LIFEWISE ASSURANCE COMPANY
(“LifeWise”)

UNIVERSITY of WASHINGTON

BOTHELL “SHIP” STUDENT HEALTH INSURANCE PLAN
2013-2014

Coverage is available to registered students and their eligible dependents. Benefits are underwritten and administered by LifeWise Assurance Company.

Note: This coverage is blanket disability insurance. Coverage provided is “excess” only and does not contain a “coordination of benefits” provision.

Your student health insurance coverage, offered by LifeWise Assurance Company may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014.

Your 2013-2014 student health insurance coverage has a limit of $500,000 per plan year. If you have any questions or concerns about this notice, contact LifeWise Assurance Company at (800) 971-1491. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

CUSTOMER SERVICE
LifeWise Assurance Company
Toll Free (800) 971-1491
TDD for Hearing-Impaired (800) 842-5357
Web site student.lifewiseac.com/uw/bt

CLAIMS SUBMISSION
LifeWise Assurance Company
PO Box 91059, Seattle, WA 98111
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INTRODUCTION
The benefits, limitations, exclusions and other coverage provisions in this plan are subject to the terms of our contract with the University of Washington (UW). This booklet is a part of that contract, which is on file in the University of Washington Student Life office and at LifeWise Assurance Company. This booklet replaces any other that you may have received.

HOW TO USE THIS BOOKLET
This booklet will help you get the most out of your benefits. Every section contains important information, but the ones below may be particularly useful:

- **Who's Eligible** – eligibility and termination provisions
- **Premiums** -- what you need to pay for coverage
- **Save Money By Using Network Providers** — how using network providers will cut your costs.
- **Understanding Your Health Insurance Plan**
- **Medical Plan Highlights** — what's covered and what you need to pay for covered services
- **What's Covered** – details of what’s covered
- **What’s Not Covered – Exclusions and Limitations** — services that are either limited or not covered
- **Claims** — step-by-step instructions for claims submissions
- **What If I Have A Question Or An Appeal?** — processes to follow if you want to file a complaint or an appeal
- **Definitions** — terms that have specific meanings under this plan. Example: "You" and "your" refer to an insured person. "Us" and "our" refer to LifeWise Assurance Company.

FOR MORE INFORMATION
You'll find our contact information on the front cover of this booklet. Please call or write Customer Service for help with:

- Questions about benefits or claims
- Questions or complaints about care you receive.
WHO’S ELIGIBLE

ELIGIBILITY

All formally admitted matriculated students at the University of Washington – Bothell are eligible to enroll. International students are required to have and maintain insurance coverage and must purchase this plan, unless the student has other coverage. Students must remain enrolled in classes for the first 14 days of instruction during the quarter in which you enroll for coverage.

The following students are not eligible to enroll in this plan: Access Program, Certificate programs, Training workshops, Distance Learning, English as a Second Language, Noncredit classes, Conferences or Institutes, TA/RA/SA Appointees or UW and other state employees attending classes under the Employee Tuition Exemption Program.

Students must actively attend classes for at least the first 14 days after the date for which coverage is purchased. Home study, correspondence, and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. LifeWise Assurance Company maintains its right to investigate student status and attendance records to verify that the plan Eligibility requirements have been met. If LifeWise Assurance Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who enroll may also insure their dependents. Dependent eligibility expires concurrently with that of the insured student. See the Definitions section for the specific requirements needed to meet domestic partner eligibility.

FAMILY MEMBERS YOU MAY COVER

If you are eligible and enroll for coverage, you may also enroll your eligible dependents in the same plan at the same time you enroll:

- Your children under age 26
  The term “child” includes an insured student's biological children, step-children, children for whom responsibility was assumed through domestic partner registration, foster children, adopted children from the date of placement in the insured student’s home and who depend on the insured student for their support, children which the insured student has been granted legal custody, and children which the insured student has legal obligation to provide coverage due to a court order.
  When a court ordered guardianship or foster care terminates or expires, the child is no longer an eligible child. Court ordered guardianship and foster care expires at the child’s age of majority.
  The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both: 1) Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and, 2) Chiefly dependent upon the insured person for support and maintenance.

- Your spouse or registered domestic partner (see below).
  For a domestic partner to be eligible for coverage, you and your domestic partner must be registered with the Washington State registry or jurisdiction where domestic partner registration is offered.
  You will be asked to submit a copy of your marriage certificate, the Washington State registration certificate or certificate from other jurisdiction where domestic partner registration is offered. If you are unable to provide this documentation, your spouse or domestic partner will be deemed ineligible and their claims will be denied.

Deadline For Adding A New Spouse Or Domestic Partner To Your Coverage

You must enroll a newly acquired spouse or registered domestic partner within 30 days of the marriage or registration.

