



“GAIP” GRADUATE APPOINTEE INSURANCE PROGRAM



INTRODUCTION

Welcome

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

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

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

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

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

On our website at student.lifewiseac.com/uw/gaip you can also:

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

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

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

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

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

Medical and payment policies we use in administration of this plan are available at student.lifewiseac.com/uw/gaip.

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

Translation Services

If you need an interpreter to help with 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: October 1, 2018

Group Number: 9000032

Plan: LifeWise GAIP PPO + Vision/Dental

Certificate Form Number: GAIP UW C (10-2018)

Discrimination is Against the Law

Connexion complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Connexion does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Connexion:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Connexion has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, 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 800-842-5357
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>.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Connexion. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-228-5798 (TTY: 800-842-5357).

አማርኛ (Amharic):

ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Connexion ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀናት ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። በስልክ ቁጥር 800-228-5798 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):

يحتوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Connexion. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ 800-228-5798 (TTY: 800-842-5357)

中文 (Chinese):

本通知有重要的訊息。本通知可能有關於您透過 Connexion 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-228-5798 (TTY: 800-842-5357)。

Oromoo (Cushite):**Beeksisni kun odeeffannoo barbaachisaa qaba.**

Beeksisti kun sagantaa yookan karaa Connexion tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-228-5798 (TTY: 800-842-5357) tii bilbilaa.

Français (French):

Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Connexion. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-228-5798 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):

Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Connexion. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resewva enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-228-5798 (TTY: 800-842-5357).

Deutsche (German):

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Connexion. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-228-5798 (TTY: 800-842-5357).

Hmoob (Hmong): Tsab ntawv tshaj xo no muaj cov

ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Connexion. Tej zaum muaj cov hnuv tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caj nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-228-5798 (TTY: 800-842-5357).

Iloko (Ilocano): Daytoy a Pakdaar ket naglaon iti

Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyon wenno coverage babaen iti Connexion. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyó wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-228-5798 (TTY: 800-842-5357).

Italiano (Italian): Questo avviso contiene

informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Connexion. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-228-5798 (TTY: 800-842-5357).

日本語 (Japanese): この通知には重要な情報が含まれています。 この通知には、Connexionの申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-228-5798 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Connexion 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하의 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하의 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-228-5798 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):

ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Connexion. ອາດຈະມີວັນທີສໍາຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈໍາເປັນຕ້ອງດໍາເນີນການຕາມກໍານົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສະຖາບັນ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-228-5798 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីប្រព័ន្ធបែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Connexion ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាក្រូការបញ្ជូនសមត្ថភាព ដល់កំណត់ថ្លៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ នឹងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-228-5798 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):

ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Connexion ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਟਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-228-5798 (TTY: 800-842-5357).

فارسی (Farsi):

این اعلامیه حاوی اطلاعات مهم میباشد. این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Connexion باشد. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-228-5798 (کاربران TTY تماس با شماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):

To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Connexion. Prosimy zwrócić uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-228-5798 (TTY: 800-842-5357).

Português (Portuguese):

Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Connexion. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-228-5798 (TTY: 800-842-5357).

Română (Romanian):**Prezenta notificare conține informații importante.**

Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin Connexion. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-228-5798 (TTY: 800-842-5357).

Русский (Russian):**Настоящее уведомление содержит важную информацию.**

Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Connexion. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуются принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-228-5798 (TTY: 800-842-5357).

Fa'asamoa (Samoan):

Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Connexion, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-228-5798 (TTY: 800-842-5357).

Español (Spanish):

Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Connexion. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-228-5798 (TTY: 800-842-5357).

Tagalog (Tagalog):**Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon.**

Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Connexion. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-228-5798 (TTY: 800-842-5357).

ไทย (Thai):

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอเขตประกันสุขภาพของคุณผ่าน Connexion และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-228-5798 (TTY: 800-842-5357)

Український (Ukrainian):

Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Connexion. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-228-5798 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Connexion. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-228-5798 (TTY: 800-842-5357).

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
- **Case Management** – Describes our case management provision
- **Disease Management** – Describes our disease management provision
- **Continuity of Care** – Describes how to continue care at the in-network level of benefits when a provider is no longer in the network
- **Covered Services** –A detailed description of what is covered
- **Exclusions** – Describes services that are not covered
- **Other Coverage** – Describes how benefits are paid when you have other coverage or what you must do when a third party is responsible for an injury or illness
- **Sending us a Claim** –Instructions on how to send in a claim
- **Complaints and Appeals** – What to do if you want to file a complaint or submit an appeal
- **Eligibility and Enrollment** – Describes who can be covered.
- **Termination of Coverage** – Describes when coverage ends
- **COBRA** – Describes how you can continue coverage after your group plan 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

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SUMMARY OF YOUR COSTS

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.
- The deductible. The costs shown below are what you pay after the deductible is met. Sometimes the deductible is waived. This is also shown below. When services are subject to in-network benefit level or cost shares, the in-network deductible applies.
- The coinsurance. The percentage of the covered service that you are responsible to pay when you receive covered services.

| | Hall Health Providers | In-Network Providers | Out-of-Network Providers |
|------------------------------------|---|----------------------|--------------------------|
| Hall Health Maximum Benefit | First \$1,000 per academic student employee per plan year are covered in full (deductible & coinsurance are waived) | Not Applicable | |
| Individual Deductible | \$75 per quarter/ \$300 per plan year | | |

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

| | Hall Health and other In-Network Providers | Out-of-Network Providers |
|---|--|--------------------------|
| Individual Out-of-Pocket Maximum | \$1,200 | Unlimited |
| Family Out-of-Pocket Maximum | \$2,400 | Unlimited |

- 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.

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

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** benefit.

FOR ACADEMIC STUDENT EMPLOYEES

| Note: Not all services are provided at Hall Health. | YOUR COSTS OF THE ALLOWED AMOUNT | | |
|--|---|-------------------------|---------------------------------|
| | HALL HEALTH/ RUBENSTEIN PHARMACY | IN-NETWORK PROVIDERS | OUT-OF- NETWORK PROVIDERS |
| Office and Clinic Visits This benefit includes consultations with a pharmacist. You may have additional costs for other services such as x-rays, lab, therapeutic injections and hospital facility charges. See those covered services for | After \$1,000 Hall Health Maximum Benefit, benefits then: | | |

| | | | |
|---|--|--|--|
| <p>details. See Preventive Care for preventive services.</p> <ul style="list-style-type: none"> Office visits (including telehealth virtual care services) Office visit for women's health Non-hospital urgent care centers All other office and clinic visits (including non-preventive nutritional therapy) | <p>Deductible, then 0% coinsurance</p> <p>Deductible, then 0% coinsurance Not available</p> <p>Deductible, then 0% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Preventive Care Benefits for preventive care that meet the federal guidelines are not subject to cost sharing when care is provided by Hall Health or an in-network provider.</p> <ul style="list-style-type: none"> Exams, screenings and immunizations (including seasonal immunizations in a provider's office) are limited in how often you can get them based on your age and gender Seasonal and travel immunizations (pharmacy, mass immunizer, travel clinic and county health department) Health education, preventive nutritional therapy for diseases such as diabetes, and nicotine dependency treatment | <p>After \$1,000 Hall Health Maximum Benefit, benefits then:</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> | <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Contraception Management and Sterilization</p> | <p>After \$1,000 Hall Health Maximum Benefit, benefits then: 0% coinsurance, deductible waived</p> | <p>0% coinsurance, deductible waived</p> | <p>Deductible, then 40% coinsurance</p> |
| <p>Diagnostic X-ray, Lab and Imaging</p> <ul style="list-style-type: none"> Preventive care screening and tests Lab Work Basic diagnostic x-ray and imaging (When treatment is referred by Hall Health to a non-Hall Health provider, the network or non-network benefits will apply depending on the provider you see. This includes x-rays sent to a non-Hall Health radiologist for review.) | <p>After \$1,000 Hall Health Maximum Benefit, benefits then:</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived for covered lab charges incurred at or referred from Hall Health</p> <p>Deductible, then 0% coinsurance</p> | <p>0% coinsurance, deductible waived</p> <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |

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| <ul style="list-style-type: none"> Major diagnostic x-ray and imaging (When treatment is referred by Hall Health to a non-Hall Health provider, the network or non-network benefits will apply depending on the provider you see. This includes x-rays sent to a non-Hall Health radiologist for review.) | Deductible, then 0% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| <p>Pediatric Vision Services Limited to members under age 19</p> <ul style="list-style-type: none"> Routine exams limited to one per plan year One pair glasses per plan year, frames and lenses One pair of contacts per plan year in lieu of glasses, or a year supply of disposable contacts. Contact lenses required for medical reasons One comprehensive low vision evaluation and four follow up visits in a five plan year period Low vision devices, high powered spectacles, medical vision hardware, magnifiers and telescopes when medically necessary | <p>Not available</p> <p>Not available</p> <p>Not available</p> <p>Not available</p> <p>Not available</p> <p>Not available</p> | <p>10% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> | <p>25% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> |
| <p>Pediatric Dental Services Limited to members under age 19. \$25 individual/ \$75 family deductible per plan year (deductible shared with Dental for Adults).</p> <ul style="list-style-type: none"> Class I Services Class II Services Class III Services Medically Necessary Orthodontia | <p>Not available</p> <p>Not available</p> <p>Not available</p> <p>Not available</p> | <p>0% coinsurance, deductible waived</p> <p>Deductible, then 20% coinsurance</p> <p>Deductible, then 50% coinsurance</p> <p>Deductible, then 50% coinsurance</p> | <p>0% coinsurance, deductible waived</p> <p>Deductible, then 20% coinsurance</p> <p>Deductible, then 50% coinsurance</p> <p>Deductible, then 50% coinsurance</p> |
| <p>Prescription Drugs– Retail Pharmacy Up to a 35-day supply (certain maintenance drugs up to 90-day supply through Rubenstein). The deductible is waived.</p> <ul style="list-style-type: none"> Preventive drugs Formulary generic drugs | <p>Rubenstein Pharmacy</p> <p>0% coinsurance, deductible waived</p> <p>\$10 copay, deductible waived. Maintenance Drugs \$10 copay, deductible waived + shipping & handling</p> | <p>UMC/UWP and all In-Network Pharmacies</p> <p>0% coinsurance, deductible waived</p> <p>20% coinsurance, deductible waived</p> | <p>Other Pharmacies</p> <p>40% coinsurance, deductible waived</p> |

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| <ul style="list-style-type: none"> Formulary brand-name drugs Non-formulary drugs | <p>\$25 copay, deductible waived. Maintenance Drugs \$40 copay, deductible waived + shipping & handling</p> <p>\$35 copay, deductible waived. Maintenance Drugs \$80 copay, deductible waived + shipping & handling</p> | <p>20% coinsurance, deductible waived</p> <p>40% coinsurance, deductible waived</p> | |
| <ul style="list-style-type: none"> Oral chemotherapy drugs | 0% coinsurance, deductible waived | 10% coinsurance, deductible waived | |
| <p>Surgery Services</p> <ul style="list-style-type: none"> Inpatient hospital and professional services Outpatient hospital, ambulatory surgical center, including professional services | <p>Not available</p> <p>After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 0% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Emergency Room In and out-of-network emergency room services covered at the same cost shares</p> <ul style="list-style-type: none"> Facility fees. Professional, diagnostic services, other services and supplies | <p>Not available</p> <p>Not available</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> |
| Emergency Ambulance Services | Not available | Deductible, then 10% coinsurance | Deductible, then 10% coinsurance |
| Urgent Care Centers | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| <p>Hospital Services</p> <ul style="list-style-type: none"> Inpatient Care Outpatient Care | <p>Not available</p> <p>After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 0% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Mental Health (Includes therapies provided for mental health conditions such as autism)</p> <ul style="list-style-type: none"> Outpatient (there are no fees at the Counseling Center for registered students) Inpatient and residential | <p>After \$1,000 Hall Health Maximum Benefit, benefits then: 0% coinsurance, deductible waived</p> <p>Not Available</p> | <p>10% coinsurance, deductible waived</p> <p>10% coinsurance, deductible waived</p> | <p>40% coinsurance, deductible waived</p> <p>40% coinsurance, deductible waived</p> |

