTIBLE

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

Quarterly/Quarter Deductible

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

Individual Deductible

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

Family Deductible

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

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

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

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

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

COPAYS

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

COINSURANCE

Coinsurance is the percentage of the allowed amount for a 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.

Out-of-Network

Except as stated below, the allowed amount is the least of the following (unless a different amount is required under applicable law or agreement):

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

There is one exception: The allowed amount is the provider's billed charge for emergency services by an ambulance that does not have a contract with us.

If applicable law requires a different allowed amount than the least of the three amounts above, this plan will comply with that law.

Non-Emergency Services Protected From Balance Billing

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

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

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

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

Note: Non-participating ground ambulances are always paid based on billed charges.

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

Air Ambulance

The allowed amount for non-participating air ambulance providers will be calculated consistent with the requirements of federal law.

HOW PROVIDERS AFFECT YOUR COSTS

MEDICAL SERVICES

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

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

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

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

Our provider directory is available any time on our website at student.lifewiseac.com. 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.

Contracted Health Care Benefit Managers

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

Non-Participating Providers

Non-participating providers are either (1) providers that are not part of your network (out-of-network) or (2) providers that do not have a contract with us (non-contracted).

If a covered service is not available from an in-network provider, you can receive benefits for services provided by a non-participating provider. See ***Prior Authorization*** for details.

When a service is covered by a non-participating provider, the provider may bill you for charges above the allowed amount. You may also be required to submit the claim yourself. See ***How Do I File A Claim*** for details.

- **Out-of-network providers.** In some cases, an out-of-network provider may have a contract with us, but is not part of your network. In the event the services are covered (See ***Benefits for Out-of-Network or Non-Contracted Providers***), contracting providers will not bill you for amounts over the allowed amount.
- **Non-contracted providers.** Non-contracted providers do not have a contract with us or with any of the other networks used by this plan. These providers may bill you the amount above the allowed amount for a covered

service.

Balance Billing Protection

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

- **Emergency Services** from a non-participating hospital or facility or from a non-participating provider that works for the hospital or facility. Emergency services includes certain post-stabilization services you may get after you are in stable condition. These include covered services provided as part of outpatient observation or during an inpatient or outpatient stay related to the emergency visit, regardless of which department of the hospital you are in.
- **Non-emergency services** from a **non-participating provider** at an **in-network hospital or outpatient surgery center**. If a non-emergency service is not covered under the in-network benefits and terms of coverage under your health plan, then the federal and state law regarding balance billing do not apply for these services.

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

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

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

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

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

- Emergency services for a medical emergency. (Please see the ***Definitions*** section for definitions of these terms.) This plan provides worldwide coverage for emergency services.
- The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider furnishing the services has a contract with us. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws.
- Covered services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Facility and hospital-based provider services received from a hospital that has a provider contract with us.
- Covered emergency 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 or non-contracted provider. However, you or your in-network provider must request this before you get the care. See ***Prior Authorization*** for details.

PEDIATRIC DENTAL SERVICES

In-Network Providers

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

You receive the highest level of coverage when you receive services from in-network providers. 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 ***How Do I File 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 before you receive it. This process is called prior authorization.

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

There are three situations where prior authorization is required:

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

Prior authorization is also not required for the first six visits of Rehabilitation and Habilitation Therapy, Spinal Manipulative Treatment or Acupuncture.

How to Ask for Prior Authorization

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

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

Services from Out-of-Network Providers: It is your responsibility to get prior authorization for any of the services on the prior authorization list when you see an out-of-network provider. You or your out-of-network provider can call us at the number listed on your ID card to request a prior authorization.

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

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

Prior Authorization for Prescription Drugs

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

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

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

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

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

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

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

Exceptions to Prior Authorization for Benefit Coverage

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

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

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

Prior Authorization for Services from Out-of-Network Providers

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

The prior authorization request must include the following:

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

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

Exceptions to Prior Authorization for Out-of-Network Providers

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

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

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

CLINICAL REVIEW

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

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

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

PERSONAL HEALTH SUPPORT PROGRAMS

The personal health support programs are designed to help make sure your health care and treatment improve your health. You will receive individualized and integrated support based on your specific needs. These services could include working with you and your 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 personal health support programs is voluntary. To learn more about the programs, contact Customer Service at the number listed on your ID card.

CONTINUITY OF CARE

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

COC applies in these situations:

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

How you qualify for Continuity of Care You may qualify if you are in an "active relationship" or treatment with your provider. This means that you have had three or more visits with the provider within the past 12 months and you meet one or more of these conditions with respect to a terminated provider or facility:

- Undergoing a course of treatment for a serious and complex condition
- Undergoing a course of institutional or inpatient care
- Are scheduled for a non-elective surgery, including receipt of postoperative care
- Are pregnant and undergoing a course of treatment for the pregnancy
- Are receiving treatment for a terminal illness

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

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

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

- The 90th day after we notified you that your Primary Care Provider (PCP)'s contract ended
- The day after you complete the active course of treatment entitling you to continuity of care
- If you are pregnant, and become eligible for continuity of care after commencement of the second trimester of the pregnancy, you will receive continuity of care

Continuity of care does not apply if your provider:

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

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

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 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 that are used to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigative status for a specific procedure, drugs, biologic agents, devices, level of care or services. Payment policies define provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at student.lifewiseac.com 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 on the back cover.

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

You may have to pay a separate copay or coinsurance for other services you get during a visit. This includes services such as x-rays, lab work, therapeutic injections, facility fees 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

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.

Please go to this government website for more information:
https://www.healthcare.gov/coverage/preventive-care-benefits/

Preventive services provided by in-network providers are covered in full. But, they have limits on how often you should get them. These limits are often based on your age and gender. After a limit has been exceeded, these services are not covered in full and may require you to pay more out-of-pocket costs.