Deadlines For Adding A New Child To Your Coverage

- A child born to or adopted by you, your enrolled spouse or domestic partner, while you are enrolled in SHIP will receive the same benefits as you for the first three weeks after birth
  If you want continuing coverage for your child after this, you must enroll your child in the timeframes listed below:
    - You must enroll a newborn child and pay any additional premium to the Student Insurance Office within 60 days of birth
    - For adoptions, notify the Student Insurance Office of adoptions in writing, and pay any additional premium within 60 days of adoption. We cover adopted children from the date the child is placed for adoption only if
you send us a written request to add the child no more than 60 days after the child is placed and include any additional premium.

- You must enroll eligible children acquired through marriage or domestic partner registration within 30 days of marriage or registration.

**HOW TO ENROLL**

If you will be enrolling in the student health insurance plan, you must enroll and submit premium payment. You can go to our web site to enroll online, submit premium payment and receive proof of coverage. If you choose not to enroll online, your enrollment form and premium payment must be postmarked no later than 14 calendar days after the school quarter starts. You will not be enrolled in the plan just by submitting premium payment.

**Your Enrollment Decisions**

- Choose or decline coverage (note: international students must enroll in SHIP and may be granted a waiver to enroll for Summer quarter of the previous plan year)
  
  Limited waivers are available from the international services office and must be requested no later than the 5th calendar day of the academic term.

- If you decide to enroll, choose who you want to cover: just you, or you and your eligible family members

- Choose to sign up for annual coverage or for one quarter. See Premium Rates below for more information.

**Making Changes**

If You Withdraw From Classes

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

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

**Cancellation**

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

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

**Adding Newly Acquired Dependents**

You may add newly acquired dependents during the quarter by contacting the university’s student insurance office. You will be required to pay a pro-rata premium based on when your newly acquired dependent is enrolled.

**Please Note:** You must enroll your newly acquired dependent within 30 days of marriage or domestic partner registration or 60 days of birth or placement for adoption.

**Domestic Partners**

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

**Adding A New Child**

A child born to or adopted by you or your spouse or domestic partner while you are enrolled will receive the same benefits as you for the first three weeks after birth or adoption only. If you want continuing coverage for your child after this, you must enroll your child in the timeframes (30 days or 60 days, depending on the situation) listed in the section called Deadlines for Adding a New Child to Your Coverage.

**PREMIUMS**

The cost of your coverage—your premium—is due at the time you enroll.
PREMIUM RATES

<table>
<thead>
<tr>
<th></th>
<th>Student Only</th>
<th>Student and Child(ren)</th>
<th>Student &amp; Spouse or Domestic Partner</th>
<th>Student, Spouse or Domestic Partner and Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single Qtr (Autumn Qtr)</strong></td>
<td>$663</td>
<td>$1,497</td>
<td>$1,653</td>
<td>$2,487</td>
</tr>
<tr>
<td><strong>Single Qtr (Spring, Winter, or Summer Qtr)</strong></td>
<td>$696</td>
<td>$1,572</td>
<td>$1,731</td>
<td>$2,607</td>
</tr>
<tr>
<td><strong>Annual at Autumn Qtr (4 quarters)</strong></td>
<td>$2,748</td>
<td>$6,216</td>
<td>$6,840</td>
<td>$10,308</td>
</tr>
<tr>
<td><strong>Annual at Winter Qtr (3 quarters)</strong></td>
<td>$2,088</td>
<td>$4,716</td>
<td>$5,193</td>
<td>$7,821</td>
</tr>
<tr>
<td><strong>Annual at Spring Qtr (2 quarters)</strong></td>
<td>$1,392</td>
<td>$3,144</td>
<td>$3,462</td>
<td>$5,214</td>
</tr>
</tbody>
</table>

An International student can purchase Summer coverage on a monthly basis for the summer prior to the school year in which they are enrolled. This provision is only allowed for international students since federal and state laws require that international students maintain adequate health insurance while attending the University of Washington.

The individual student’s coverage becomes effective on the first day of the quarter for which premium has been paid. Premium payments must be received within 14 days of the beginning of the quarter. No enrollments after the first 14 days will be allowed except in the case of a newly acquired dependent as described above. The individual student’s coverage terminates on the last day of the plan year or the end of the period for which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the insured student or extend beyond that of the insured student.

You must meet the eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 14 days after the coverage expiration date. It is the student’s responsibility to make timely renewal payments to avoid a lapse in coverage. Refunds of premiums are allowed only upon entry into the armed forces.

**WHEN COVERAGE BEGINS AND ENDS**

SHIP is a one-year plan that begins on September 20, 2013 and ends on September 19, 2014. The benefits described in this booklet are applicable during this term only.