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|--|--|---|---|
| <p>Chemical Dependency</p> <ul style="list-style-type: none"> • Outpatient | <p>After \$1,000 Hall Health Maximum Benefit, benefits then 0% coinsurance, deductible waived</p> | <p>Deductible, then 0% coinsurance</p> | <p>Deductible, then 0% coinsurance</p> |
| <ul style="list-style-type: none"> • Inpatient and residential | <p>Not Available</p> | <p>Deductible, then 0% coinsurance</p> | <p>Deductible, then 0% coinsurance</p> |
| <p>Maternity and Newborn Care Prenatal, postnatal, delivery, inpatient care and termination of pregnancy. See also Diagnostic X-ray, Lab and Imaging. For specialty care see also Office and Clinic Visits.</p> <ul style="list-style-type: none"> • Inpatient Hospital and professional services • Birthing center or short-stay facility • Diagnostic tests during pregnancy • Outpatient Professional • Midwife | <p>Not available</p> <p>Not available</p> <p>After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 10% coinsurance</p> <p>After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 10% coinsurance</p> <p>Not available</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 20% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 20% coinsurance</p> |
| <p>Home Health Care Limited to 130 visits per plan year</p> | <p>Not available</p> | <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> |
| <p>Hospice Care</p> <ul style="list-style-type: none"> • Home visits • Respite care, inpatient or outpatient | <p>Not available</p> <p>Not available</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Habilitation Therapy (Neurodevelopmental) Neuropsychological testing to diagnose is not subject to any maximum. Please see <i>Mental Health</i> for therapies provided for mental health conditions such as autism.</p> <ul style="list-style-type: none"> • Inpatient (limited to 30 days per plan year) • Outpatient. Medical necessity will be reviewed after 12 visits combined in-network and out-of-network. | <p>Not available</p> <p>After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 10% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |

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| Rehabilitation Therapy Please see <i>Mental Health</i> for therapies provided for mental health conditions such as autism. <ul style="list-style-type: none"> Inpatient (limited to 30 days per plan year) | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| <ul style="list-style-type: none"> Outpatient. Medical necessity will be reviewed after 12 visits combined in-network and out-of-network. | After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 10% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Skilled Nursing Facility and Care <ul style="list-style-type: none"> Skilled nursing facility care limited to 90 days per plan year Skilled nursing care in the long-term care facility care limited to 90 days per plan year | Not available Not available | \$300 copay, deductible then 10% coinsurance \$300 copay, deductible then 10% coinsurance | \$300 copay, deductible then 40% coinsurance \$300 copay, deductible then 40% coinsurance |
| Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics Shoe inserts and orthopedic shoes not covered, except when diabetes-related. Sales tax, shipping and handling costs apply to any limit if billed and paid separately. | Not available | Deductible, then 10% coinsurance | Deductible, then 10% coinsurance |
| Acupuncture, Massage Therapy, Naturopathic Visits and Spinal Manipulation | After \$1,000 Hall Health Maximum Benefit, benefits then: Deductible, then 25% coinsurance | Deductible, then 25% coinsurance | Deductible, then 50% coinsurance |
| Allergy Testing and Treatment | After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 0% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Chemotherapy, Radiation Therapy and Kidney Dialysis | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Clinical Trials | Not available | Covered as any other service | Covered as any other service |
| Dental Injuries | Not available | 0% coinsurance, deductible waived | 0% coinsurance, deductible waived |
| Dental Anesthesia When medically necessary | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Foot Care Routine care that is medically necessary | After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 0% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Hearing Care Non-preventive, medically necessary hearing care supplies and procedures | After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 25% coinsurance | Deductible, then 25% coinsurance | Deductible, then 25% coinsurance |

| | | | |
|--|---|----------------------------------|----------------------------------|
| Infusion Therapy | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Mastectomy and Breast Reconstruction | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Medical Foods | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Temporomandibular Joint (TMJ) Disorders | After \$1,000 Hall Health Maximum Benefit, benefits then: | | |
| • Office visits | Deductible, then 0% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| • Inpatient facility fees | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| • Other professional services | Deductible, then 0% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Therapeutic Injections | After \$1,000 Hall Health Maximum Benefit, benefits then: deductible, then 0% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Transgender Surgery | After \$1,000 Hall Health Maximum Benefit, benefits then: | | |
| • Office visits | Deductible, then 10% coinsurance, | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| • Inpatient facility fees | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| • Other professional services | Deductible, then 10% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Transplants All approved transplant centers covered at in-network benefit level. | After \$1,000 Hall Health Maximum Benefit, benefits then: | | |
| • Office visits | Deductible, then 0% coinsurance, | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| • Inpatient facility fees | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| • Other professional services | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| • Travel and lodging (as permitted under current IRS guidelines) | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Abortion | Not available | Deductible, then 10% coinsurance | Deductible, then 20% coinsurance |

Vision for Adults

The services below do not apply toward the out-of-pocket maximum. Sales tax, shipping and handling costs apply to limits shown below. You can receive services from any licensed vision care provider. The plan does not cover facility fees (if any) charged by some providers (such as hospitals). If facility fees are a standalone fee these charges will not be covered by the plan. For medically necessary contacts and glasses for adults see *Medical Vision Hardware*. For vision exams and hardware for a child under age 19 see *Pediatric Vision Services*.

| | | | | | | | |
|--|--|--|-----------------------------------|---|---|---|-----------------------------------|
| <ul style="list-style-type: none"> • Deductible • Exam • Frames • Basic Lenses <ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal • Lenticular • Contacts (instead of lenses and frames, lenses not covered for 12 months and frames for 24 months after purchase) • Medically Necessary Contacts and Glasses | <p>\$10 for exam \$25 for frames/lenses combined \$25 for contacts</p> <p>Plan pays 100% after deductible once every 12 months up to \$60</p> <p>Plan pays 100% after deductible once every 24 months up to \$70</p> <p>Plan pays 100% after deductible once every 12 months up to:</p> <p>\$50 per pair \$70 per pair \$90 per pair \$135 per pair</p> <p>Plan pays 100% after deductible once every 12 months up to \$105/pair</p> <p>Plan pays 100% after deductible once every 12 months</p> | | | | | | |
| <p>Dental for Adults Maximum of \$1,500 per plan year. \$25 individual/ \$75 family deductible per plan year (deductible shared with Pediatric Dental). Under this plan you have the option of seeking care from any licensed dentist. The services below do not apply toward the overall deductible and out-of-pocket maximum amounts shown above. For dental care for a child under age 19 see <i>Pediatric Dental Services</i>.</p> <table border="1" data-bbox="131 827 1523 1136"> <tr> <td data-bbox="131 827 667 953"> <ul style="list-style-type: none"> • Preventive and Diagnostic Services (includes routine exams, cleanings and x-rays). See the <i>Dental for Adults</i> for more detail. </td> <td data-bbox="667 827 1523 953">0% coinsurance, deductible waived</td> </tr> <tr> <td data-bbox="131 953 667 1041"> <ul style="list-style-type: none"> • Minor Services (restorative, oral surgery, periodontics and endodontics such as fillings and extractions) </td> <td data-bbox="667 953 1523 1041">Deductible, then 20% coinsurance</td> </tr> <tr> <td data-bbox="131 1041 667 1136"> <ul style="list-style-type: none"> • Major Services (major restorative and prosthodontics such as crowns and dentures) </td> <td data-bbox="667 1041 1523 1136">Deductible, then 50% coinsurance</td> </tr> </table> | | <ul style="list-style-type: none"> • Preventive and Diagnostic Services (includes routine exams, cleanings and x-rays). See the <i>Dental for Adults</i> for more detail. | 0% coinsurance, deductible waived | <ul style="list-style-type: none"> • Minor Services (restorative, oral surgery, periodontics and endodontics such as fillings and extractions) | Deductible, then 20% coinsurance | <ul style="list-style-type: none"> • Major Services (major restorative and prosthodontics such as crowns and dentures) | Deductible, then 50% coinsurance |
| <ul style="list-style-type: none"> • Preventive and Diagnostic Services (includes routine exams, cleanings and x-rays). See the <i>Dental for Adults</i> for more detail. | 0% coinsurance, deductible waived | | | | | | |
| <ul style="list-style-type: none"> • Minor Services (restorative, oral surgery, periodontics and endodontics such as fillings and extractions) | Deductible, then 20% coinsurance | | | | | | |
| <ul style="list-style-type: none"> • Major Services (major restorative and prosthodontics such as crowns and dentures) | Deductible, then 50% coinsurance | | | | | | |
| <p>Emergency Medical Evacuation and Repatriation of Remains Services do not apply toward the out-of-pocket maximum shown above.</p> <table border="1" data-bbox="131 1213 1523 1365"> <tr> <td data-bbox="131 1213 667 1297"> <ul style="list-style-type: none"> • Emergency Medical Evacuation (\$50,000 per evacuation maximum) </td> <td data-bbox="667 1213 967 1297">Not available</td> <td data-bbox="967 1213 1523 1297">0% coinsurance, deductible waived</td> </tr> <tr> <td data-bbox="131 1297 667 1365"> <ul style="list-style-type: none"> • Repatriation of Remains (\$25,000 maximum). </td> <td data-bbox="667 1297 967 1365">Not available</td> <td data-bbox="967 1297 1523 1365">0% coinsurance, deductible waived</td> </tr> </table> | | <ul style="list-style-type: none"> • Emergency Medical Evacuation (\$50,000 per evacuation maximum) | Not available | 0% coinsurance, deductible waived | <ul style="list-style-type: none"> • Repatriation of Remains (\$25,000 maximum). | Not available | 0% coinsurance, deductible waived |
| <ul style="list-style-type: none"> • Emergency Medical Evacuation (\$50,000 per evacuation maximum) | Not available | 0% coinsurance, deductible waived | | | | | |
| <ul style="list-style-type: none"> • Repatriation of Remains (\$25,000 maximum). | Not available | 0% coinsurance, deductible waived | | | | | |

| FOR DEPENDENTS | | | |
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| Note: Not all services are provided at Hall Health. | YOUR COSTS OF THE ALLOWED AMOUNT | | |
| | HALL HEALTH/ RUBENSTEIN PHARMACY | IN-NETWORK PROVIDERS | OUT-OF- NETWORK PROVIDERS |
| <p>Office and Clinic Visits This benefit includes consultations with a pharmacist. 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.</p> | | | |

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| <ul style="list-style-type: none"> Office visits (including telehealth virtual care services) Office visit for women's health Non-hospital urgent care centers All other office and clinic visits (including non-preventive nutritional therapy) | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance Not available</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Preventive Care</p> <p>Benefits for preventive care that meet the federal guidelines are not subject to cost sharing when care is provided by Hall Health or an in-network provider.</p> <ul style="list-style-type: none"> Exams, screenings and immunizations (including seasonal immunizations in a provider's office) are limited in how often you can get them based on your age and gender Seasonal and travel immunizations (pharmacy, mass immunizer, travel clinic and county health department) Health education, preventive nutritional therapy for diseases such as diabetes, and nicotine dependency treatment | <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> | <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Contraception Management and Sterilization</p> | <p>0% coinsurance, deductible waived</p> | <p>0% coinsurance, deductible waived</p> | <p>Deductible, then 40% coinsurance</p> |
| <p>Diagnostic X-ray, Lab and Imaging</p> <ul style="list-style-type: none"> Preventive care screening and tests Lab Work Basic diagnostic x-ray and imaging Major diagnostic x-ray and imaging | <p>0% coinsurance, deductible waived</p> <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>0% coinsurance, deductible waived</p> <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Pediatric Vision Services</p> <p>Limited to members under age 19</p> <ul style="list-style-type: none"> Routine exams limited to one per plan year One pair glasses per plan year, frames and lenses One pair of contacts per plan year in lieu of glasses, or a year supply of disposable contacts. Contact lenses required for medical reasons One comprehensive low vision evaluation and four follow up visits in a five plan year period | <p>Not available</p> <p>Not available</p> <p>Not available</p> <p>Not available</p> <p>Not available</p> | <p>10% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> | <p>25% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> <p>0% coinsurance, deductible waived</p> |