Some of the services your doctor does during a routine exam may not meet preventive guidelines. These services are then covered the same as any other similar medical service and are not covered in full.

For example:

During your preventive exam, your doctor may find an issue or problem that requires further testing or screening for a proper diagnosis to be made. Also, if you have a chronic disease, your doctor may check your condition with tests. These types of screenings and tests help to diagnose or monitor your illness and would not be covered under your preventive benefits. They would require you to pay a greater share of the costs.

You can also get a complete list of the preventive care services with the limits on our website or call us for a list. This list may be changed as state and federal preventive guidelines change. The list will include website addresses where you can see current federal preventive guidelines.

The plan covers the following as preventive services:

- Covered preventive services include those with an “A” or “B” rating by the United States Preventive Services Task Force (USPSTF); 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. Included are exams for school, sports and employment
- Preventive services, tests, screening and supplies as recommended by the HRSA women’s preventive service

guidelines.

- 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 ***How Do I File A Claim*** for instructions.

- Professional services to prevent falling for members who are 65 years and older and have a history of falling or mobility issues
- Prostate cancer screening. Includes digital rectal exams and prostate-specific antigen (PSA) tests.
- Colon cancer screening for high risk individuals under 45 years of age, all individuals 45 years of age or older. Includes pre-colonoscopy consultations, exams, colonoscopy, sigmoidoscopy and fecal occult blood tests. Removal and pathology (biopsy) related to polyps found during a screening procedure are covered as part of the preventive screening. Includes anesthesia your doctor considers medically appropriate for you.
- Colonoscopies as follow up to a positive non-invasive stool based screening test
- Outpatient lab and radiology for preventive screening and tests
- Diabetes screening
- 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 for seasonal and travel immunizations you may need to pay out of pocket and submit a claim for reimbursement. See ***How Do I File A Claim*** for instructions.
- Depression screening
- Obesity screening and counseling for weight loss for children age six and older who are considered obese and for adults with a body mass index of 30 kg/meter squared or higher
- Contraceptive management. Includes exams, treatment, prescription and over-the-counter drugs, and supplies you get at your provider's office, including all FDA approved contraceptives that are required to be covered by state or federal law. FDA approved contraceptives include but are not limited to, emergency contraceptives, and contraceptive devices (insertion and removal). Tubal ligation is 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. The number therapy visits that are covered as preventive depends on your medical need.
- Pre-exposure (PrEP) for members at high risk for HIV infection.
- 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. See ***Prescription Drugs*** for covered drug benefits.

This Preventive Care benefit does not cover:

- 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
- Male sterilization. See ***Surgery Services***.

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
- Standard ultrasounds
- Diagnosis and treatment of the underlying medical conditions that may cause infertility

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.
- Testing required for employment, schooling, screening or public health reasons that is not for the purpose of treatment.

Pediatric Care

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

Pediatric Vision Services

Coverage for routine eye exams and glasses includes the following:

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

Pediatric Dental Services

This plan covers pediatric dental services until the end of the month of a member's 19th birthday, when all eligibility requirements are met.

Pediatric dental services are covered as stated on the ***Summary of Your Costs, Pediatric Dental Services*** section.

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

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

- They must be dentally or medically necessary (see ***Definitions***)
- They must be named in this plan as covered
- They must be furnished by a licensed dentist (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. We will request these materials directly from your dental provider. If we're unable to obtain the necessary materials, we'll provide benefits only for those dental services we can verify as covered.

Estimate of Dental Benefits

You can ask for an **Estimate of Benefits** before you receive dental services. An **Estimate of Benefits** verifies your eligibility and benefits of this plan for you and your provider. It may also clarify what is covered or not covered. This can protect you from unexpected out-of-pocket expenses.

An **Estimate of Benefits** isn't required 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 you received services. See ***How to Contact Us*** 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 – Diagnostic and Preventive Services

- Routine comprehensive and periodic oral evaluations are limited to 2 visits per plan year. (See definition of ***Comprehensive Oral Evaluation***)
- Pre-diagnostic visual oral screenings or assessments are limited to 2 visits per plan year. (See definition of ***Visual Oral Screenings or Assessments***)
- X-rays include:
    - Either a complete series (full-mouth) x-ray or panoramic films, once every 36 months, but not both
    - Bitewing x-rays up to a maximum of 4 are limited to 2 per plan year
    - Periapical x-rays
    - Occlusal intraoral x-rays are limited to once every 24 months
- Prophylaxis (cleaning) is limited to 2 per plan year
- Fluoride treatment (including fluoride varnish) is limited to 3 treatments per plan year
- Oral hygiene instruction is limited to 2 times per plan year for ages 8 and under if not performed on the same day as prophylaxis (cleaning)
- Sealants are limited to permanent bicuspids and molars only
- Fixed space maintainers are covered for members age 12 years and younger only when designed to preserve space for permanent teeth
    - Re-cement or re-bond space maintainers is covered for members age 12 years and younger
    - Removal of fixed space maintainer is covered when removed by a different provider
    - Replacement of space maintainers will be covered only when dentally necessary

Class II – Basic Services

- Limited oral evaluations – problem focused or emergent. (See definition of ***Limited Oral Evaluation – Problem Focused)***
- Other x-rays include:
    - Cephalometric film is limited to once every 24 months
    - Oral and facial photographic images and other non-routine x-rays are subject to review for dental necessity on a case by case basis
- Fillings, consisting of amalgam and resin-based composite on any tooth surface are limited to once every 24 months. Multiple restorations on any tooth surface will be considered one surface regardless of the number or combination of restorations.
- Prefabricated stainless steel crowns including those made with porcelain, ceramic or resin material are limited to once every 36 months on permanent or primary teeth
- Recement or rebond permanent crown or fixed partial denture is covered for members age 12 years and older
- Repair to crowns (indirect) is limited to once per tooth per lifetime
- Repair to complete and partial dentures is limited to once in a 12 month period
- Pulp vitality tests
- Non-surgical periodontics include:
    - Full mouth debridement is limited to once per 3 years
    - Periodontal maintenance following periodontal therapy is limited to 4 per plan year for members age 13 and older
- Simple extractions
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- House/extended care facility call is limited to 2 per facility per day, when medically or dentally necessary