<table>
<thead>
<tr>
<th>2013-2014 Dates of Coverage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Autumn Quarter</strong></td>
<td>September 20, 2013 – January 5, 2014</td>
</tr>
<tr>
<td><strong>Winter Quarter</strong></td>
<td>January 6, 2014 – March 30, 2014</td>
</tr>
<tr>
<td><strong>Spring Quarter</strong></td>
<td>March 31, 2014 – June 22, 2014</td>
</tr>
<tr>
<td><strong>Summer Quarter</strong></td>
<td>June 23, 2014 – September 19, 2014</td>
</tr>
</tbody>
</table>

**When Coverage Begins**

If you purchase quarterly coverage, you are covered for the dates in the quarters in which you purchase coverage, as shown in the chart.
If you purchase annual coverage, you will be covered from the date listed above for the quarter in which you purchase the annual coverage and continuing until September 19, 2014.

**If You’re In the Hospital When Coverage Would Otherwise Begin**

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

**When Coverage Ends**

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

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

**If You’re In the Hospital When Coverage Would Otherwise End (Extension of Benefits After Termination)**

If you or your covered family member is in the hospital on the termination date due to a covered injury for which benefits were paid before the termination date, covered medical expenses for that injury will continue to be paid as long as the condition continues, for up to a maximum of one year (365 days) after the termination date, subject to the maximum benefit.

**SAVE MONEY BY USING NETWORK PROVIDERS**

To help you manage the cost of health care, we have contracted with local providers and providers throughout the country to furnish covered services to you. These networks consist of hospitals and other health care facilities, physicians and professionals. Throughout this section of your booklet, you’ll find important information on how to manage your health care costs and out-of-pocket expenses through your choice of providers.

This plan’s benefits are designed to provide lower out-of-pocket expenses when you receive care from network providers. The provider networks are different depending upon where you receive care.

Throughout this booklet, the term “network provider” means a provider in the LifeWise provider network or one of the provider networks that has contracted with us to provide services under this LifeWise Assurance Company plan.

This booklet refers to the benefits payable to network providers as “network” benefits.

Throughout this booklet, “non-network provider” refers to a provider that is not in the LifeWise provider network or one of the provider networks that has contracted with us to provide services under this plan. This booklet refers to the benefits payable to non-network providers as “non-network” benefits.

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

You can get current provider information by calling our Customer Service Department at the phone number shown on the front cover of this booklet.

**HOW SELECTING A PROVIDER AFFECTS YOUR OUT-OF-POCKET EXPENSES**

You’ll always get the highest level of benefits and lowest out-of-pocket costs when you get covered services from a network provider. If the provider you see is a network provider (as defined above), the provider agrees to accept the allowable charge as payment in full. (Please see the Definitions section of this booklet for an explanation of the allowable charge.) You’re responsible only for applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies.

Your choice of a particular provider may affect your out-of-pocket costs because different providers in a network may have contracted to accept different allowable charges as payment in full even though all the contracts are with the same network. You’ll never have to pay more than your share of the allowable charge when you use network providers. See Medical Plan Highlights for information on copays, deductibles and coinsurance that you’re required to pay.

If the provider you see isn’t a network provider, you’ll get the lowest level of benefits under this plan for covered services and supplies, except as stated otherwise below. You’ll also be responsible for amounts above the...
allowable charge, in addition to applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies. Amounts in excess of the allowable charge do not count toward the calendar year deductible, if any, or as coinsurance. You may also have to pay the provider for your care and ask us for reimbursement. (To do this, please see the How Do I File A Claim? section of this booklet.)

**BENEFITS FOR NON-NETWORK PROVIDERS**

The following services and/or providers will always be covered at the highest applicable network benefit applied to the allowable charge for covered services and supplies (please see the Definitions section in this booklet):

- **Emergency care.** If you have a “medical emergency” (please see the Definitions section in this booklet), your plan provides worldwide coverage. The benefits of this plan will be provided for covered emergency services without the need for any prior authorization determination and without regard as to whether the health care provider furnishing the services is a network provider. “Emergency care” (please see the Definition section of this booklet) furnished by a non-network provider will be reimbursed on the same basis as a network provider. If you see a non-network provider, you are always responsible for any amounts that exceed the allowable charge.

- **Certain types of providers in Washington and Alaska with whom we have no agreements.** These types of providers are known as “non-contracting providers” and aren’t included in our provider directory.

- **Services associated with admission by a network provider to a network hospital that are provided by hospital-based providers.**

- **Facility and hospital-based provider services at any of our contracted hospitals if you’re admitted by a provider in the LifeWise provider network who doesn’t have admitting privileges at one of the LifeWise provider network hospitals.**

- **Covered services received from providers located outside the United States.**

**Important Note:** Services you receive in a network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are non-network providers. When you receive services from these non-network providers, you will be responsible for amounts over the allowable charge. Amounts in excess of the allowable charge don’t count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

Please see the Benefit Level Exceptions For Non-Emergent Care section for more information on how to request network benefits for services other than those listed above from non-network providers.