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| <ul style="list-style-type: none"> Low vision devices, high powered spectacles, medical vision hardware, magnifiers and telescopes when medically necessary | Not available | 0% coinsurance, deductible waived | 0% coinsurance, deductible waived |
| <p>Pediatric Dental Services Limited to members under age 19. \$25 individual/ \$75 family deductible per plan year (deductible shared with Dental for Adults).</p> <ul style="list-style-type: none"> Class I Services Class II Services Class III Services Medically Necessary Orthodontia | <p>Not available</p> <p>Not available</p> <p>Not available</p> <p>Not available</p> | <p>0% coinsurance, deductible waived</p> <p>Deductible, then 20% coinsurance</p> <p>Deductible, then 50% coinsurance</p> <p>Deductible, then 50% coinsurance</p> | <p>0% coinsurance, deductible waived</p> <p>Deductible, then 20% coinsurance</p> <p>Deductible, then 50% coinsurance</p> <p>Deductible, then 50% coinsurance</p> |
| <p>Prescription Drugs– Retail Pharmacy Up to a 35-day supply (certain maintenance drugs up to 90-day supply through Rubenstein). The quarterly deductible is waived.</p> <ul style="list-style-type: none"> Preventive drugs | <p>Rubenstein Pharmacy</p> <p>0% coinsurance, deductible waived</p> | <p>UMC/UWP and all In-Network Pharmacies</p> <p>0% coinsurance, deductible waived</p> | <p>Other Pharmacies</p> |
| <ul style="list-style-type: none"> Formulary generic drugs | \$10 copay, deductible waived. Maintenance Drugs \$10 copay, deductible waived + shipping & handling | 20% coinsurance | 40% coinsurance, deductible waived |
| <ul style="list-style-type: none"> Formulary brand-name drugs | \$25 copay, deductible waived. Maintenance Drugs \$40 copay, deductible waived + shipping & handling | 20% coinsurance, deductible waived | |
| <ul style="list-style-type: none"> Non-formulary drugs | \$35 copay, deductible waived. Maintenance Drugs \$80 copay, deductible waived + shipping & handling | 40% coinsurance, deductible waived | |
| <ul style="list-style-type: none"> Oral chemotherapy drugs | 0% coinsurance, deductible waived | 10% coinsurance, deductible waived | |
| <p>Surgery Services</p> <ul style="list-style-type: none"> Inpatient hospital and professional services Outpatient hospital, ambulatory surgical center, including professional services | <p>Not available</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |

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| Emergency Room In and out-of-network emergency room services covered at the same cost shares <ul style="list-style-type: none"> • Facility fees. | Not available | Deductible, then 10% coinsurance | Deductible, then 10% coinsurance |
| <ul style="list-style-type: none"> • Professional, diagnostic services, other services and supplies | Not available | Deductible, then 10% coinsurance | Deductible, then 10% coinsurance |
| Emergency Ambulance Services | Not available | Deductible, then 10% coinsurance | Deductible, then 10% coinsurance |
| Urgent Care Centers | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Hospital Services <ul style="list-style-type: none"> • Inpatient Care | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| <ul style="list-style-type: none"> • Outpatient Care | Deductible, then 10% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Mental Health (Includes therapies provided for mental health conditions such as autism) <ul style="list-style-type: none"> • Outpatient • Inpatient and residential | 10% coinsurance, deductible waived Not Available | 10% coinsurance, deductible waived 10% coinsurance, deductible waived | 40% coinsurance, deductible waived 40% coinsurance, deductible waived |
| Chemical Dependency <ul style="list-style-type: none"> • Outpatient • Inpatient and residential | Deductible, then 0% coinsurance Not Available | Deductible, then 0% coinsurance Deductible, then 0% coinsurance | Deductible, then 0% coinsurance Deductible, then 0% coinsurance |
| Maternity and Newborn Care Prenatal, postnatal, delivery, inpatient care and termination of pregnancy. See also Diagnostic X-ray, Lab and Imaging. For specialty care see also Office and Clinic Visits. <ul style="list-style-type: none"> • Inpatient Hospital and professional services • Birthing center or short-stay facility • Diagnostic tests during pregnancy • Outpatient Professional • Midwife | Not available Not available Deductible, then 10% coinsurance Deductible, then 10% coinsurance Not available | Deductible, then 10% coinsurance Deductible, then 10% coinsurance Deductible, then 10% coinsurance Deductible, then 10% coinsurance Deductible, then 20% coinsurance | Deductible, then 40% coinsurance Deductible, then 40% coinsurance Deductible, then 40% coinsurance Deductible, then 40% coinsurance Deductible, then 20% coinsurance |
| Home Health Care Limited to 130 visits per plan year | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |

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| <p>Hospice Care</p> <ul style="list-style-type: none"> • Home visits • Respite care, inpatient or outpatient | <p>Not available</p> <p>Not available</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Habilitation Therapy (Neurodevelopmental) Neuropsychological testing to diagnose is not subject to any maximum. Please see <i>Mental Health</i> for therapies provided for mental health conditions such as autism.</p> <ul style="list-style-type: none"> • Inpatient (limited to 30 days per plan year) • Outpatient. Medical necessity will be reviewed after 12 visits combined in-network and out-of-network. | <p>Not available</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Rehabilitation Therapy Please see <i>Mental Health</i> for therapies provided for mental health conditions such as autism.</p> <ul style="list-style-type: none"> • Inpatient (limited to 30 days per plan year) • Outpatient. Medical necessity will be reviewed after 12 visits combined in-network and out-of-network. | <p>Not available</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 40% coinsurance</p> |
| <p>Skilled Nursing Facility and Care</p> <ul style="list-style-type: none"> • Skilled nursing facility care limited to 90 days per plan year • Skilled nursing care in the long-term care facility care limited to 90 days per plan year | <p>Not available</p> <p>Not available</p> | <p>\$300 copay, deductible then 10% coinsurance</p> <p>\$300 copay, deductible then 10% coinsurance</p> | <p>\$300 copay, deductible then 40% coinsurance</p> <p>\$300 copay, deductible then 40% coinsurance</p> |
| <p>Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics Shoe inserts and orthopedic shoes not covered, except when diabetes-related. Sales tax, shipping and handling costs apply to any limit if billed and paid separately.</p> | <p>Not available</p> | <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> |
| <p>Acupuncture, Massage Therapy, Naturopathic Visits and Spinal Manipulation</p> | <p>Deductible, then 25% coinsurance</p> | <p>Deductible, then 25% coinsurance</p> | <p>Deductible, then 50% coinsurance</p> |
| <p>Allergy Testing and Treatment</p> | <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> |
| <p>Chemotherapy, Radiation Therapy and Kidney Dialysis</p> | <p>Not available</p> | <p>Deductible, then 10% coinsurance</p> | <p>Deductible, then 40% coinsurance</p> |
| <p>Clinical Trials</p> | <p>Not available</p> | <p>Covered as any other service</p> | <p>Covered as any other service</p> |
| <p>Dental Injuries</p> | <p>Not available</p> | <p>0% coinsurance, deductible waived</p> | <p>0% coinsurance, deductible waived</p> |

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| Dental Anesthesia When medically necessary | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Foot Care Routine care that is medically necessary | Deductible, then 10% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Hearing Care Non-preventive, medically necessary hearing care supplies and procedures | Deductible, then 25% coinsurance | Deductible, then 25% coinsurance | Deductible, then 25% coinsurance |
| Infusion Therapy | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Mastectomy and Breast Reconstruction | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Medical Foods | Not available | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Temporomandibular Joint (TMJ) Disorders <ul style="list-style-type: none"> • Office visits • Inpatient facility fees • Other professional services | Deductible, then 10% coinsurance Not available Deductible, then 10% coinsurance | Deductible, then 10% coinsurance Deductible, then 10% coinsurance Deductible, then 10% coinsurance | Deductible, then 40% coinsurance Deductible, then 40% coinsurance Deductible, then 40% coinsurance |
| Therapeutic Injections | Deductible, then 10% coinsurance | Deductible, then 10% coinsurance | Deductible, then 40% coinsurance |
| Transgender Surgery <ul style="list-style-type: none"> • Office visits • Inpatient facility fees • Other professional services | Deductible, then 10% coinsurance Not available Deductible, then 10% coinsurance | Deductible, then 10% coinsurance Deductible, then 10% coinsurance Deductible, then 10% coinsurance | Deductible, then 40% coinsurance Deductible, then 40% coinsurance Deductible, then 40% coinsurance |
| Transplants All approved transplant centers covered at in-network benefit level. <ul style="list-style-type: none"> • Office visits • Inpatient facility fees • Other professional services • Travel and lodging (as permitted under current IRS guidelines) | Deductible, then 10% coinsurance Not available Not available Not available | Deductible, then 10% coinsurance Deductible, then 10% coinsurance Deductible, then 10% coinsurance Deductible, then 10% coinsurance | Deductible, then 40% coinsurance Deductible, then 40% coinsurance Deductible, then 40% coinsurance Deductible, then 40% coinsurance |
| Abortion | Not available | Deductible, then 10% coinsurance | Deductible, then 20% coinsurance |

Vision for Adults

The services below do not apply toward the out-of-pocket maximum. Sales tax, shipping and handling costs apply to limits shown below. You can receive services from any licensed vision care provider. The plan does not cover facility fees (if any) charged by some providers (such as hospitals). If facility fees are a standalone fee these charges will not be covered by the plan. For medically necessary vision hardware for adults see *Medical Vision Hardware*. For vision exams and hardware for a child under age 19 see *Pediatric Vision Services*.

| | |
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| • Deductible | \$10 for exam \$25 for frames/lenses combined \$25 for contacts |
| • Exam | Plan pays 100% after deductible once every 12 months up to \$60 |
| • Frames | Plan pays 100% after deductible once every 24 months up to \$70 |
| • Basic Lenses | Plan pays 100% after deductible once every 12 months up to: |
| • Single Vision | \$50 per pair |
| • Bifocal | \$70 per pair |
| • Trifocal | \$90 per pair |
| • Lenticular | \$135 per pair |
| • Contacts (instead of lenses and frames, lenses not covered for 12 months and frames for 24 months after purchase) | Plan pays 100% after deductible once every 12 months up to \$105/pair |
| • Medically Necessary Contacts | Plan pays 100% after deductible once every 12 months |

Dental for Adults Maximum of \$1,500 per plan year. \$25 individual/ \$75 family deductible per plan year (deductible shared with Pediatric Dental). Under this plan you have the option of seeking care from any licensed dentist. 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 and Diagnostic Services (includes routine exams, cleanings and x-rays). See the <i>Dental for Adults</i> for more detail. | 0% coinsurance, deductible waived |
| • Minor Services (restorative, oral surgery, periodontics and endodontics such as fillings and extractions) | Deductible, then 20% coinsurance |
| • Major Services (major restorative and prosthodontics such as crowns and dentures) | Deductible, then 50% coinsurance |

Emergency Medical Evacuation and Repatriation of Remains

Services do not apply toward the out-of-pocket maximum shown above.

| | | |
|--|---------------|-----------------------------------|
| • Emergency Medical Evacuation (\$50,000 per evacuation maximum) | Not available | 0% coinsurance, deductible waived |
| • Repatriation of Remains (\$25,000 maximum). | Not available | 0% coinsurance, deductible waived |

IMPORTANT PLAN INFORMATION

This plan is a Preferred Provider Plan (PPO). Your plan provides you benefits for covered services from providers within the LifeWise network without referrals. You have access to one of the many providers included in your network of providers for covered services included in your plan. Please see **How Providers Affect Your Costs** for more information. You also have access to facilities, emergency rooms, surgical centers, equipment vendors providing covered services throughout the United States and wherever you may travel.

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** benefit.

PLAN YEAR DEDUCTIBLE

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

Individual Deductible

This plan includes a combined individual deductible when you see in-network providers and 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

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

- There is no carry over provision. Amount credited to your deductible during the current plan year will not carry forward to the next plan year deductible
- Amounts credited to the deductible will not exceed the allowed amount
- 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

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 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

The allowed amount is the least of the following (unless a different amount is required under applicable law or agreement):

- An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
- The provider's billed charges. Note: Ambulances are always paid based on billed charges.

If applicable law requires a different allowable charge than the least of the three amounts above, this plan will comply with that 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 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 Care

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

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

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

Note: Non-contracted 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.

HOW PROVIDERS AFFECT YOUR COSTS

MEDICAL SERVICES

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

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

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

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

In-Network Providers

In-network providers provide medical services for a negotiated fee. This fee is the allowed amount for in-network

providers.