- Behavior management (behavior guidance techniques used by dental provider)

Class III – Major Services

- Diagnostic casts or study models
- Inlay, onlay, crowns (indirect), crown build-ups including pins, and cast post and core are covered for members age 12 years and older, limited to permanent anterior teeth only and limited to once every five years when there is significant loss of clinical crown and no other dentally appropriate restoration will restore function
- Endodontics Services include:
    - Direct pulp cap
    - Therapeutic pulpotomy is limited to primary teeth only
    - Pulpal debridement is limited to permanent teeth only
    - Pulpal therapy (resorbable filling) is limited to primary teeth only
    - Endodontic treatment is limited to primary posterior and permanent anterior, bicuspid, and molar teeth excluding teeth 1, 16, 17, and 32 teeth only
    - Endodontic retreatment includes the removal of post, pin, and old root canal filling material, and all procedures necessary to prepare the canal with placement of new filling material and is limited to permanent anterior, bicuspid, and molar teeth excluding teeth 1, 16, 17, and 32. Endodontic retreatment provided by the original treating provider or clinic is subject to review for medical or dental necessity.
    - Apexification for apical closures is limited to anterior permanent teeth only. Apicoectomy and retrograde filling is limited to anterior teeth only
- Periodontal scaling and root planing are covered for members age 13 years and older and are limited to once per quadrant every 24 months
- Surgical periodontics include:
    - Gingivectomy and gingivoplasty is limited to once every 3 years
    - Osseous surgery including flap entry and closure, and mucogingival surgery is limited to once every 5 years
- Initial placement of bridges (fixed partial dentures). Replacement is limited to once every 7 years after the original was placed.
- Initial placement of complete dentures, including overdentures is covered when the denture cannot be made serviceable by a less costly procedure
    - Includes six-month post-delivery care (e.g., adjustments, soft relines, and repairs) after placement
    - Replacement of complete denture or overdenture is limited to 1 per lifetime and at least 5 years after the original was placed
- Initial placement of resin base partial dentures is covered when one or more anterior teeth are missing or four or more posterior teeth (excluding third molars) per arch and the remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis
    - Includes six-month post-delivery care (e.g., adjustments, soft relines, and repairs) after placement
    - Replacement of resin partials is limited to once every three years
- Denture rebase and reline is limited to once in a three year period when performed at least six months after placement
- Denture adjustment, excluding six-month post-delivery care
- Dental implant crown and implant abutment related procedures limited to 1 every 7 years
- Repair of implant supported prosthesis or abutment, limited to one per tooth per member lifetime
- Other oral surgery related to the teeth and supporting structures in a dental office including:
    - Surgical extraction and removal of erupted or impacted tooth
    - Biopsy of oral tissue, hard or soft
    - Removal of odontogenic cyst or tumor

    - Alveoplasty
    - Vestibuloplasty
    - Frenuloplasty/frenulectomy is covered for members age 6 and under
- Therapeutic parenteral/therapeutic drugs such as antibiotics, steroids, and anti-inflammatory medication administered in a dental office
- Anesthesia in conjunction with covered services in a dental care provider's office includes:
    - General anesthesia, deep sedation or intravenous (conscious) sedation when dentally necessary. This includes members who are under the age of 7 or are disabled physically or developmentally.
    - Non intravenous conscious sedation,
    - Nitrous oxide is limited to once per day
    - Local anesthesia and regional blocks are considered part of the global fee if billed with any covered service
- Treatment of post-surgical complications such as dry socket by a dental provider
- Hospital call including emergency services limited to 1 per day, when dentally necessary
- Occlusal guard (nightguard) is covered for bruxism and other occlusal factors when dentally necessary for members age 12 and over

Medically necessary orthodontia services

- This benefit includes braces and orthodontic retainer for specific malocclusions associated with:
    - Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement
    - Craniofacial anomalies (Hemifacial Microsomia, Craniosynostosis syndromes, Arthrogryposis and Marfan syndrome)

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

The pediatric dental services benefit does not cover:

- Application of any type of desensitizing medicament
- Cast-metal framework, flexible base, and removable unilateral partial dentures
- Cleaning of appliances
- Coping
- Cosmetic services:
    - Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and aftereffects thereof
    - Cosmetic orthodontia
- Diagnostic tests and examinations including collection, preparation, analysis, viral culture, genetic and caries susceptibility tests, and adjunctive pre-diagnostic tests
- Diagnostic tomographic surveys, cone beam, MRI, ultrasound, 3-D imaging, and posterior-anterior or lateral skull and facial bone survey films
- Duplicate appliances
- Extra dentures or other duplicate appliances, including replacements due to loss or theft
- Fabrication of an athletic mouthguard
- Facility charges (hospital and ambulatory surgical center) for dental procedures
- Home use products. Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.
- Gold foil restorations
- Labial veneers
- Implants. Dental implants and implant related services including but not limited to:

    - Surgical placement or implants including indosteal, eposteal, and transosteal; interim endosseous implants; endodontic endosseous implants; sinus augmentations or lift; implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis; radiographic/surgical implant index; and unspecified implant procedures.
- Localized delivery of antimicrobial agents
- Increase of vertical dimension. Any service to increase or alter the vertical dimension.
- Indirect pulp caps
- Immediate dentures
- Multiple providers. Services provided by more than one dental care provider for the same dental procedure.
- Non-standard techniques. Techniques other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.
- Occlusion analysis and limited and complete occlusal adjustments
- Oral pathology laboratory including collection of tissue samples, cultures and specimens
- Plaque control programs (dietary instruction and home fluoride kits)
- Precision attachments, replacement of replaceable parts for semi-precision or precision attachments and personalization of appliances
- Provisional splinting
- Sedative filings
- 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)
- Surgical procedures including:
    - Incision and drainage of abscess-extra oral soft tissue
    - Radical resection of maxilla or mandible
    - Removal of non-odontogenic cyst, tumor or lesion
    - Surgical stent
    - Surgical procedures for isolation of a tooth with rubber dam
- Temporary, interim or provisional services for crowns, bridges or dentures
- Testing and treatment for mercury sensitivity or that are allergy-related
- Tobacco cessation and nutritional counseling for control of dental disease
- Tooth preparation, acid etching, all adhesives, and liners
- Tooth transplantation including re-implantation from one site to another and splinting and/or stabilization

Prescription Drugs

This 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 investigative 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 website, or contact Customer Service for a complete list of your plan's covered prescription drugs.

Drugs not included in the formulary are not covered by this plan.

Exceptions Request for Non-Formulary Drugs

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

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

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

Expedited Exceptions Request for Non-Formulary Drugs

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

External Review for Non-Formulary Drugs

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

Covered Prescription Drugs

- FDA approved formulary 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 prescription and over-the-counter oral contraceptive drugs and devices that are required to be covered by state or federal law, such as diaphragms and cervical caps are covered when provided by an in-network pharmacy, see ***Prescription 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 specialist or a specific provider
- Step therapy, meaning you must try a generic drug or a specified brand name drug first
- Drug synchronization, meaning the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period. Cost-shares are adjusted if the fill is less than the standard refill amount in compliance with state law

These limitations are based on medical criteria, the drug maker's recommendations, and the circumstances of the individual case. They are also based on 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.

Visit the pharmacy section of our website at student.lifewiseac.com. 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. Exceptions to this limit may be allowed as required by law. For example, a pharmacist can authorize an early refill of a prescription for topical ophthalmic products in certain circumstances. You must pay a copay for each limited days' supply.

Preventive Drugs

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

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

Using In-network Pharmacies

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

Diabetic Injectable Supplies

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

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

Oral Chemotherapy

This benefit covers self-administered oral drugs when the medication is dispensed by a pharmacy. These drugs are covered the same as any other similar medication. See the ***Summary of Your Costs***.

This benefit does not cover:

- Drugs and medicines that you can legally buy over the counter (OTC) without a prescription. OTC drugs are not covered even if you have a prescription. Examples include, but are not limited to, nonprescription drugs and vitamins, herbal or naturopathic medicines, and nutritional and dietary supplements such as infant formulas or protein supplements. This exclusion does not apply to OTC drugs that are required to be covered by state or federal law.
- Drugs for cosmetic use such as for wrinkles
- Drugs to promote or stimulate hair growth
- Blood or blood derivatives. ***See Surgery Services*** for more information on blood and blood derivative coverage.
- Any prescription refill beyond the number of refills shown on the prescription or any refill after one year from the original prescription
- Replacement of lost or stolen drugs
- Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and injectable medications other than drugs you inject yourself, 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 other than drugs you inject yourself.
- Immunizations. See ***Preventive Care***.
- Drugs to enhance fertility or to treat sexual dysfunction

- Weight management drugs
- Therapeutic devices or appliances. See ***Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics***.

Drug Discount Program

LifeWise may receive drug rebates or discounts.

- Your benefit programs include per-claim rebates that LifeWise receives from its pharmacy benefit manager or other vendors. We consider these rebates when we set the subscription charges, or we credit them to administrative charges that we would otherwise pay. These rebates are not reflected in your allowed amount.
- We also may receive discounts from our pharmacy benefit manager. These discounts are reflected in your allowed amount. If the allowed amount for prescription drugs is higher than the price we pay after our discount, then 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 premium rates for the next benefit year

If your benefit includes a copay, 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 or specialty pharmacy is described in the ***Summary of Your Costs***.

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

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

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

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

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

Benefits for refills will be provided only when the member has used 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. Storage is covered only when medically necessary.
- 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 dependent child's congenital anomaly
- Cosmetic surgery for correction of functional disorders. This does not include removal of excess skin and or fat related to weight loss surgery or the use of weight loss drugs.
- Repair of a defect that is the direct result of an injury

- Sexual reassignment surgery if medically necessary and not for cosmetic purposes. See ***Gender Affirming Care*** for details.
- Male sterilization/vasectomy

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 benefit covers:

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

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

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. Transportation to your home is covered when medically necessary.

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 or quarter deductible and coinsurance for related to facility fees charged by the hospital.

Hospital Services

This benefit covers:

- Inpatient room and board
- Doctor and nurse services
- Intensive care or special care units
- Operating rooms, procedure rooms and recovery rooms
- Surgical supplies and anesthesia

- Drugs, blood, medical equipment and oxygen for use in the hospital
- X-ray, lab and testing billed by the hospital

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

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

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

This benefit does not cover:

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

Mental Health, Behavioral Health and Substance Abuse

This plan covers mental health care and treatment for substance abuse disorder. 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. Please call Customer Service for help in finding a physician approved to provide these services.