**CARE AWAY FROM HOME**

Benefits for covered services are provided at the network benefit level if you see a network provider anywhere in the United States. These providers will not charge you for amounts over our allowable charge, and they will submit claims directly to us.

Availability of providers may vary by location. Please call Customer Service at the phone number shown on the front cover of this booklet to find a network provider.

When you receive covered services or supplies from non-network providers, this plan will pay its non-network benefit level. The only exceptions are those shown in Benefits For Non-Network Providers above in this section. All benefits are still based on our allowable charges.

**Please Note:** See Benefits For Non-Network Providers earlier in this section for coverage if you have a medical emergency while you’re away from home.

The plan’s network and non-network benefit levels are described in Medical Plan Highlights later in this booklet.

You’re always responsible for applicable deductibles, copays, coinsurance, amounts over this plan’s benefit maximums, and charges for non-covered services and supplies. If you receive covered services or supplies from a non-network provider, you’ll also be responsible for amounts above the allowable charge. Amounts in excess of the allowable charge don’t count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

**BENEFIT LEVEL EXCEPTIONS FOR NON-EMERGENT CARE**

A benefit level exception is our decision to provide network benefits for covered services from a non-network provider.

You, your provider, or the medical facility may ask us for the benefit level exception. However, the request must
be made before you get the service or supply. If we approve the request, benefits for covered services and
supplies will be provided at the network benefit level. Payment of your claim will be based on your eligibility and
benefits available at the time you get the service or supply. You'll be responsible for amounts applied toward
applicable deductibles, copays, coinsurance, amounts that exceed benefit maximums, amounts above the
allowable charge and charges for non-covered services. If we deny the request, network benefits won't be
provided.

Please call Customer Service at the phone number shown on the front cover of this booklet to request a benefit
level exception.

UNDERSTANDING YOUR HEALTH INSURANCE COVERAGE

This section of your booklet explains the types of expenses you must pay for covered services before the benefits
of this plan are provided. To prevent unexpected out-of-pocket expenses, it’s important for you to understand
what you're responsible for. To find out the specific dollar amounts of any applicable copayments, deductible,
coinsurance and out-of-pocket maximum as well as when they apply, please see the Medical Plan Highlights
section.

Coinsurance

Coinsurance is the percentage you and the plan pay for many covered services, like visits to your doctor when
you’re sick. For example, the plan pays 75% of the allowable charge for network provider charges, and you pay
the other 25%. Since both you and the plan each pay a portion of the cost, this is called “coinsurance.” Please
note that you'll pay a lower coinsurance percentage when you use network doctors, hospitals, labs and other
providers.

When you use non-network providers (providers that don't have agreements with us), you'll also pay any
amount above the allowable charge.

Copayments

Copayments (hereafter referred to as “copays”) are fixed up-front dollar amounts that you’re required to pay.

Coinsurance Maximum

An important feature of your coverage is the "coinsurance maximum."

If the amount of money you have to pay out of your own pocket (your 25% or 40% “coinsurance”) reaches the
annual coinsurance maximum limit, you don't have to pay any more coinsurance for most covered medical
expenses for the rest of the plan year. The rest of your eligible medical expenses for that plan year are paid at
100% of the allowable charge.

Only coinsurance counts toward the coinsurance maximum. The deductible or copayments do not count toward
the coinsurance maximum, nor do any penalties or balances remaining after maximums have been met, like
amounts above allowable charges. Also, covered medical expenses for prescription drugs, outpatient
rehabilitation and neurodevelopmental therapy do not count towards the coinsurance maximum.

Deductible

A deductible is the amount of covered medical expenses you incur each quarter before this plan provides certain
benefits. The amount credited toward the deductible for any covered service or supply won’t exceed the
allowable charge (please see the Definitions section in this booklet). Copays don’t count toward the deductible.

Only one deductible will be charged per quarter, per participant, regardless of whether services are received from
network or non-network providers.

Annual Plan Maximum

The amount of benefits for services described in this booklet that are available to any one member is $500,000
per plan year. The following benefits don't accrue to an annual plan maximum:

- Benefits described in the Prescription Drugs benefit
- Benefits described in the Preventive Care benefit
## MEDICAL PLAN HIGHLIGHTS

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network Provider</th>
<th>Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit Per Condition</td>
<td>$500,000 per plan year</td>
<td></td>
</tr>
<tr>
<td>Deductible (per participant)</td>
<td>$100 per quarter; $400 per plan year maximum</td>
<td>The deductible is waived for services at the campus clinic</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Plan pays 75%**</td>
<td>Plan pays 60%*</td>
</tr>
<tr>
<td></td>
<td>You pay the other 25%**</td>
<td>You pay the other 40%*</td>
</tr>
<tr>
<td>Coinsurance Maximum (per participant per plan year)</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