When you receive covered services from an in-network provider, your medical bills will be reimbursed at a higher percentage (the in-network provider benefit level). In-network providers will not charge more than the allowed amount. This means that your portion of the charges for covered services will be lower.

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

Out-of-Network Providers

Out-of-network providers are providers that are not part of your network. Your bills will be reimbursed at the lower percentage (the out-of-network benefit level) and the provider will bill you for charges above the allowed amount. You may also be required to submit the claim yourself. See **Sending Us a Claim** for details.

In-Network Benefits for Out-of-Network Providers

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

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

The benefits of this plan will be provided for covered emergency care without the need for any prior authorization and without regard as to whether the health care provider furnishing the services is a network provider. Emergency care furnished by an out-of-network provider will be reimbursed at the in-network benefit level. As explained above, if you see an out-of-network provider, you may be responsible for amounts that exceed the allowed amount.

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

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

PEDIATRIC DENTAL SERVICES

In-Network Providers

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

You receive the highest level of coverage when you receive services from in-network providers. You have access to these network providers wherever you are in the United States.

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

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

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

Out-of-Network Providers

Out-of-network providers are providers that do not have contracts with us. Your bills will be reimbursed at the percentage indicated in the **Summary of Your Costs** (the out-of-network benefit level) and the provider will bill you for charges above the allowed amount. You may also be required to submit the claim yourself. See **Sending Us a Claim** for details.

CARE MANAGEMENT

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

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

PRIOR AUTHORIZATION

Your coverage for some services depends on whether the service is approved 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
- Before you schedule a planned admission to certain inpatient facilities
- When you want to receive the higher benefit level for services you received from an out-of-network provider

Prior authorization is never required for emergency care.

How to Ask for Prior Authorization

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

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

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

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

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

Services from Out-of-Network Providers

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

The prior authorization request must include the following:

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

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

CLINICAL REVIEW

LifeWise has developed or adopted guidelines and medical policies that outline clinical criteria used to make

medical necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria. Our medical policies are on our website. You or your provider may review them at student.lifewiseac.com/uw/gaip. 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

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

We will not provide continuity of care if your provider:

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

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

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

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

Duration of Continuity of Care

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

- The 90th day after we notified you that your Primary Care Provider (PCP)'s contract ended
- The 90th day after we notified you that your provider's contract ended, or the date your request for continuity of care was received or approved, whichever is earlier

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

When continuity of care terminates, you may continue to receive services from this same provider, however, we will pay benefits at the out-of-network benefit level subject to the allowed amount. Please refer to the **How Providers Affect Your Costs** for an illustration about benefit payments. If we deny your request for continuity of care, you may request an appeal of the denial. Please refer to **Complaints and Appeals** for information on how to submit a complaint review request.

COVERED SERVICES

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

- The reason for the services is to prevent, diagnose or treat a covered illness or injury
- The service takes place in a medically necessary setting. For more information about what medically necessary means, see **Definitions**.
- 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 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/uw/gaip 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. The visits can be for examination, consultation and diagnosis of an illness or injury, including second opinions, for any covered medical diagnosis or treatment plan.

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

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

Preventive Care

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 Task Force (USPTF); immunizations recommended by the Centers for Disease Control and Prevention and as required by state law; and preventive care and screening recommended by the Health Resources and Services Administration (HRSA).
- Routine exams and well-baby care. Included are exams for school, sports and employment
- Women’s preventive exams. Includes pelvic exams, pap smear and clinical breast exams.
- Screening mammograms. See **Diagnostic Lab, X-ray and Imaging** for mammograms needed because of a medical condition.
- Pregnant women’s services such as breast feeding counseling before and after delivery and maternity diagnostic screening
- Electric breast pumps and supplies. Includes the purchase of a non-hospital grade breast pump or rental of a hospital grade breast pump. The cost of the rental cannot be more than the purchase price. For electric breast pumps and supplies purchased at a retail location you will need to pay out of pocket and submit a claim for reimbursement. See **Sending Us a Claim** for instructions.
- BRCA genetic testing for women at risk for certain breast cancers
- 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 50 years of age, all individuals 50 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.
- 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 **Sending Us a Claim** for instructions.
- Obesity screening and counseling for weight loss
- Contraceptive management. Includes exams, treatment, and supplies you get at your provider’s office, including all FDA approved contraceptives. FDA approved contraceptives include but are not limited to, emergency contraceptives, and contraceptive devices (insertion and removal). Tubal ligation and vasectomy

are also covered. See **Prescription Drugs** for prescribed oral contraceptives and devices.

- Health education and training for covered conditions such as diabetes, high cholesterol and obesity. Includes outpatient self-management programs, training, classes and instruction.
- Nutritional therapy or counseling. 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 of therapy visits that are covered as preventive depends on your medical need.
- Preventive drugs required by federal law. See **Prescription Drugs**.
- Approved tobacco use cessation programs recommended by your physician. After you have completed the program, please provide us with proof of payment and a completed reimbursement form. You can get a reimbursement form on our website at student.lifewiseac.com/uw/gaip. See **Prescription Drugs** for covered drug benefits.
- Depression screening
- Vision screening for members under 19
- Review of oral health for member under 19

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

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.

When diagnostic X-ray and imaging treatment is referred by Hall Health to a non-Hall Health provider, the network or non-network benefits will apply depending on the provider you see. This includes x-rays sent to a non-Hall Health radiologist for review.

Covered lab charges incurred at or referred from Hall Health will be covered at 100% and not subject to the deductible.

Preventive Care Screening and Tests

Preventive care screening and tests are covered in full when provided by an in-network provider. “Preventive care” is as 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 EKGs
- Services that are medically necessary to diagnose infertility or that are part of treatment for the cause of infertility.
- Lab services
- Mammograms for a medical condition

- Neurological and neuromuscular tests
- Pathology tests
- Standard ultrasounds

Major Diagnostic X-ray and Imaging

Major diagnostic x-ray and imaging services include:

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

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

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

Pediatric Care

This plan covers vision and dental services for covered children until the end of the month of a member's 19th birthday. A child under age 19 is eligible for these services as stated on the ***Summary of Your Costs***, unless otherwise stated below.

Pediatric Vision Services

Coverage for routine eye exams and glasses includes the following:

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

Pediatric Dental Services

Coverage is available for a covered dental condition. Such services must meet all of the following requirements:

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

At times we may need to review diagnostic materials such as dental x-rays to determine if the services requested are medically necessary. These materials will be requested directly from your dental care provider.

You can ask for an ***Estimate of Benefits***. An ***Estimate of Benefits*** verifies, for the dental care provider and yourself, your eligibility and benefits. It may also clarify, before services are rendered, treatment that isn't covered in whole or in part. This can protect you from unexpected out-of-pocket expenses.

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

about your out-of-pocket expenses.

Our **Estimate of Benefits** is not a guarantee of payment. Payment of any service will be based on your eligibility and benefits available at the time services are rendered. Please see the back cover for the address and fax for an **Estimate of Benefits**, or call Customer Service.

Alternative Benefits

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

Dental Care Services for Congenital Anomalies

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

Dental care coverage includes the following:

Class I Services

Benefits include the following services:

- Routine oral examinations are limited to 2 visits per plan year. Comprehensive and periodic oral examinations count toward the limit for oral examinations.
- Prophylaxis (cleaning, scaling, and polishing of teeth) is limited to 2 per plan year
- Fluoride treatment (including fluoride varnishes) is limited to 3 treatments per plan year
- Covered dental x-rays include either a complete series or panoramic x-ray once every 36 months, but not both. Supplemental bitewing and periapical x-rays are covered.
- Sealants are covered up to age 19 for permanent teeth and primary (baby) molars, once every three plan years
- Space maintainers are only covered when designed to preserve space for permanent teeth. Replacement of space maintainers will be covered only when medically necessary.
- Oral hygiene instruction is limited to 2 times per calendar year for ages 8 and under if not performed on the same day as prophylaxis (cleaning).

Class II Services

Benefits include the following services:

- Non-routine x-rays, including occlusal intraoral x-rays when medically necessary are limited to once every 24 months
- Oral and facial photographic images subject to review for medical necessity on a case by case basis
- Full mouth debridement
- Simple extractions
- Emergency, limited problem focused and other non-routine oral exams are limited to 1 per plan year
- Behavior management (behavior guidance techniques used by dental provider)
- Fillings, consisting of silver amalgam tooth colored composite. Limited to once every 24 months for the same restoration. Resin based composite fillings performed on second and third molars are considered cosmetic and will be reduced to the amalgam allowance.
- 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.
- Periodontal (non-surgical) maintenance is limited to 1 per plan year.
- Recementing of crowns, inlays, bridgework and dentures. Recementing of permanent crowns is limited to ages 12 up to age 19.
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- Repair of crowns, bridgework & dentures is limited to once every 3 plan years (if performed 6 months or more from seating date).
- Limited occlusal adjustment (reshaping of a limited number of teeth to attain proper bite) are limited to once every 12 months as medically necessary.

- Pulp vitality test
- Extended care facility or nursing home calls is limited to 2 per facility per day, when medically necessary

Class III Services

Benefits include the following services:

- Surgical Extractions
- Therapeutic parenteral/therapeutic drugs such as antibiotics, steroids, and anti-inflammatory medication administered in a dental office
- Diagnostic casts, study models and cephalometric film when medically necessary are included in conjunction with another covered dental procedure
- Oral and Maxillofacial surgery which includes:
 - Alveoplasty and Vestibuloplasty
 - Cancer treatment
 - Care of abscesses
 - Cleft palate treatment
 - Cyst removal
 - Excision of lesion
 - Frenulectomy or Frenuloplasty (limited to ages 6 and under)
 - Post-surgical complications
 - Surgical biopsy
 - Treatment of fractures
- Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns for decayed or fractured teeth when amalgam or composite resin fillings wouldn't adequately restore the teeth. Crowns, inlays, and onlays consisting of porcelain, ceramic, or resin, performed on second or third molars will be limited to the allowed amount that we would have paid for a metal crown, inlay or onlay. An Estimate of Benefits is suggested.
- Replacement inlays, onlays, laboratory-processed labial veneers and crowns, but only when:
 - The existing restoration was seated at least 5 plan years before replacement; or
 - The service is a result of an injury as described under "Dental Care Services For Injuries"
- Partial dentures and fixed bridges are covered. Replacement of partial dentures and fixed bridges is limited to once per 3 plan years. A replacement is covered three years from original seat date.
- Complete denture (upper and lower) is covered. Replacement of complete denture (upper and lower) is limited to 1 per lifetime. Replacement of complete denture must be 5 years after the seat date
- Repreparation of the natural tooth structure under the existing bridgework is required as a result of an injury to that structure, and such repair is performed within 12 months of the injury as described under "Dental Care Services For Injuries"
- The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement
- Relining, rebasing and adjustments of dentures when performed 6 or more months after denture installation.
- Tooth cast and core or prefabricated post and core limited to permanent teeth
- General, regional blocks, oral or parenteral sedation and deep sedation in a dental care provider's office when medically necessary and provided with a covered service. This includes members who are under the age of 9 or are disabled physically or developmentally. An Estimate of Benefits is suggested.
 - This benefit also covers drugs and medications used for parenteral conscious sedation, deep sedation and general anesthesia when medically necessary.
 - Local anesthesia in conjunction with operative or surgical procedures would combined in allowance for the primary procedure
- Osseous and mucogingival surgery (surgical periodontal treatment) is covered in the same quadrant once every 3 plan years. Surgical periodontal services also cover post-operative gingivectomy and gingivoplasty. This benefit covers post-surgical complications.
- Endodontic (root canal) therapy and pulpal therapy (restorable filling) is limited to once per tooth per lifetime

- Retreatment of a root canal when services are performed at least 12 months after the original procedure
- Benefits for root canals performed in conjunction with overdentures are limited to 2 per arch
- Open and drain (open and broach) (open and medicate) procedures may be limited to a combined allowance based on our review of the services rendered
- Other than the initial diagnostic x-ray, additional x-rays done in conjunction with a root canal are included in the fee for root canals
- Apexification for apical closures
- Apicoectomy and retrograde filling
- Periodontal scaling and root planning services are covered for ages 13 up to age 19. Services are limited to once per quadrant every 24 months
- Periodontal surgery, including post-surgical complications
- Occlusal guard (nightguard) is covered for bruxism and other occlusal factors when medically necessary. This benefit is limited to one every 36 months for members age 12 up to age 19.
- Hospital call including emergency care limited to 1 per day, when medically necessary.