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

Mental Health Care

This plan covers all of the following services:

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

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

Alcohol and Drug Dependence (Also called “Chemical Dependency” or “Substance Abuse Disorder Treatment”)

This plan covers all of the following services:

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

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

- A physician (MD or DO) who is a psychiatrist, developmental pediatrician, or pediatric neurologist
- A hospital
- A state hospital maintained by the state of Washington for the care of the mentally ill.
- A state-licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
- A state-licensed masters-level mental health clinician (e.g., licensed clinical social worker, licensed marriage and family counselor, licensed mental health counselor)

- A state-licensed occupational or speech therapist
- A state-licensed psychologist
- A state-licensed community mental health agency or behavioral health agency
- Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care.

Applied Behavioral Analysis (ABA) Therapy

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

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

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

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

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

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

Maternity and Newborn Care

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

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

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
- Donor breast milk

Home Health Care

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

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

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

General Home Health Care

General Home Health Care is short-term care performed at your home. These occasional visits are done by a medical professional that's employed through a home health agency that is state-licensed or Medicare-certified. Care is covered when a doctor states in writing that care is needed in your home.

The following are covered under the Home Health Care benefit:

- Home visits and short-term nursing care
- Home medical equipment, medical supplies and devices
- Prescription drugs given by the home health agency
- Therapy, such as physical, occupational or speech therapy to help regain function

Only the following employees of a home health agency are covered:

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

Skilled Hourly Nursing

Skilled Hourly Nursing is also covered under the Home Health Care benefit. Skilled Hourly Nursing is medically intensive care at home that is provided by a licensed nurse.

Skilled Hourly Nursing is covered only when provided in lieu of hospitalization.

You must have a written plan of care from your doctor and requires prior authorization by the plan. See ***Prior Authorization***. This type of care is not subject to any visit limit shown in the ***Summary of Your Costs***.

The Home Health Care benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Private Duty Nursing that is not General Home Health Care or Skilled Hourly Nursing
- 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
- Non-medical 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. Hospice care benefits may be provided, with your consent, when medically appropriate as an alternative to inpatient or institutional care.

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 (neurodevelopmental) 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*** and prior authorization requirements stated below under outpatient care do not apply to cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or disease.

Inpatient Care

You can get inpatient care in a specialized rehabilitative unit of a hospital. If you are already 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 rehabilitative and habilitative therapy received in an outpatient setting. Certain therapies require prior authorization for services beyond the first six visits per episode of care. An "episode of care" is treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous ninety days and is not currently undergoing any active treatment. Initial evaluations do not count toward the six visit limit.

Benefits are provided for the following services:

- 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:

- Aniridia
- Aniseikonia
- Anisometropia
- Aphakia
- Bullous keratopathy
- Congenital cataract
- Corneal abrasion
- Corneal disorders
- Corneal ulcer
- Irregular astigmatism
- Keratoconus
- Pathological myopia

- Post-traumatic disorders
- Progressive high (degenerative) myopia
- Recurrent erosion of cornea
- Sjogren's disease
- Tear film insufficiency

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

Prosthetics and Orthotic Devices

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

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 eyeglasses 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

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

This benefit covers acupuncture to:

- Relieve pain

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

Allergy Testing and Treatment

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

This benefit covers:

- Testing
- Allergy shots
- Serums

App-based Care

On-demand virtual care that connects you to providers via an application (app) software program. Benefits are provided for services for low-level medical conditions using virtual methods like secure chat, text, voice or video chat. App-based care select providers can be found at https://student.lifewiseac.com/uw/ship/find-a-doctor.aspx or contact LifeWise Customer Service for assistance.

Chemotherapy, Radiation Therapy and Kidney Dialysis

This plan covers the following services:

- Outpatient chemotherapy and radiation therapy services
- Outpatient or home kidney dialysis
- Tooth extractions to prepare your jaw for radiation therapy
- Supplies, solutions and drugs used during chemotherapy or radiation visit (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.

Clinical Trials

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

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

A qualified clinical trial is a phase I, II, III or IV clinical trial that is conducted on the prevention, detection or treatment of cancer or other life-threatening disease or conditions. The trial must also be funded or approved by a federal body, such as one of the National Institutes of Health (NIH), a qualified private research entity that meets the standards for NIH support grant eligibility, or by an institutional review board in Washington that has approval by the NIH Office for Protection from Research Risks.

A “clinical trial” does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab tests performed solely to collect data for the trial)
- The investigative item, device or service itself
- A service that is clearly not consistent with widely accepted and established standards of care for a particular condition
- Services, supplies or pharmaceuticals that would not be charged to the member, if there were no coverage.
- Services provided in a clinical trial that are fully funded by another source

We encourage you or your provider to call Customer Service before you enroll in a clinical trial. We can help you

verify that the clinical trial is a qualified clinical trial.

Dental Injuries

This plan covers injuries to teeth, gums or jaw. Benefits are based on the type of service you get. For example, if you have an office visit, it's covered under ***Office and Clinic Visits***, and if you have a lab test it's covered under ***Diagnostic X-ray, Lab and Imaging***.

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 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 care is 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 19 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 medically necessary foot care. Covered services include treatment for corns, calluses, toenail conditions other than infection and hypertrophy or hyperplasia of the skin of the feet.

Gender Affirming Care

Benefits for medically necessary gender affirming care are subject to the same cost-shares that you would pay for inpatient or outpatient treatment for other covered medical conditions, for all ages. To find the amounts you are responsible for, please see the ***Summary of Your Costs*** earlier in this booklet.

Benefits are provided for all gender affirming care surgical services which meet the criteria of the LifeWise medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from Customer Service, or at student.lifewiseac.com

Benefits for gynecological, urologic and genital surgery for covered medical and surgical conditions, other than as part of gender affirming care surgery, are covered under the surgical benefits applicable to those conditions.

Please Note: Coverage of prescription drugs, and mental health treatment associated with gender reassignment surgery, are eligible under the general plan provisions for prescription drugs and behavioral health, subject to the

applicable plan limitations and exclusions.