### INPATIENT EXPENSES

| Inpatient Hospital/Surgical (all covered medical expenses associated with inpatient hospitalization and surgery) | You pay a $300 copay per admission, then the plan pays 75%** after deductible | You pay a $400 copay per admission, then the plan pays 60%* after deductible |

### OUTPATIENT EXPENSES

| Outpatient/Surgical (services like office visits, diagnostic x-ray, laboratory tests and rehabilitation therapy) | The plan pays 75%** after deductible | The plan pays 60%* after deductible |
| For preventive care see the Preventive Care Highlights | | |

### EMERGENCY SERVICES

| Emergency Room Services (copay is waived if admitted) | You pay a $100 copay, then the plan pays 75%** after deductible | You pay a $100 copay, then the plan pays 75%** after deductible |
| Ambulance | The plan pays 75%** after deductible | The plan pays 75%* after deductible |

### PREVENTIVE CARE HIGHLIGHTS

Benefits for preventive care that meet the federal guidelines aren't subject any deductible, copay or coinsurance when you use, or care is coordinated through, the campus clinic. If you are out of the area or the campus clinic can't provide a preventive service, then referred services provided at other network locations are covered at 100% of allowable charges. See the What's Covered section for more information.

| Preventive Care | Plan pays 75%** after deductible | Plan pays 60%* after deductible |
| Preventive Care Benefits for preventive care that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use, or care is coordinated through, the campus clinic. Please see the Preventive Care benefit for detail. | You pay the other 25%** after deductible | You pay the other 40%* after deductible |
| Preventive Care Benefits when you use, or care is coordinated through, the campus clinic You pay 0% deductible is waived | | |
**BENEFITS**

### PRESCRIPTION DRUG HIGHLIGHTS

This chart provides an overview of the plan's prescription drug benefits. The quarterly deductible is waived for covered drugs under the Prescription Drug benefit. Please note that if the drug costs less than the copay, you would only pay the price of the drug. See the What's Covered Section for details.

<table>
<thead>
<tr>
<th>Network Retail and Specialty Pharmacy</th>
<th>You pay the higher of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail pharmacy is limited up to a 30-day supply of covered medication.</td>
<td>• Generic: 20% or $20 copay</td>
</tr>
<tr>
<td>Specialty drugs provided by network Specialty Pharmacies are limited up to a 30-day supply of covered medication.</td>
<td>• Brand formulary: 30% or $30 copay</td>
</tr>
<tr>
<td>Services that meet the federal guidelines aren't subject any to deductible, copay or coinsurance when you use a network pharmacy. See the Preventive Care benefit.</td>
<td>• Non-formulary: 40% or $35 copay</td>
</tr>
<tr>
<td></td>
<td>• Specialty drugs**: 50% or $50 copay</td>
</tr>
<tr>
<td></td>
<td>Maximum copay/coinsurance of up to $150/prescription</td>
</tr>
</tbody>
</table>

**Network Retail and Specialty Pharmacy**

<table>
<thead>
<tr>
<th>Non-Network Retail Pharmacy</th>
<th>You pay the entire cost of the prescription to the pharmacy and then submit an itemized prescription receipt and claim form to us for reimbursement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan will pay 50%* up to a $150 out-of-pocket maximum per prescription.</td>
<td></td>
</tr>
</tbody>
</table>

**Non-Network Retail Pharmacy**

<table>
<thead>
<tr>
<th>Mail Order Pharmacy</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Non-network pharmacy claims are paid based on billed charges.</td>
<td></td>
</tr>
<tr>
<td>**Specialty drugs dispensed and billed by a physician are covered the same as any other outpatient expense</td>
<td></td>
</tr>
</tbody>
</table>

**How to Find a Network Pharmacy**

To find a network pharmacy, visit the Lifewise web site at [www.lifewisewa.com](http://www.lifewisewa.com) and click on Pharmacy. Click on Find a pharmacy, Enter your starting location, Click on Start, under Pharmacies, click on Search.