Medically Necessary Orthodontia

- This benefit includes braces and orthodontic retainer for specific malocclusions associated with:
 - Cleft lip and palate, cleft palate, or cleft lip with alveolar process improvement
 - Craniofacial anomalies (hemifacial microsomia, craniosynostosis syndromes)

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 benefit does not cover:

- Cleaning of appliances
- Complete occlusal adjustment
- Cosmetic services:
 - Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and aftereffects thereof
 - Cosmetic orthodontia
- Crowns and copings in conjunction with an overdenture
- Dental services received from a:
 - Dental or medical department maintained for employees by or on behalf of an employer
 - Mutual benefit association, labor union, trustee, or similar person or group
- Duplicate appliances
- Extra dentures or other duplicate appliances, including replacements due to loss or theft
- Facility charges (hospital and ambulatory surgical center) for dental procedures
- Home use products. Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.
- Implants. Dental implants and implant related services.
- Increase of vertical dimension. Any service to increase or alter the vertical dimension.
- Non-standard techniques. Techniques other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting
- Plaque control programs (dietary instruction and home fluoride kits)
- Precision attachments, replacement of replaceable parts for semi-precision or precision attachments, and personalization of appliances
- Services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends)

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

The following are deemed service start dates:

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

The following are deemed service completion dates:

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

Prescription Drugs

This plan uses the prescription drug formulary shown on the **Summary of Your Costs**.

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.

Covered Prescription Drugs

- FDA approved formulary prescription drugs. Federal law requires a prescription for these drugs. They are known as "legend drugs."
- Compound drugs when the main drug ingredient is a covered prescription drug
- Oral drugs for controlling blood sugar levels, insulin and insulin pens
- Throw-away diabetic test supplies such as test strips, testing agents and lancets
- Drugs for shots you give yourself
- Needles, syringes and alcohol swabs you use for shots
- Glucagon emergency kits
- Inhalers, supplies and peak flow meters
- Drugs for nicotine dependency
- Human growth hormone drugs when medically necessary
- All FDA approved oral contraceptive drugs and devices such as diaphragms and cervical caps are covered in

full when provided by an in-network pharmacy, see **Preventive Drugs** in the **Summary of Your Costs**

- Oral chemotherapy drugs
- Drugs associated with an emergency medical condition (including drugs from a foreign country)

Pharmacy Management

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

- A specific number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment
- Certain drugs for a specific diagnosis
- Certain drugs from certain pharmacies, or you may need to get prescriptions from an appropriate medical specialists or a specific provider
- Drug synchronization, meaning when a member requests a new prescription to be filled and the cost-sharing adjusted 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.

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 web site to inquire about whether a drug is on our preventive care list.

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

Using In-network Pharmacies

When you use an in-network pharmacy, always show your LifeWise ID Card. In-network pharmacies include, but are not limited to, Rubenstein Pharmacy (located at Hall Health) and University of Washington Medical Center pharmacies. 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 **Sending Us a Claim** for instructions.

Diabetic Injectable Supplies

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

Oral Chemotherapy

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

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 (storage and procurement, including blood banks), when medically necessary
- Any prescription refill beyond the number of refills shown on the prescription or any refill after one year from the original prescription
- Replacement of lost or stolen drug
- Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and injectable medications. Exceptions to this exclusion are injectable drugs for self-administration such as insulin and glucagon and growth hormones. See **Infusion Therapy** for covered infusion therapy services.
- Drugs dispensed for use in a healthcare facility or provider's office or take-home medications. Exceptions to this exclusion are injectable drugs for self-administration such as insulin and glucagon and growth hormones. See **Prescription Drugs** for injectable drugs for self-administration.
- Immunizations. See **Preventive Care**.
- Drugs to enhance fertility or to treat sexual dysfunction
- Weight management drugs
- Therapeutic devices or appliances, except for contraceptive supplies and devices and syringes and needles for drugs you give yourself. See **Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics**.

Drug Discount Program

LifeWise may receive rebates from its drug benefit manager or other vendors. Such rebates are LifeWise's property. These rebates are retained by LifeWise and may be taken into account in setting subscription charges or may be credited to administrative charges and are not reflected in your allowable charge. The allowable charge is not adjusted to reflect rebates received as part of Drug Discount Programs.

In addition, the allowable charge that your payment for drugs is based on may be higher than the price LifeWise pays its drug benefit manager or other vendors for those drugs. The difference constitutes LifeWise property. LifeWise is entitled to retain and shall retain the difference and may apply it to the cost of LifeWise's operations. If your drug benefit includes a copay, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the allowable charge. The allowable charge is not adjusted to reflect discounts received as part of Drug Discount Programs.

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."

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.

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 mail-order through Rubenstein 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 receive the highest level of coverage when you have your prescriptions filled by participating pharmacies.

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

The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies and through the mail-order pharmacy benefit are described in the "Dispensing Limit" provision above.

Benefits for refills will be provided only when the member has used 75% of a supply of a single medication. The 75% is calculated based on both of the following:

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

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

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

Surgery Services

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

Covered services include:

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

This benefit does not cover:

- Breast reconstruction. See **Mastectomy and Breast Reconstruction** for those covered services.
- The use of an anesthesiologist for monitoring and administering general anesthesia for colon health screenings

unless medically necessary when specific medical conditions and risk factors are present.

- Transplant services. See **Transplant** for details.

Emergency Room

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

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

Covered services include the following:

- Professional and facility charges for the emergency room and the emergency room doctor
- Services used for emergency medical conditions, including screenings, exams, and patient observation for stabilizing a medical condition
- Outpatient tests billed by the emergency room and that you get with other emergency room services

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

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

Emergency Ambulance Services

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

Hospital Services

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

Inpatient Care

Covered services include:

- Room and board, general duty nursing and special diets

- Doctor services and visits
- Use of an intensive care or special care units
- Operating rooms, surgical supplies, anesthesia, drugs, blood, dressing, durable medical equipment and oxygen
- X-ray, lab and testing

Outpatient Care

Covered services include:

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

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 and Chemical Dependency

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. When medically appropriate, services may be provided in your home. This plan will comply with federal mental health parity requirements.

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

Mental Health Care

This plan covers all of the following services:

- Inpatient, residential treatment and outpatient care to manage or reduce the effects of the mental condition
- Individual or group therapy
- Family therapy as required by law
- Lab and testing
- Take-home drugs you get in a facility

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

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

This plan covers all of the following services:

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

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
- Licensed community mental health agency or behavioral health agency

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:

- Treatment of sexual dysfunctions
- EEG biofeedback or neurofeedback
- Outward bound, wilderness, camping or tall ship programs or activities
- Mental health tests that are not used to assess a covered mental condition or plan treatment. This plan does not cover tests to decide legal competence or for school or job placement

Maternity and Newborn Care

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

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

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

This benefit covers:

- Prenatal and postnatal care and screenings (including in utero care)
- Home birth services, including associated supplies, provided by a licensed women's health care provider who is working within their license and scope of practice

- Nursery services and supplies for newborn
- Genetic testing of the child's father is covered

This benefit does not cover:

- Outpatient x-ray, lab and imaging. These services are covered under ***Diagnostic Lab, X-ray and Imaging***.
- Home birth services provided by family members or volunteers

Home Health Care

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

Covered employees of a home health agency are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a master's degree in social work.

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

- Home visits and acute nursing (short-term nursing care for illness or injury)
- Home medical equipment, medical supplies and devices.
- Prescription drugs and insulin
- Therapeutic services such as respiratory therapy and phototherapy

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services provided by family members or volunteers
- Services or providers not in the written plan of care or not named as covered in this benefit
- Custodial care
- Nonmedical services, such as housekeeping
- Services that provide food, such as Meals on Wheels or advice about food

Hospice Care

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

Covered services include:

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

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services provided by family members or volunteers
- Services or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Nonmedical services, such as housekeeping, dietary assistance or spiritual bereavement, legal or financial counseling
- Services that provide food, such as Meals on Wheels or advice about food

Rehabilitation and Habilitation Therapy

This plan covers rehabilitation and habilitation therapy. Benefits must be provided by a licensed physical therapist, occupational therapist, speech language pathologist or a licensed qualified provider. Services must be prescribed in writing by your provider. The prescription must include site, type of therapy, how long and how often you should get the treatment.

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

Habilitation therapy is therapy that helps a person keep, learn or improve skills and functioning for daily living. Examples are therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, aural (hearing) therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings, including school-based settings.

See ***Mental Health and Chemical Dependency*** for therapies provided for mental health conditions such as autism.

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 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. Whether a less intensive setting is medically appropriate or not is determined based on the medical needs of the individual patient.
- The care is part of a written plan of treatment prescribed doctor

Outpatient Care

This plan covers outpatient rehabilitative services only when it meets these conditions:

This plan covers the following types of outpatient therapy:

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

This benefit does not cover:

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

Skilled Nursing Facility and Care

This plan covers skilled nursing facility services. Covered services include room and board for a semi-private

room, plus services, supplies and drugs you get while confined in a skilled nursing facility. Sometimes a patient goes from acute nursing care to skilled nursing care without leaving the hospital. When that happens, this benefit starts on the day that the care becomes primarily skilled nursing care.

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

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

You must get prior authorization 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. 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 medically necessary prescription dressings, braces, splints, rib belts and crutches, as well as related fitting expenses. Covered Services also include the following diabetic care supplies such as blood glucose monitor, insulin pump (including accessories), and insulin infusion devices.

Medical Vision Hardware

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

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

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

Prosthetics and Orthotic Devices

Benefits for external prosthetic devices (including fitting expenses) are covered when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or

malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device cannot be repaired. Replacement devices must be prescribed by a physician because of a change in your physical condition.

Shoe Inserts and Orthopedic Shoes

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

This benefit does not cover:

- Hypodermic needles, lancets, test strips, testing agents and alcohol swabs. These services are covered under the **Prescription Drugs**.
- Supplies or equipment not primarily intended for medical use
- Over the counter orthotic braces, cranial banding, trusses, hernia belts, ultrasonic nebulizers, compression stockings, blood pressure cuffs, and enuresis alarms that do not require a prescriptions
- 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
- 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
- Eyeglasses or contact lenses for conditions not listed as a covered medical condition, including routine eye care
- 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, Massage Therapy, Naturopathic Visits and Spinal Manipulation

Benefits that are medically necessary to treat a covered illness, injury, or condition.

Allergy Testing and Treatment

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

Chemotherapy, Radiation Therapy and Kidney Dialysis

This plan covers the following services:

- Outpatient chemotherapy and radiation therapy services
- Outpatient or home kidney dialysis
- Extraction of teeth to prepare the jaw for treatment of neoplastic disease
- Supplies, solutions and drugs (See **Prescription Drugs** for oral chemotherapy drugs)

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

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 accidental injuries to teeth, gums or jaw. Covered services include exams, consultations, dental treatment, and oral surgery when repair is performed within 12 months of the injury. 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 are covered the same as any other emergency service.

Dental Anesthesia

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

- The member is under age 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.

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.

Hearing Care

This plan covers hearing supplies and procedures if medically necessary.

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). In some cases of severe malabsorption (eosinophilic gastrointestinal disease) a medical food called "elemental formula" may be covered.

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:

- All stages of 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

If you would like more information on WHCRA benefits please go to www.dol.gov/ebsa/publications/whcra.html.

Telehealth Virtual Care Services

Your plan covers access to care via online and telephonic methods when medically appropriate.

Benefits for telehealth are provided the same as any other office visit. in the **Summary of Your Cost Shares**. Services must be medically necessary to treat a covered illness, injury or condition.

Coverage for all psychiatric conditions as medically appropriate.

Your provider may provide these services or you may use our preferred telehealth provider. See the back cover for contact information for the preferred telehealth provider.

Temporomandibular Joint (TMJ) Disorders

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

Therapeutic Injections

This plan covers therapeutic injections given at the doctor's office, including serums, needles and syringes.

Transgender Surgery

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

Transgender Surgical Services Criteria

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

Surgical Procedures

For all surgical procedures approved in the most current Standards of Care published by the World Professional

Association for Transgender Health (WPATH), transgender benefits are available if you are at least 18 years old and diagnosed as having gender identity disorder or gender dysphoria.