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 Costs***.

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

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

Temporomandibular Joint (TMJ) Disorders

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

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

•Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case

•Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food

•Recognized as effective, according to the professional standards of good medical practice

•Not experimental or investigational, according to the criteria stated under the "Definitions" section, or primarily for cosmetic purposes

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 has developed expertise in performing organ transplants or bone marrow or stem cell reinfusion.

It must also meet the other approval standards we use. We have agreements with approved transplant centers in Washington, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we will direct you to an approved transplant center that we've contracted with for transplant services.

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

Covered Transplants

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

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

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

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

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

Recipient Costs

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

Covered services consist of all phases of treatment:

- Evaluation
- Pre transplant care
- Transplant

- Follow up treatment

Donor Costs

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

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

Transportation and Lodging

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

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

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

Companions:

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

Non-Covered Expenses

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

Vision for Adults

See 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.

Vision hardware can still be covered after the date your coverage under the plan has ended if 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 after** the date your coverage under this benefit or plan ended.

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, other than as stated above in this benefit.

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 Injuries***. 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

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. Oral hygiene instruction is covered as part of the routine exam.
- 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 allowed amount
- Charges for any services in excess of the percentage and maximums listed
- Charges for failure to keep scheduled appointments or for filling out claim forms
- Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements
- Charges that would not have been made, or that the member would have had no obligation to pay in the absence of this plan
- Cleaning of a prosthetic appliance
- Consultations
- Local anesthesia, sterilization, and supplies billed as separate charges. (These services and items are included in the allowance for the procedure.)
- Materials not approved by the American Dental Association
- Oral hygiene instruction not listed above, dietary instruction and home fluoride kits
- Plaque control program
- Prescription drugs, medications, or supplies provided by a dental office not related to covered dental care. For prescriptions dispensed by a pharmacy 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 $150,000 to transport you to your home country or country of regular domicile. Evacuation must be recommended and approved by the attending physician. Emergency Medical Evacuation means after being treated at a local Hospital, your medical condition warrants transportation to your home country to obtain further medical treatment to recover. Covered Expenses are Expenses up to the maximum for transportation, medical services and medical supplies necessarily incurred in connection with your Emergency Medical Evacuation. All transportation arrangements made for your evacuation must be:

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

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

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

Repatriation of Remains

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

EXCLUSIONS

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

Amounts Over the Allowed Amount

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

Assisted Reproduction

Assisted reproduction technologies such as:

- Artificial insemination or assisted reproduction methods, such as in-vitro fertilization. It does not matter why you need the procedure.
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery
- Complications of these services

Benefits from Other Sources

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

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

Benefits That Have Been Exhausted

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

Broken or Missed Appointments

Caffeine Dependence

Charges for Records or Reports

Charges from providers for supplying records or reports not requested for utilization review.

Comfort or Convenience

- Personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport.
- Dietary assistance, including “Meals on Wheels”.
- Charges for provider travel time
- Transporting a member in place of a parent or other family member, or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.
- Arrangements in which the provider lives with the member and provides Cosmetic Services

Complications
This plan does not cover complications of a non-covered service, including follow-up services or effects of those services.

Cosmetic Services
Drugs, services or supplies for cosmetic services not medically necessary.

Counseling, Education And Training

Counseling education or training in the absence of illness including:

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

Court-Ordered Services

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

Custodial Care

This plan does not cover custodial care.

Dental Care

This plan does not cover dental care that is not medically necessary.

Drugs and Food Supplements

This plan does not cover the following:

- Over-the-counter drugs, solutions, supplies, vitamins, food, or nutritional supplements when coverage is not required by law
- Herbal, naturopathic, or homeopathic medicines or devices

EEG Biofeedback or Neurofeedback Services

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental and Investigative Services

Experimental or investigative services or supplies.

Family Members or Volunteers

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

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer

Government Facilities

This plan does not cover services provided by a non-contracted state or federal facility that are not emergency services unless required by law or regulation.

Hair Analysis

Hair Loss

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

Hearing Exams

This plan does not cover routine hearing exams and testing used to prescribe or fit hearing aids and any associated service or supply.

Hearing Hardware

This plan does not cover hearing aids and devices used to improve hearing sharpness and any associated service or supply.

Illegal Acts, Illegal Services, and Terrorism

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

Laser Therapy

Low-level laser therapy.

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

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.

Non-Covered Services

Services or supplies:
- Ordered when this plan is not in effect or when the person is not covered under this plan
- Provided to someone other than the ill or injured member. This includes health care provider training or educational services.
- Directly related to any condition, or related to any other service or supply that is not covered
- You are not required to pay or would not have been charged for if this plan were not in force
- That are not listed as covered under this plan

Non-Treatment Charges

- Charges for provider travel time
- Transporting a member in place of a parent or other family member, or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping, housework or chores for the member or helping do housework or chores.

Non-Treatment Facilities, Institutions or Programs

- Institutional care
- Housing
- Incarceration
- Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered services. Examples are prisons, nursing homes, juvenile detention facilities.

Orthognathic Surgery

Procedures to lengthen or shorten the jaw not required due to temporomandibular joint disorder, injury, sleep apnea or congenital anomaly.

Private Duty Nursing

Benefits are not provided for private duty or 24-hour nursing care.

Provider's Licensing 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.

Recreational, Camp and Activity Programs

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

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

Serious Adverse Events and Never Events

Members and this plan are not responsible for payment of services provided by in-network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally-published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. In-Network providers may not bill members for these services and members are held harmless.
Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.
Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.
Not all medical errors are serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed on the back of this booklet or on the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov.

Services or Supplies For Which You Do Not Legally Have To Pay

Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.