### ADDITIONAL EXPENSES

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>NETWORK PROVIDER</th>
<th>NON-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Plan pays 75%**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>You pay the other 25%** after deductible</td>
<td>Plan pays 75%*</td>
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</tr>
<tr>
<td>Braces, Appliances and Durable Medical Equipment</td>
<td>Paid as any other condition</td>
<td>Paid as any other condition</td>
</tr>
<tr>
<td>Diabetic Treatment and Equipment</td>
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<td>Paid as any other condition</td>
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<tr>
<td>Diabetic Supplies</td>
<td>See above Prescription Drug Expenses</td>
<td>See above Prescription Drug Expenses</td>
</tr>
<tr>
<td></td>
<td>Services that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use, or care is coordinated through, the campus clinic. See the Preventive Care benefit.</td>
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</tr>
</tbody>
</table>

**Network Provider**

**Non-Network Provider**
<table>
<thead>
<tr>
<th>Service</th>
<th>Co-payment Details</th>
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<tbody>
<tr>
<td>Home Health Care (maximum of 130 visits/plan year)</td>
<td>Paid as any other condition</td>
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<tr>
<td>Hospice (maximum of 6 months per lifetime)</td>
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<td>Infusion Therapy</td>
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<tr>
<td>Mammography</td>
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</tr>
<tr>
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<td>Paid as any other condition</td>
</tr>
<tr>
<td>Reconstructive Breast Surgery (post mastectomy)</td>
<td>Paid as any other condition</td>
</tr>
<tr>
<td>Skilled Nursing Facility (maximum of 90 days/plan year)</td>
<td>You pay a $300 copay per admission, then the plan pays 75%** after deductible</td>
</tr>
<tr>
<td>Sterilization</td>
<td>Paid as any other condition</td>
</tr>
<tr>
<td>Services that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use, or care is coordinated through, the campus clinic. See the Preventive Care benefit.</td>
<td>Paid as any other condition</td>
</tr>
<tr>
<td>Transgender Medical Treatment (maximum of $35,000/plan year)</td>
<td>Paid as any other condition</td>
</tr>
<tr>
<td>Transplant</td>
<td>Paid as any other condition</td>
</tr>
</tbody>
</table>

* Non-network benefits (non-network providers) are limited to allowable charges. In addition to your percentage of the coinsurance, you are responsible for all amounts that exceed the allowable charges.

** Of the allowable charge.

WHAT’S COVERED

PREVENTIVE CARE

What Are Preventive Services?

Preventive services are now defined as follows:

- Evidence-based items or services with a rating of “A” or “B” in the current recommendations of the U.S. Preventive Task Force (USPSTF). Also included are additional preventive care and screenings for women not described above in this paragraph as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) and Prevention.
- Evidence-informed infant, child and adolescent preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- Women’s preventive care, as defined by regulation for women’s health.

A full list of these preventive services is available on our web site or by calling Customer Service. The list also provides the guidelines on how often the services should be provided and who should receive them. Not all services recommended or billed by your doctor as part of your routine physical may comply with these guidelines. The list and guidelines are subject to change as required by law and regulation.
Benefits for preventive care that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use, or care is coordinated through, the campus clinic. If you are out of the area or the campus clinic can't provide a preventive service, then referred services provided at other network locations are covered at 100% of allowable charges. Please see the Preventive Care Highlights for how non-referred preventive care provided at other locations is covered. Non-preventive services are covered the same as any other service. Please see the Medical Plan Highlights.

Exams And Screening
Benefits include:
- Routine physical exams
- Well-baby and well-child exams
- Physical exams related to school, sports and employment
- Preventive diagnostic services
- Screening mammograms
- Healthy eating assessments and nutritional counseling.

Health Education
Examples of covered health education services are asthma education, pain management, childbirth and newborn parenting training and lactation.

Diabetes Health Education
Benefits are provided for outpatient health education and training services to manage the condition of diabetes.

Nicotine Dependency Programs
Benefits are provided for nicotine dependency programs. You pay for the cost of the program and send us proof of payment along with a reimbursement form. When we receive these items, the plan will provide benefits as stated above in this benefit. Please contact our Customer Service department for a reimbursement form.

Prescription drugs for the treatment of nicotine dependency are also covered under this plan. Please see the Prescription Drugs benefit.

Contraceptive Management
Benefits include:
- Office visits and consultations related to contraception
- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable)

Sterilization procedures
Sterilization procedures for men and women are covered as preventive. However, when sterilization is performed as the secondary procedure, associated services such as anesthesia and facility expenses will be subject to your deductible and coinsurance and will not be reimbursed under this benefit. Please see the Medical Plan Highlights.

Women's Preventive Care
Benefits include:
- Contraceptive drugs, devices and supplies
- Breast feeding counseling
- Maternity diagnostic screening (including screening for gestational diabetes)
- Counseling for sexually transmitted infections.

Breast Pumps
Standard Electric breast pumps are covered only when provided by a medical equipment supplier or a provider approved by us. Please see the definitions of Provider. Rental of hospital grade breast pumps are only covered when medically necessary.