Breast Surgery

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

Genital Surgery

For genital surgery all the following criteria must be met:

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

Prior Authorization

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

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

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

The following surgeries are covered:

- Rhinoplasty or nose implants
- Face-lifts
- Lip enhancement or reduction
- Facial bone reduction or enhancement
- Blepharoplasty
- Breast augmentation to any size
- Liposuction of the waist (body contouring)
- Reduction thyroid chondroplasty
- Hair removal
- Voice modification surgery (laryngoplasty or shortening of the vocal cords)
- Skin resurfacing

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.

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 (including live donor, cadavers and artificial organs) 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.

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)

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.

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

Coverage includes all prescription lenses and frames, fittings, and special features, as shown in the **Summary of Your Costs**.

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.
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
 - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended
 - You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended

Dental for Adults (age 19 and older)

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

- They must be medically necessary (see **Definitions**)
- They must be furnished by a licensed dentist (D.M.D. or D.D.S.) or dentist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of his or her license or certification, as allowed by law.
- They must not be excluded from coverage under this benefit

Dental care coverage includes the following:

Preventive & Diagnostic Care

The dental plan covers these diagnostic services at 100%:

- Complete series of x-rays (four bitewing x-rays and up to 10 periapical x-rays) or panoramic x-rays once every three policy years; supplementary bitewing x-rays once every six months
- Emergency exams (unlimited visits)
- Exam by a specialist in an American Dental Association recognized specialty (unlimited visits)
- Routine exam, up to two times each plan year.

The plan covers the following preventive services at 100%:

- Prophylaxis (cleaning), up to two times each plan year
- Space maintainers, when used to maintain space for eruption of permanent teeth.

Minor Services

Restorative

The dental plan covers these restorative benefits at 80% after you meet the deductible:

- Amalgam, composite or filled resin restorations (fillings) to treat carious lesions (visible destruction of hard tooth structure from dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), once every two plan years for the same surfaces of each tooth
- An amalgam allowance if a composite or filled resin restoration is placed on a posterior tooth (any difference in cost is your responsibility)
- Stainless steel crowns once every two plan years (refer to Major Services if teeth are restored with crowns, inlays or onlays).

Oral Surgery

The plan covers the following oral surgery benefits at 80% after you meet the deductible:

- General anesthesia/intravenous sedation
- Preparation of the alveolar ridge and soft tissue of the mouth to insert dentures
- Removal of teeth and surgical extractions
- Treatment of pathological conditions and traumatic facial injuries.

Periodontics

The plan covers these periodontic benefits at 80% after you meet the deductible:

- General anesthesia/intravenous sedation
- Gingivectomy and limited adjustments to occlusion (eight or fewer teeth, once every 12 months)
- Root planing (once every 12 months)
- Surgical and nonsurgical procedures to treat the tissues supporting the teeth.

Endodontics

The plan covers these endodontic benefits at 80% after you meet the deductible:

- General anesthesia/intravenous sedation
- Pulpal and root canal treatment (once every two plan years on the same tooth); refer to Major Services if the root canals are in conjunction with a prosthetic appliance
- Pulp exposure treatment, pulpotomy and apicoectomy.

Major Services

Major Restorative

Once you meet the deductible, the dental plan pays 50% of covered charges for:

- Crowns
- Inlays (only when used as an abutment for a fixed bridge)
- Onlays (gold, porcelain or plan-approved gold substitute casting, except processed resin)
- Combinations of the above.

All these treatments must be for carious lesions (visible destruction of hard tooth structure from dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when filling materials such as amalgam or filled resins can't reasonably restore the tooth.

Crowns, inlays or onlays on the same teeth are covered once every five plan years. (Inlays are covered on the same teeth once every five plan years only when used as an abutment for a fixed bridge.)

If a tooth can be restored with filling materials such as amalgam or filled resin, the plan will pay an allowance toward any other type of restoration. The plan will allow the appropriate amount for an amalgam or composite restoration toward the cost of processed filled resin or processed composite restorations

Prosthodontics

The plan covers these prosthodontic benefits at 50% after you meet the deductible:

- Denture adjustments and relines done more than six months after the initial placement, except as noted below for temporary/interim dentures (subsequent relines and jump rebases, but not both, will be covered once every 12 months)
- Dentures, fixed bridges, removable partial dentures and adjustment or repair of an existing prosthetic device once every five plan years (only if it is unserviceable and cannot be made serviceable)

- Root canal treatment performed in conjunction with overdentures, limited to two teeth/arch

In the following instances, the plan lets you apply the allowed amount for one service toward the cost of another:

- Full, immediate and overdentures – Cost may be applied toward any other procedure, such as personalized restorations or specialized treatment
- Implants – Cost for a standard crown, bridge, partial denture or full denture may be applied toward appliances constructed on implants; the plan will not pay for any replacement within five plan years from the original placement
- Partial dentures – Cast chrome and acrylic partial denture cost may be applied toward any other procedure if a more elaborate or precision device is used to restore the cast
- Temporary/interim dentures – Reline cost may be applied toward an interim partial or full denture; after placement of the permanent prosthesis, an initial reline will be covered after 12 months.

The following Diagnostic & Preventive Care Services and supplies are not covered:

- Caries susceptibility tests
- Cleaning of a prosthetic appliance
- Consultations
- Diagnostic services/x-rays related to temporomandibular joints (jaw joints). See the **Temporomandibular Joint (TMJ) Disorders** benefit for additional coverage information.
- Oral hygiene instruction, dietary instruction or home fluoride kits
- Plaque control programs
- Replacement of a space maintainer previously paid for by the plan
- Study models.

The following Minor Services are not covered:

- Bleaching of teeth
- Crowns as part of periodontal therapy or periodontal appliances
- Gingival curettage
- Iliac crest or rib grafts to alveolar ridges
- Major (complete) occlusal adjustment
- Nightguards or occlusal splints
- Overhang removal or re-contouring or polishing of restoration
- Periodontal splinting or crown and bridgework in conjunction with periodontal splinting
- Restorations necessary to correct vertical dimension or to alter morphology (shape) or occlusion
- Ridge extension for insertion of dentures (vestibuloplasty)
- Tooth transplants.

The following Major Services and supplies are not covered:

- Crowns or copings in conjunction with overdentures
- Crowns or onlays placed because of weakened cusps or existing large restorations without overt pathology
- Crowns used as an abutment to a partial denture for re-contouring, repositioning or providing additional retention, unless the tooth is decayed to the extent a crown would be required to restore the tooth whether or not a partial denture is required
- Crowns used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or existing restorations with defective margins when no pathology (disease) exists
- Duplicate dentures
- Personalized dentures
- Surgical placement or removal of implants or attachments to implants.

Additional Adult Dental Exclusions:

- All other services not specifically named in the plan as covered
- Analgesics such as nitrous oxide, conscious sedations, euphoric drugs, injections and prescriptions drugs

- Application of desensitizing agents
- Benefits payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage or similar contract or insurance, whether or not you apply for those benefits (reimbursement to the plan will be made without reduction for any attorney's fees)
- Broken appointments
- Completing insurance forms
- Conditions compensable under Workers' Compensation or employers' liability laws
- Cosmetic dentistry
- Experimental services or supplies
- General anesthesia/intravenous (deep) sedation, except as specified by the plan for certain oral, periodontal or endodontic surgical procedures
- Habit-breaking appliances or orthodontic services or supplies
- Hospitalization charges or any additional dentist fees for hospital treatment
- Patient management problems
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, such as restoration of tooth structure lost from attrition, abrasion or erosion or restorations for malalignment of teeth
- Services provided by any federal, state or provincial government agency or provided without cost by any municipality, county or other political subdivision (other than medical assistance in the State of Washington, under medical assistance RCW 74.09.500, or in any other state, under 42 U.S.C., Section 1396a section 1902 of the Social Security Act)
- Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery. See the **Temporomandibular Joint (TMJ) Disorders** and **Surgical Services** benefits for additional coverage information.

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 per evacuation maximum of \$50,000 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

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

Amounts Over the Allowed Amount

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

Assisted Reproduction

This plan does not cover:

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

Benefits from Other Sources

This plan does not cover services that are covered by:

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

Benefits That Have Been Used Up

Broken Appointments

Caffeine Dependence

Charges for Records or Reports

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

Comfort or Convenience

This plan does not cover:

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

Cosmetic Services

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

The only exceptions to this exclusion are:

- Repair of a defect that is the direct result of an injury, see ***Surgery Services***
- Repair of a dependent child's congenital anomaly, see ***Surgery Services***
- Reconstructive breast surgery in connection with a mastectomy, except as stated under ***Mastectomy and Breast Reconstruction Services***
- Correction of functional disorders. This does not include removal of excess skin and or fat related to weight loss surgery or the use of weight loss drugs. See ***Surgery Services***.

- Procedures that are typically cosmetic for a cisgender person can be determined to be medically necessary for a transgender person

Counseling, Education or Training

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

- 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 otherwise should be provided by school staff. This does not apply to training that is directed at the member's significant behavioral difficulties during schoolwork covered under ***Mental Health, Behavioral Health and Substance Abuse***.

Court-Ordered Services

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

Custodial Care

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

Dental Care

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

Drugs and Food Supplements

This plan does not cover the following:

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

Environmental Therapy

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

Experimental and Investigative Services

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

Family Members or Volunteers

This plan does not cover services that you give to yourself. It also does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer, except as described in ***Home Health and Hospice Care***

Government Facilities

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

Growth Hormone

This plan does not cover growth hormones for the following:

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

Hair Loss

This plan does not cover:

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

Hospital Admission Limitations

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

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

Illegal Acts and Terrorism

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

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

Military-Related Disabilities

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

Military Service and War

This plan does not cover illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, national guard or navy. It also includes any related civilian forces or units.

Not Eligible for Coverage

The plan does not cover services that are:

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

No Charge or You Do Not Have to Pay

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

Non-Treatment Facilities, Institutions or Programs

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

Not Medically Necessary

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

Orthognathic and Maxillofacial Surgery

This plan does not cover procedures to make the jaw longer or shorter, except orthognathic surgery and supplies

for the treatment of Temporomandibular Joint (TMJ) Disorders, Sleep Apnea or Congenital Anomalies. See the **Temporomandibular Joint (TMJ) Disorders** and **Surgical Services** benefits for additional coverage information.

Private Duty Nursing

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

Provider's License or Certification

This plan does not cover services that the provider's license or certification does not allow him or her perform. It also does not cover a provider that does not have the license or certification that the state requires. The only exception is for applied behavior analysis providers covered under **Mental Health, Behavioral Health and Substance Abuse**.

Records and Reports

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

Serious Adverse Events and Never Events

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

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

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

Sexual Problems

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

Voluntary Support Groups

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

Weight Loss (Surgery or Drugs)

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

Work-Related Illness or Injury

This plan does not cover any illness or injury for which you can get benefits under:

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

OTHER COVERAGE

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

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 is your primary plan, you or your provider should contact any of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan(s) to determine which is primary and will let you know within 30 calendar days.

Caution: All health plans have timely filing requirements. If you or your provider fails to submit your claim to your secondary 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 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 **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 calendar 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:

- **Birthdate 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. If the parent who is responsible has no health coverage for the dependent, but that parent's spouse does, that spouse's plan is primary. This rule applies to calendar 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 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 we do not have your start date under the other plan, we will use the employee's hire date with the other group instead. We will compare that hire date to the date your coverage started under this plan to find out which plan covered you for the longest time.

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 calendar year are not more than the total allowable expenses incurred in that year. **However, the secondary plan is never required to pay more than its benefit in the absence of COB 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 calendar year, whether or not they are normally covered.

This plan requires you or your provider to ask for prior authorization from LifeWise before you get certain services or drugs. Your other plan may also require you to get prior authorization for the same service or drug. In that case, when this plan is secondary to your other plan, you will not have to ask LifeWise for prior authorization of any service or drug for which you asked for prior authorization from your other plan. This does not mean that this plan will cover the service or drug. The service or drug will be reviewed once we receive your claim.

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**.

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 tortfeasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

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

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

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

SENDING US A CLAIM

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

Step 1

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

Step 2

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

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

Step 3

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

Step 4

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

Step 5

Sign the claim form.