Services or Supplies Not Medically Necessary

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

Sexual Dysfunction

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

Vision Therapy

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

Voluntary Support Groups

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

Weight Loss Surgery or Drugs

This plan does not cover surgery, drugs or supplements for weight loss or weight control.

Work-Related Illness or Injury

This plan does not cover any illness or injury for which you get benefits by law or from separate coverage for illness or injury on the job. For details, see ***Third Party Liability*** under ***Other Coverage***.

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.

COORDINATING BENEFITS WITH OTHER PLANS

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

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

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

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

DEFINITIONS

For the purposes of COB:

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

benefits, while medical benefits are coordinated only with other plans' medical benefits.

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

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

  The exceptions to this rule are when a Medicare, a Medicare Advantage plan, or a Medicare Prescription Drug plan (Part D) is primary to your other coverage. In those cases, the allowable expense set by the Medicare plan will also be the allowable expense amount used by the secondary plan.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the plan year, excluding any temporary visitation.
- **Gatekeeper requirements** Any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. Examples are restrictions of coverage to providers in a network, prior authorization, or primary care provider referrals.

Primary and Secondary Rules

A plan that does not have a COB provision that complies with Washington regulations is primary to a complying plan unless the rules of both plans make the complying plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

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

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

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

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

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

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

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

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

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

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

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

COB's Effect on Benefits

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

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

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

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

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

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

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

Right of Recovery/Facility of Payment If your other plan makes payments that this plan should have made, we have the right, at our reasonable discretion, to remit to the other plan the amount we determine is needed to comply with COB. To the extent of such payments, we are fully discharged from liability under this plan. We also have the right to recover any payment over the maximum amount required under COB. We can recover excess

payment from anyone to whom or for whom the payment was made or from any other issuers or plans.

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

THIRD PARTY LIABILITY (SUBROGATION)

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

Definitions The following terms have specific meanings in this contract:

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

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

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

We have the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy, personal injury protection (PIP) or similar type of insurance or contract.

HOW DO I FILE A CLAIM

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

Step 1

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

Step 2

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

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

Step 3

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

Step 4

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

Step 5

Sign the claim form.

Step 6

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

Prescription Claims

For retail pharmacy purchases, you do not have to send us a claim form. Just show your LifeWise ID card to the pharmacist, who will bill us directly. If you do not show Your LifeWise ID card, you will have to pay the full cost of the prescription. Send your pharmacy receipts attached to a completed Prescription Drug Claim form for reimbursement. 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 or when required by law or regulation. Payment of all claims will be made within the time limits required.

Notice Required for Reimbursement and Payment of Claims

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

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

for the service or supply.

COMPLAINTS AND APPEALS

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

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

What is a Complaint?

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

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

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

What is an Appeal?

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

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

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

What you can appeal

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

Appeal Levels

You have the right to two levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. LifeWise will review your appeal.	180 days from the date you were notified of our decision.
External	If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your	180 days from the date you were notified of our Level 1 appeal decision. OR

	appeal. OR You can ask for an IRO review if LifeWise has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	180 days from the date of the response to your Level 1 appeal, if you did not get a response or it was late.

How to Submit an Appeal in Writing

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

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

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

LifeWise Assurance Company
PO Box 91102
Seattle, WA 91102

Appeal Response Time Limits

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

Type of Appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing
Pre-service appeals (a decision made by us before you received services)	Within 14 days
Appeals of experimental and investigative denials	Within 20 days

All other appeals	14-30 days
External appeals	• Urgent appeals within 72 hours • Other IRO appeals within 15 days after the IRO gets the information or 20 days from the date the IRO gets your request

If we need more time

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

What if you have ongoing care?

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

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

What if it's urgent?

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

Examples of urgent situations are:

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

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

How to ask for an external review

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

Step 1. **Get the form**	**We'll tell you about your right to an external review with the written decision of your internal appeal.** • Complete the Independent Review Organization (IRO) Request form, you can find it on student.lifewiseac.com or call Customer Service to request a copy. You may also write to us directly to ask for an external appeal.
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.
Step 3. **Send in my external review request**	To help process your external review, be sure to complete the form and return with any supporting documents. **Send your documents to:** LifeWise Assurance Company

	PO Box 91102 Seattle, WA 98111-9202 Fax to 866-903-9899

Note: You may also call Customer Service to verbally submit an external review request.

Once the IRO decides

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

If the IRO:

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

If you have questions about understanding a denial of a claim or your appeal rights, you may 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 admitted to the university by the appropriate UW Principal Designated School Official (PDSO) in accordance with applicable United States law;
2. Are temporarily outside your home country or country of regular domicile as a non-resident alien, or a non-domiciled United States citizen with dual citizenship, in the United States;
3. Have a current passport and a current F-1 or J-1 student visa status which allows you to enroll in a course of study (non-domiciled United States citizen – passport only);
4. Meet the criteria established, published, and updated from time to time by the Student and Exchange Visitor Program administered by the Department of 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 one of the University of Washington Seattle, Bothell or Tacoma campuses.

Who's Not Eligible

Some students are not eligible to enroll:

- International students who have been approved for permanent residency in the 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 or physical disability; and, 2) Chiefly dependent upon the insured person for support and maintenance.
- The lawful spouse of the subscriber, unless legally separated. ("Lawful spouse" means a legal union of two persons that was validly formed in any jurisdiction. For purposes of the rights and benefits of this plan, the term "spouse" also means the domestic partner of the subscriber.)
- All rights and benefits afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage"; the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."

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

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

Deadlines for Adding a New Child to Your Coverage

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

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

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

HOW TO ENROLL

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

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

Once you enroll, you must also pay the premium.