The Preventive Care benefit doesn’t cover:
• Charges for preventive services that exceed what’s covered under this benefit
• Charges for preventive services or items that don’t meet the federal guidelines for preventive services described at the start of this benefit, except as required by law. This includes services or items provided more often than as stated in the guidelines or to patients who are not in the population targeted by the guidelines.
• Hysterectomy. (Covered on the same basis as other surgeries).
• Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit.
• Non-prescription contraceptive drugs, supplies or devices (except emergency contraceptive methods)
• Routine or other dental care
• Routine vision and hearing exams
• Physical exams for basic life or disability insurance
• Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member.
• Sterilization reversal
• Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs
• Work-related or medical disability evaluations

INPATIENT EXPENSES

After the quarterly deductible has been met and a $300 copay per admission for network hospitals or a $400 copay for non-network hospitals, these charges are covered at 75% for network providers and 60% of allowable charges for non-network providers.

Benefits include:
• Hospital room and board
• Consultant physician fees
• Miscellaneous hospital expense
• In-hospital doctor visit and medical expense
• Surgery
• Anesthetist
• Assistant surgeon
• Multiple surgical procedure expense.

Pre-Admission Testing

The plan will pay benefits for covered medical expenses made by a hospital for use of its outpatient facilities for tests ordered by a physician. The tests must be performed as a planned preliminary to your admission as an inpatient for surgery in that same hospital. However:
• The test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed
• Reservations for a hospital bed and for an operating room must be made prior to the date the tests are done
• The surgery actually takes place within seven days of pre-surgical tests; and
• You are physically present at the hospital for the tests.

The plan covers these charges the same as covered medical expenses for any other condition.

OUTPATIENT EXPENSES

After the quarterly deductible has been met, these charges are covered at 75% for network providers and 60% of allowable charges for non-network providers.

Benefits include:
• Doctor’s office visit (while not confined in a hospital)
• Hospital outpatient department and other services
• Emergency room, is subject to a copayment of $25 per visit which will be waived if the insured person is
admitted to the Hospital

- Diagnostic x-ray and laboratory tests (when X-rays or laboratory tests are performed at the campus clinic but referred to and/or billed from non-campus clinic providers, the applicable coinsurance and deductible will apply)
- Clinical lab
- Radiological lab or other similar facility licensed by the state
- An Ambulatory Surgical Center for covered surgery
- Anesthetist
- Assistant surgeon
- Consultant physician fees
- Surgery
- Multiple surgical procedure expense
- Blood-borne pathogen protocol
- Rehabilitation Therapy -- means medically necessary treatments provided to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies. Services must be furnished and billed by a hospital, rehabilitation facility, physician, physical, occupational, or speech therapist, chiropractor, or massage therapist. Services must be referred by the attending physician. After 12 visits a medical review will be performed to ensure additional sessions are medically necessary.
- Home phototherapy: the services and supplies furnished by an approved home phototherapy provider will be covered for newborn hyperbilirubinemia
- Radiation therapy, kidney dialysis, inhalation therapy
- Chemotherapy
- Surgical dressings, splints, casts, and other devices used to correct fractures and dislocations.

Please Note: Even if you are not charged for services provided at the campus clinic, when x-rays and laboratory tests are performed at the campus clinic and are referred to and/or billed from a lab other than the campus clinic lab, the deductible and applicable coinsurance apply.

PRESCRIPTION DRUGS

Prescription drugs are covered as described in the Prescription Drugs Highlights. They are only covered when prescribed by a physician. Prescriptions are filled or refilled up to a 30-day supply for each medication, once per month. 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

Also covered under this benefit are injectable supplies.

The following limitations apply:

The plan only covers drugs that are approved by the Food and Drug Administration. A drug is covered if prescribed for a treatment of a covered service for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:
- American Medical Association Drug Evaluations
- American Hospital Formulary Service Drug Information
- United States Pharmacopoeia Drug Information, or
- It is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

However, covered medical expenses do not include experimental or investigational drugs or any drug that the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

Services that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use a
network pharmacy. See the Preventive Care benefit.

**Network Retail And Specialty Pharmacy**

You pay the higher of:
- Generic ................................................................. 20% or $20 copay
- Brand Name........................................................... 30% or $30 copay
- Non-Formulary......................................................... 40% or $35 copay
- Specialty Drugs....................................................... 50% or $50 copay

Maximum copay/coinsurance of up to $150 per prescription. Please note that if the drug costs less than the copay, you would only pay the price of the drug.

For pharmacy purchases at network retail and specialty pharmacies, you don't have to send us a claim. Just show your LifeWise Assurance ID card to the pharmacist, who will bill us directly. If you don't show your ID card, you must pay the entire cost of the prescription to the pharmacy and then submit an itemized prescription receipt and claim form to us for reimbursement. The address of where to send the form is located on the claim form.

Services that meet the federal guidelines aren't subject to any deductible, copay or coinsurance when you use a network pharmacy. See the Preventive Care benefit.

**Non-Network Retail Pharmacy**

The participant must pay the entire cost of the prescription to the pharmacy and then submit an itemized prescription receipt and claim form to us for reimbursement. The address of where to send the form is located on the claim form.