Step 6

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

Prescription Claims

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

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

Coordination of Prescription Claims

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

Timely Payment of Claim

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

COMPLAINTS AND APPEALS

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

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

WHEN YOU HAVE IDEAS

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

WHEN YOU HAVE QUESTIONS

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

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

WHEN YOU HAVE A COMPLAINT

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

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

WHEN YOU DO NOT AGREE WITH A PAYMENT OR BENEFIT DECISION

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

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

What is an adverse benefit determination?

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

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

WHEN YOU HAVE AN APPEAL

After you find out about an adverse benefit decision, you can ask for an internal appeal. Your plan has two levels of internal appeals. Your Level I internal appeal will be reviewed by people who were not involved in the initial

adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be done by a provider. They will review all of the information about your appeal and will give you a written decision. If you are not satisfied with the decision, you may request a Level II appeal.

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

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

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

Who may file an internal appeal?

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

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

How do I file an internal appeal?

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

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

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

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

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

What if my situation is clinically urgent?

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

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

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

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

Can I provide more information for my appeal?

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

Can I get copies of information relevant to my appeal?

We will also send you any new or additional information we considered, relied upon or generated in connection to your appeal. We will send it as soon as possible and free of charge. You will have the chance to review it and respond to us before we make our decision.

What happens next?

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

- For expedited appeals, as soon as possible, but no later than 72 hours after we got your request. We will call, fax or email and then follow up in writing.
- For appeals for benefit decisions made before you received the services, within 14 days of the date we got your request.
- For appeals of experimental and investigative denials, within 20 days. Only with your informed consent may the review period be extended.
- For all other appeals, within 14 days of the date we got your request. If we need more time to review your request, we may extend the review to no more than 30 days, unless we ask for and receive your agreement for more time after the 30 days.

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

Appeals about ongoing care

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

WHEN AM I ELIGIBLE FOR EXTERNAL REVIEW?

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

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

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

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

When the IRO completes the external review

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

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

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

What Happens Next?

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

If the IRO upheld our decision, there is no further review available under this plan's appeal process. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about understanding a denial of a claim or your appeal rights, you may contact LifeWise Customer Service at the number listed on the back cover. If you want to make a complaint or need help filing an appeal, you can also contact the Washington Consumer Assistance Program at any time during this process.

Washington Consumer Assistance Program
5000 Capitol Blvd.
Tumwater, WA 98501
1-800-562-6900
E-mail: cap@oic.wa.gov

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY FOR ACADEMIC STUDENT EMPLOYEES (SUBSCRIBERS)

If you are a graduate student service appointee, Teaching Assistant, Research Assistant or Student Assistant* (TA/RA/SA), fellow/trainee and meet the University's eligibility requirements, you will be enrolled in the program.

*Graduate Research Student Assistant (GRSA) is limited to appointments during the summer quarter only. This job code may not be used during fall, winter or spring quarters.

Appointees

Eligibility rules vary depending on whether you're a TA/RA/SA or a fellow/trainee and whether you hold an academic quarter (fall, winter, and spring) appointment or a summer quarter appointment. Be sure to review the information in the following sections to determine whether you're eligible for coverage.

In all cases, regardless of when you enroll, you must be registered for classes by the 10th day of the quarter. Eligibility for coverage begins on the first of the month within the coverage period following the entry of an eligible appointment into the payroll system. See ***When Your Coverage Begins*** for details about the various coverage effective dates for each coverage period.

Academic Year TA/RA/SA Appointments

You are eligible for appointee coverage, paid by the University, in any coverage period you:

- Hold at least a 50% appointment
- Are paid in an eligible job class and pay type
- Receive payroll distributions for five of the six pay days during the coverage period, and
- Are registered for at least 10 credits.

Academic Year Fellow/Trainee Appointments

You are eligible for appointee coverage, paid by the University, in any coverage period you:

- Are paid at least \$800/month in an eligible job class
- Receive payroll distributions for five of the six pay days during the coverage period, and
- Are registered for at least 10 credits.

If your funding is paid directly to you and not administered through University payroll

You may enroll in the Self-Pay Option for the coverage period for which you're eligible and may continue to be enrolled through the end of the plan year (September 30) if:

- Your funding equals \$800/month for at least one academic quarter, and
- You're registered for at least 10 credits that same quarter.

The Total Benefits Office must approve eligibility for this option. To find out if you're eligible, review the eligibility rules online at <http://www.uw.edu/admin/hr/benefits/insure/gaip/index.html>.

Note for Academic Student Employees Abroad

If you are abroad for a quarter or longer, you may be able to waive the 10-credit eligibility requirement if you have official on-leave status. You also may meet the \$800 funding minimum with a comparable amount of funding in foreign currency. You must provide the Total Benefits Office with documentation of the appointment and funding, including a statement of the funding in US dollars.

FAMILY MEMBERS YOU MAY COVER (DEPENDENTS)

Academic student employees who are eligible and enrolled in this program may also enroll eligible dependents at the same time they enroll. The same dependent eligibility rules apply year-round. Academic Student Employees who are eligible and enrolled in this program are not eligible dependents. An eligible dependent is defined as:

- Your legally married spouse
- Your Qualified Domestic Partner (QDP). For a QDP to be eligible for coverage, you and your qualified domestic partner must be registered with the Washington State registry or jurisdiction where domestic partner registration is offered.

A copy of the qualified domestic partner registration form or a copy of the marriage certificate for a spouse must be submitted before any claims for a qualified domestic partner/spouse will be considered. The Declaration of Tax Status for SSDP form must also be submitted. This form is needed only to determine if contributions are taxable or not. This form is available online at <https://student.lifewiseac.com/documents/023471.pdf>.

- You or your spouse's or qualified domestic partner's children (including adopted children) who are:
 - Under age 26, or
 - Incapable of self-support because of a physical handicap or developmental disability (documentation required; contact the UW Total Benefits Office at uwgaip@uw.edu for more information).

The term children includes the following who are under age 26:

- Natural children
- Your adopted children
- Children legally placed for adoption including a child for whom you've assumed total or partial legal obligation for support in anticipation of adoption (documentation required)
- Stepchildren, foster children or children for whom you're the legally designated guardian (documentation of court order required). 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.

In addition, your child will be eligible for coverage under this program if required by a court order and if a copy of the court order is provided.

Coverage for a newborn automatically begins at birth for a limited amount of time – the first three weeks after birth – and includes injury and sickness, with necessary treatment of congenital defects, birth abnormalities or premature birth. However, you **must enroll** your newborn within 60 days of birth in order to continue coverage past the initial three-week period. A copy of the child's birth certificate must be on file for benefits to be available.

While academic student employee coverage is automatic as long as you remain eligible, **you must re-enroll your dependents at the beginning of each plan year (no later than October 31st) and update your contact information to expedite claim payment and plan communication. If you have a break in coverage during the same plan year and later regain eligibility your coverage will default to Student Only unless you actively re-enroll any dependents.**

If You Are a UW Student Covered as an Eligible Dependent

If you are a student and enrolled in the International Student Health Insurance Plan (Student Insurance), but are covered under GAIP as an eligible dependent, benefits will be paid under the GAIP Plan. Dual coverage is not possible so consider which single plan best meets your needs.

HOW TO ENROLL

Graduate Appointees

If you are an eligible TA/RA/SA or fellow/trainee, your academic student employee coverage is automatic and the

premiums will be administered by the University's payroll system under this program. Even though coverage is automatic, you'll need to complete online enrollment at student.lifewiseac.com/uw/gaip so that your claims can be paid. Note that your dependents **are not** enrolled automatically; you must elect coverage for them as part of the online enrollment process.

If your funding is paid directly to you and not administered through University payroll, you must enroll through the Self-Pay Option for your coverage.

For all other students, if you have already purchased the International Student Health Insurance Plan and then receive a graduate appointment, you may be able to get a premium refund for the International Student Health Insurance Plan premiums you paid by notifying the UW Total Benefits Office by the third Friday of the quarter. Contact Student Life for complete information about the Student Health Insurance Plan and how to terminate coverage at <http://www.washington.edu/ship/international-student-insurance-health-plan/>.

Please note you may not re-enroll in the International Student Health Insurance Plan (ISHIP) during the same plan year that you had enrolled in ISHIP annual coverage. If you lose eligibility under the Graduate Appointee Insurance Plan, you can continue coverage as described under, "COBRA".

Automatic Summer Quarter Coverage

If you are a TA/RA/SA who had graduate insurance through an eligible appointment for fall, winter, and spring quarters, you'll automatically receive paid coverage for summer quarter, regardless of student status (e.g. graduation, no summer appointment, no classes). If you are in this group and you choose to enroll your dependents in the summer quarter, you will be responsible for paying the entire portion of the summer dependent premium at the beginning of summer paid directly to LifeWise. You will be contacted about this payment in early summer quarter. You won't be refunded any portion of this payment, even if you later decide to drop dependent coverage.

Dependents

To add your dependents, you must use the online enrollment system at student.lifewiseac.com/uw/gaip. Current dependents must be added to your coverage no later than the last day of the month of your benefits start date except for summer quarter. For summer quarter dependent enrollment, you will be notified of the enrollment period at the time of enrollment. Otherwise, dependents cannot be enrolled until the following quarter if you continue to be eligible. Only newly acquired dependents may be added mid-quarter, as described below. There are additional documentation requirements for dependents. Please see the LifeWise enrollment site for details.

Newly acquired dependents can be added during the quarter if you:

- Are covered under this program
- Complete a paper enrollment form found at student.lifewiseac.com/uw/gaip/forms.aspx within 31 days of the date of your marriage or domestic partnership registration or within 60 days of the date of birth, placement for adoption or date of adoption.

If your newly acquired dependent is a new spouse, you must submit your marriage certificate to LifeWise by the deadline.

If your newly acquired dependent is a child, you must submit a copy of the child's birth certificate to LifeWise by the deadline.

If your newly acquired dependent is a new domestic partner and/or domestic partner's eligible children, the following paperwork must be submitted to LifeWise by the deadline:

- Copy of the State of Washington domestic partnership registration or certificate from another jurisdiction offering domestic partner registration, and
- Declaration of Tax Status for SSDP form. This form is available online at <http://www.edu/admin/hr/benefits/forms/insure/gaip/declaration-tax-status.doc>.

Coverage for your newly acquired dependents will begin on the date of marriage, domestic partnership registration, birth, adoption or placement for adoption if your premiums have been paid. Premium payment deductions for newly acquired dependents will begin on the pay period following the notification date of marriage, domestic partnership registration, birth, adoption or placement for adoption.

To remove a dependent from coverage, you must use the online enrollment system at student.lifewiseac.com/uw/gaip. Dependents can only be removed during the first calendar month of the coverage period, except for summer quarter. For summer quarter, you will be notified of the open enrollment

period that will allow you to remove a dependent from coverage, at the time of your enrollment.

You must re-enroll your dependents at the beginning of each plan year.

WHEN COVERAGE BEGINS

This is a one-year plan that starts on October 1, 2018 and ends on September 30, 2019. The benefits described in the brochure are in force during this period only.

No facility, physician's office, or billing office can verify your eligibility and coverage start date. You are responsible for knowing your coverage start and end dates. Any information provided by another source cannot be guaranteed and you may be liable for the cost of services.

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 ***How To Enroll***.

WHEN COVERAGE ENDS

In most cases, your coverage stops at the end of the month your graduate appointment ends; however, your coverage may continue under the following circumstances:

- If you were eligible during and received the first five paychecks of the quarter, the program pays for your coverage until the end of the quarter in which the coverage period ends; this is based on payroll dates, not academic dates
- If you are eligible for the graduate appointee coverage after having International Student Insurance Plan 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 30 days
- If you lose eligibility or your graduate appointment ends before the quarter ends, the program pays for your coverage until the end of the month and you can continue coverage through the self-pay option. The self-pay option allows you to continue your coverage until the plan year ends (September 30), by enrolling and paying your monthly premiums, plus a \$4.00 fee directly to LifeWise. In this case, you can continue coverage for the remainder of the plan year, regardless of whether you're a registered student, before electing COBRA.

Cancellation

If you choose not to use your coverage, you will not receive any refund of premium except in the event you or your spouse or domestic partner goes on full time active duty in the armed forces and submit a written request to the UW Total Benefits Office.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this plan ceases on the termination date. However, if an insured is hospital-confined on the termination date from a covered injury or sickness for which benefits were paid before the termination date, covered medical expenses for such injury or sickness will continue to be paid as long as the condition continues but not to exceed 365 days after the termination date. The total payments made in respect of the insured for such condition both before and after the termination date will never exceed the maximum benefit.