Your Enrollment Decisions

- Choose to sign up for a whole academic year (also called the "plan year") or for one quarter.
  - **Whole year (annual) option**—The "annual" option is also offered at the beginning of each subsequent quarter for the rest of the plan year. For example, if you sign up for annual coverage beginning in Winter quarter, you'll be enrolling for the remaining three quarters of that academic year: winter, spring and summer. In all academic terms, annual coverage only runs through August 31, 2023
  - **Quarterly option**—you may enroll on a quarterly basis. You must be registered for school during the quarter in which you enroll. To be covered during a quarter when you will not be registered, sign up and pay for the annual option at the beginning of a quarter when you are registered. If you enroll on a quarterly basis, benefits are paid during that quarter term only. You must renew the plan for coverage to continue in the next quarter.
- If you enroll for annual coverage, you will remain covered during Summer quarter even if you are not registered for classes.
- Choose **who** you want to cover: just you, or you and your eligible family members.
- If you enroll in the plan during pre-registration, the premium will be included on your tuition statement sent after the quarter begins. If you enroll in the plan after the quarter begins, you may not receive an adjusted bill. You will not be enrolled in the plan by just sending in the premium.
- Limited waivers are available from the International Student Services (ISS) office and must be requested no later than the 5th calendar day of the academic term.

Making Changes

If You Withdraw From Classes

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

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

Cancellation

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

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

Adding New Dependents

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

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

Domestic Partners

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

Adding A New Child

A child born to or adopted by you or your spouse or domestic partner while you are enrolled will receive the same benefits as you for the first three weeks after birth or adoption only. If you want continuing coverage for your child after this, you must enroll your child in the timeframes (60 days for a child born to you or your spouse/domestic partner, or 60 days from placement for adopted children) listed in 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	$437
Annual Autumn (4 Qtrs)	$1,748
Annual Winter (3 Qtrs)	$1,311
Annual Spring (2 Qtrs)	$874

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, 2022 and ends on August 31, 2023. The benefits described in this booklet are applicable during this term only.

2022-2023 Dates of Coverage	
Autumn Qtr	September 1, 2022–January 2, 2023
Winter Qtr	January 3, 2023–March 26, 2023
Spring Qtr	March 27, 2023–June 18, 2023
Summer Qtr	June 19, 2023–August 31, 2023

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, 2023.

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.

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

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

There is no extension of coverage beyond the date for which you purchased coverage, unless you continue to qualify as a student, in which case you would need to re-enroll in a timely manner. See 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. You also have the right to ask for any documents, instruments or other information that this contract refers to. If you have any questions about your plan or want to request additional information or forms please call Customer Service or go to student.lifewiseac.com. Information about your plan is provided to you free of charge.

Benefits Not Transferable

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

Conformity with the Law

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

Entire Contract

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

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

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

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

Evidence of Medical Necessity

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

ID Card

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

The University of Washington and You

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

When you get care outside Washington

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

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

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

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

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

To verify that an individual provider, office location or provider group is a preferred provider before obtaining services, please contact us at the number listed on the back cover. You can also locate the nearest provider in the network by visiting our website at student.lifewiseac.com/uw/ship (for Seattle campus) and student.lifewiseac.com/uw/bt (for Bothell and Tacoma campuses).

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.

Newborns and Mothers Health Protection Act

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

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***.

DISCLOSURES REQUIRED BY THE STATE OF WASHINGTON

Misstatement of Age or Sex

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

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

Time Limit on Certain Defenses

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

Incontestable

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

application.

Reinstatement

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

Notice of Claim

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

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

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

Claim Forms

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

Proofs of Loss

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

Time of Payment of Claims

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of

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

Payment of Claims

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

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

Physical Examination and Autopsy

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

Legal Actions

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

Grace Period

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

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

Right to Return This Contract within Ten Days

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

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

DEFINITIONS

The information here will help you understand what these words mean. We have the responsibility and authority to use our expertise and judgment to reasonably construe the terms of this contract as they apply to specific eligibility and claims determinations. For example, we use the medical judgment and expertise of Medical Directors to determine whether claims for benefits meet the definitions below of "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

Your Provider Network is: LifeWise Assurance Co.

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

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

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.

Clinical Trials

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

- An institutional review board that complies with federal standards for protecting human research subjects and
- One or more of the following:

- The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
- The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
- The United States Department of Defense
- The United States Department of Veterans' Affairs
- A nongovernmental research entity abiding by current National Institute of Health guidelines

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.

Comprehensive Oral Evaluation

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

Congenital Anomaly

A 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.

Dental Emergency

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

Dentally Necessary and Dental Necessity

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

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

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. and A.R.N.P.) 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 member, in serious jeopardy
- Result in serious impairment to bodily functions
- With respect to a pregnant member 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 member or the unborn child

Emergency Services

- A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary services given in an emergency department. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health.

- Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical, mental health, or substance use disorder treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant member in active labor, to perform the delivery.
- Ambulance transport, as needed, in support of the services above.

Endorsement

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

Essential Health Benefits

Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency 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/Investigative 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.

Full Premium

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

Health Care Benefit Managers

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

Home 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.

Limited Oral Evaluation – Problem Focused

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

Long-term Care Facility

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

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.

Non-Participating Provider

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

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. 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 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.

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.

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (ex. home) with a provider that is diagnostic and treatment focused. The member is not located at a healthcare site.

Visual Oral Screenings or Assessments

Performed by a licensed dentist or dental hygienist under the supervision of a licensed dentist to determine the need for sealants, fluoride treatment, and/or when triage services are provided in settings other than dental offices or dental clinics.

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
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

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

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

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

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

Local and toll-free TTY number
for the deaf and hard-of-hearing:
711f

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

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 for information and secure online access to claims information

App-based Care

Website: https://student.lifewiseac.com/uw/ship/find-a-doctor.aspx