COVERAGE DURING LABOR DISPUTE

An academic student employee may pay premium charges through the University to keep coverage in effect for up to 6 months in the event of suspension of compensation due to a lockout, strike, or other labor dispute

SELF-PAY OPTION

The Self-Pay Option allows individuals who meet the following eligibility rules to enroll in GAIP coverage at their own cost through the end of the plan year (September 30). Those enrolling in the Self-Pay Option must enroll before the last day of the first calendar month of eligibility. In all instances, the UW Total Benefits Office must approve Self-Pay eligibility.

Those enrolled in the Self-Pay Option are responsible for making academic student employee and dependent premium payments. You must enroll in this option when you first become eligible. If at any time you do not pay the monthly premium, your coverage will be terminated. Based on the type of coverage you choose, your cost varies. Specific information about the cost of coverage under the Self-Pay Option is available at <http://www.uw.edu/admin/hr/benefits/insure/gaip/premiums.html>.

While covered under self-pay, if you are not registered for classes at the UW and do not pay the student activity fee, your benefits will be paid at the network level of benefits regardless if you incur services at Hall Health.

Eligibility

If your funding is paid directly to you and not administered through University payroll your department can request you be made eligible under this option

You may enroll in the Self-Pay Option for the coverage period you're eligible and may continue to be enrolled through the end of the plan year (September 30) if:

- Your funding equals \$800/month for at least one academic quarter, and
- You're registered for at least 10 credits that same quarter.

Enrolling

If you are eligible for the self-pay option, you will receive a self-pay letter. To enroll return the letter to LifeWise with your payment. You are responsible to keep the Plan informed of any address change. If you have questions regarding self-pay option, contact LifeWise directly at:

(800) 421-3531 (toll free)

(800) 842-5357 (TTY for deaf and hard-of-hearing)

COBRA

When group coverage is lost because of a "qualifying event" shown below, federal laws and regulations known as "COBRA" require the Group to offer qualified members an election to continue their group coverage for a limited time. Under COBRA, a qualified member must apply for COBRA coverage within a certain time period and may also have to pay the subscription charges for it.

At the Group's request, we'll provide qualified members with COBRA coverage under this plan when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. Members' rights to this coverage may be affected by the Group's failure to abide by the terms of its contract with us. The Group, **not us**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

The following summary of COBRA coverage is taken from COBRA. Members' rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by Congress or interpretations of COBRA by the courts and federal regulatory agencies.

Qualifying Events And Length Of Coverage

Please contact the Group immediately when one of the qualifying events highlighted below occurs. The continuation periods listed extend from the date of the qualifying event.

Covered domestic partners and their children have the same rights to COBRA coverage as covered spouses and their children.

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:

- **The subscriber's work hours are reduced.**
- **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.**

However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.

- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
 - **The subscriber dies.**

- **The subscriber and spouse legally separate or divorce.**
- **The subscriber becomes entitled to Medicare.**
- **A child loses eligibility for dependent coverage.**

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the first qualifying event.

Conditions Of COBRA Coverage

For COBRA coverage to become effective, all of the requirements below must be met:

You Must Give Notice Of Some Qualifying Events

The plan will offer COBRA coverage only after the Plan Administrator receives timely notice that a qualifying event has occurred.

The subscriber or affected dependent must notify the Plan Administrator in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in "Qualifying Events and Lengths Of Coverage." The subscriber or affected dependent must also notify the Plan Administrator if the Social Security Administration determines that the subscriber or dependent was disabled on any of the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Plan Administrator this notice for you.

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage.

Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Plan Administrator. The notice period starts on the date shown below.

- For determinations of disability, the notice period starts on the **later** of: 1) the date of the subscriber's termination or reduction in hours; 2) the date the qualified member would lose coverage as the result of one of these events; or 3) date of the disability determination. **Please note: Determinations that a qualified member is disabled must be given to the Plan Administrator before the 18-month continuation period ends. This means that the subscriber or qualified member might not have the full 60 days in which to give the notice.** Please include a copy of the determination with your notice to the Plan Administrator.

Note: The subscriber or affected dependent must also notify the Plan Administrator if a qualified member is deemed by the Social Security Administration to no longer be disabled. See "When COBRA Coverage Ends."

- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

Important Note: The Group must tell you where to direct your notice and any other procedures that you must follow. If the Group informs you of its notice procedures after the notice period start date above for your qualifying event, the notice period will not start until the date you're informed by the Plan Administrator.

The Group must notify qualified members of their rights under COBRA. If the Group has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the group. In such cases, the Group has 30 days in which to notify its plan administrator of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement. The plan administrator then has 14 days after it receives notice of a qualifying event from the Group (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

You Must Enroll And Pay On Time

- You must elect COBRA coverage no more than 60 days after the **later** of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage. You may be eligible for a second COBRA election period if you qualify under section 201 of the Federal Trade Act of 2002. Please contact the Group or your bargaining representative for more information if you believe this may apply to you.

Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

If you're not notified of your right to elect COBRA coverage within the time limits above, you must elect COBRA coverage no more than 60 days after the date coverage was to end because of the qualifying event in order for COBRA coverage to become effective under this plan. If you're not notified of your right to elect COBRA

coverage within the time limit, and you don't elect COBRA coverage within 60 days after the date coverage ends, we won't be obligated to provide COBRA benefits under this plan. The Group will assume full financial responsibility for payment of any COBRA benefits to which you may be entitled.

- You must send your first subscription charge payment to the Plan Administrator no more than 45 days after the date you elected COBRA coverage.
- Subsequent subscription charges must be paid to the Plan Administrator and submitted to us with the Group's regular monthly billings.

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed under "Special Enrollment" or "Open Enrollment" in the "When Does Coverage Begin?" section. With one exception, family members added after COBRA begins aren't eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under "Qualifying Events and Lengths Of Coverage" earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

Keep The Group Informed Of Address Changes

In order to protect your rights under COBRA, you should keep the Plan Administrator informed of any address changes. It is a good idea to keep a copy, for your records, of any notices you send to the Plan Administrator.

When COBRA Coverage Ends

COBRA coverage will end on the last day for which subscription charges have been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.
- The next monthly subscription charge isn't paid when due or within the 30-day COBRA grace period.
- When coverage is extended from 18 to 29 months due to disability (see "Qualifying Events and Lengths Of Coverage" in this section), COBRA coverage beyond 18 months ends if there's a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which subscription charges have been paid in the first month that begins more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.
- You become covered under another group health care plan after the date you elect COBRA coverage.
- You become entitled to Medicare after the date you elect COBRA coverage.
- The Group ceases to offer group health care coverage to any academic student employee.

However, even if one of the events above hasn't occurred, COBRA coverage **under this plan** will end on the date that the contract between the Group and us is terminated.

When COBRA coverage under this plan ends, you may be eligible for benefits as described in "Extended Benefits" later in this section. You may also be eligible to apply for one of our individual plans as explained in "Converting To A Non-Group Plan" later in this section.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the Group. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

Converting to a Nongroup Plan

You may be entitled to coverage under one of an Individual plans when your coverage under this plan ends. Individual plans differ from this plan. You pay the monthly payment. You must apply and send the first

subscription charge payment to us within 31 days of the date your coverage ends under this plan or you were first notified that your coverage had ended under this plan, whichever is later.

You can apply for an Individual plan if you live in Washington State and you're not eligible for Medicare coverage. For more information about Individual plans, contact your employer or our Customer Service department.

Please Note: The rates, coverage and eligibility requirements of Individual plans differ from those of your current group plan. In addition, enrollment in an individual plan may limit your ability to later purchase an individual plan.

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. If you have any questions about your plan or want to request additional information or forms please call customer services 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.

The University of Washington and You

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

Health Care Providers - Independent Contractors

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

Intentionally False or Misleading Statements

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

Recovery later in this section.

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

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

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

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

Member Cooperation

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

Newborn's and Mother's Health Protection Act

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

Notice

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

Notice of Information Use and Disclosure

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

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

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

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

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

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

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

Notice of Other Coverage

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

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

Rights of Assignment

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

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

Right of Recovery

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

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

Right to and Payment of Benefits

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

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

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

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

Venue

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

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

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

Women's Health and Cancer Rights Act of 1998

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

DEFINITIONS

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

Affordable Care Act

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

Ambulatory Surgical Facility

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

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

Benefit Booklet

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

Plan Year (Year)

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

Chemical Dependency

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.

State and federal law require that the copays and coinsurance for medically necessary outpatient and inpatient services provide to treat chemical dependency will be no more than the copays and coinsurance for medical and surgical services. Prescription drugs to treat chemical dependency are covered under the same terms and conditions as other prescription drugs covered under this plan.

Claim

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

Coinsurance

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

Community Mental Health Agency

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

Congenital Anomaly

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

Copay

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

Cosmetic Services

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

Covered Service

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

Custodial Care

Any part of a service, procedure, or supply that is mainly to:

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

Deductible

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

Dependent

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

Detoxification

Detoxification is active medical management of medical conditions due to substance intoxication or withdrawal, which requires repeated physical examination appropriate to the substance ingested, and use of medication. Observation alone is not active medical management.

Doctor (Also called "Physician")

A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.).

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

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

Effective Date

The date your coverage under this plan begins.

Emergency Medical Condition

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

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

Emergency Care

- Services and supplies including ancillary services given in an emergency department
- Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant woman in active labor, to perform the delivery.

Endorsement

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

Essential Health Benefits

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

Experimental/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

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.

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.

Group

The entity which sponsors this large group employer health plan, and has signed the group contract. A large employer is one that had an average of at least 51 common law employees on its normal work days in the preceding calendar year. It must also have at least 51 common law employees on the first day of the current contract term.

Home Medical Equipment (HME)

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

Home Health Agency

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

Hospice

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

Hospital

A healthcare facility that meets all of these criteria:

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

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

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

Illness

A sickness, disease, medical condition, or pregnancy.

Injury

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

Inpatient

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

Long-term Care Facility

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

Medically Necessary and Medical Necessity

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

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

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

Member

Any person covered under this plan.

Mental Condition

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

Mental Health Services

Medically necessary outpatient and inpatient services provided to treat mental conditions. State and federal law require that the copays and coinsurance for mental health services will be no more than the copays and coinsurance for medical and surgical services. Prescription drugs for mental conditions are covered under the same terms and conditions as other prescription drugs covered under this plan.

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 Administrator

LifeWise Assurance Company (LifeWise)

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***. The defined terms below are how we show a provider's network status.

For providers of dental care, we use two terms:

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

For providers of medical care, we use these terms.

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

Reconstructive Surgery

Reconstructive Surgery is surgery:

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

Service Area

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

Services

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

Skilled Care

Medical care ordered by a physician and requiring the knowledge and training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility licensed by the state to provide nursing services that require the direction of a physician and nursing supervised by a registered nurse, and that is approved by Medicare or would qualify for Medicare approval if so requested.

Sound Natural Tooth

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured)
- Has not been extensively restored
- Has not become extensively decayed or involved in periodontal disease
- Is not more susceptible to injury than a whole natural tooth

Spouse

Spouse means:

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

Subscription Charge

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

Urgent Care

Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours.

We, Us and Our

LifeWise Assurance Company.

You and Your

A member enrolled in this plan.

Where To Send Claims

MAIL YOUR CLAIMS TO

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

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
P.O. Box 14711
Lexington, KY 40512

Contact the Pharmacy Benefit Administrator At

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

Customer Service

Mailing Address

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

Phone Numbers

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

Physical Address

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

Local and toll-free TTY number
for the deaf and hard-of-hearing:
1-800-842-5357

UW Total Benefits Office

Box 354969
4300 Roosevelt Way N.E.
Seattle, WA 98195-4963

(206) 543-4444

UW Integrated Service Center

UW Tower, Floor O-2
Seattle, WA 98195

(206) 543-8000
ischelp@uw.edu

Campus Mail Box 359555
4333 Brooklyn Ave NE

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

Telehealth

You can get telehealth care from Teladoc. Log onto your account at member.teladoc.com/lifewise, or call 1-855-332-4059.

Dental Estimate of Benefits

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

Fax 425-918-5956

Complaints and Appeals

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

Website

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