The plan will pay 50% of the billed charge up to a $150 out-of-pocket maximum per prescription.

**Mail-Order Pharmacy**

Medication received by any mail-order pharmacy are not covered.

**Preventive Care Prescription Drugs**

Benefits for certain preventive care prescription drugs will be provided at 100% of the allowable charge when received from participating pharmacies. Contact Customer Service or visit our web site to inquire about whether a drug is on our preventive care list.

**Specialty Drugs**

“Specialty drugs” are drugs that are used to treat complex or rare conditions and that require special handling, storage, administration or patient monitoring. They are high cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis, multiple sclerosis, or growth disorders (excluding idiopathic short stature without growth hormone deficiency). Please go to our web site, or contact Customer Service for a specialty drug list. Specialty drugs dispensed and billed by a physician are covered the same as any other outpatient expense.

**ADDITIONAL EXPENSES**

**Abortion**

The plan covers these charges at 75% for network providers and 75% of allowable charges for non-network providers.

**Braces, Appliances And Durable Medical Equipment**

If, by reason of injury or sickness, you require the use of durable medical equipment or braces and appliances, the plan will pay you the covered percentage of covered medical expenses incurred, subject to the deductible shown in the Medical Plan Highlights, if all of the following are true:

- Ordered by a physician
- Is designed for repeated use
- Is mainly and customarily used for medical purposes
- Is not generally of use to a person in the absence of a disease or injury
- Is usable only by the patient
- Is not primarily for the comfort or hygiene of the patient; and
Not for prevention purposes or exercise.

The plan pays the covered percentage of your covered medical expenses for the rental of braces, appliances and durable medical equipment at 60% of allowable charges for non-network providers up to an amount equivalent to the purchase price. (There are no network providers for this service.) Replacement of braces, appliances or durable medical equipment or for batteries is not covered. (Examples of covered items: wheelchair, breathing machine, brace, crutch, splints, and casts. Examples of non-covered items include but are not limited to: air conditioners, humidifiers, spas or whirlpool baths, orthopedic shoes, adjustable beds, orthopedic chairs, communication devices, heating pads, bed wetting devices, deluxe items or personal hygiene items.)

**Diabetes Treatment**

The plan covers charges for the following appropriate and medically necessary equipment and supplies for the care and treatment of diabetes, if recommended or prescribed by a Physician. Coverage includes, but is not limited to: insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescription oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes and glucagon emergency kits. The plan also covers charges for covered medical expenses incurred for outpatient diabetes self-management training and education the same as for any other condition, including medical nutrition therapy, as ordered by a Physician and provided by an approved provider with expertise in diabetes.

The plan treats charges for equipment the same way covered medical expenses are treated for any other condition. Charges for supplies are treated the same as covered medical expenses for Prescriptions if acquired at a pharmacy as shown in the Prescription Drug Highlights. Benefits are subject to all deductible, coinsurance, limitations and any provisions of the plan, except as required by law. Please see the Preventive Care benefit for further detail.

**Home Health Care And Hospice Care**

Benefits will be provided on the same basis as any other sickness or injury for home health care and hospice care for you if you were homebound and would otherwise require hospitalization. Benefits will consist of services rendered by home health and hospice agencies licensed by the Department of Social and Health Services when recommended by a Physician.

Home health care coverage will provide benefits for a maximum of 130 health care visits per plan year. Hospice care coverage will provide benefits for terminally ill patients for a period of care of not more than six months. Limited extensions will be granted if you are facing imminent death as certified in writing by the attending physician.

Benefits are subject to all deductible, coinsurance, limitations and any provisions of the plan.

**Infusion Therapy**

The plan will cover charges for services and supplies provided for infusion therapy when furnished by an approved infusion therapy provider. Drugs and supplies used in conjunction with infusion therapy will be provided only under this infusion therapy benefit. No other benefits for infusion therapy will be provided under this plan. The plan covers these charges the same way covered medical expenses are treated for any other condition.

**Mammography**

The plan covers charges for screening and diagnostic mammography services when recommended by your Physician or advanced registered nurse practitioner or physician assistant. These charges are covered the same way covered medical expenses are treated for any other condition. Benefits are subject to all deductibles, coinsurance, benefit maximums, limitations and all other provisions of the plan, except as required by law. Please see the Preventive Care benefit for further detail.

**Reconstructive Breast Surgery**

Benefits will be paid for reconstructive breast surgery (including prosthesis) resulting from a mastectomy which resulted from disease, illness, or injury; regardless of when the mastectomy or the condition that made the mastectomy necessary was covered by this plan. Benefits will be paid for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size to the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. Benefits for Reconstructive Breast Surgery are covered the same as the hospital and surgical benefits otherwise provided by this plan. Benefits will be limited by any
maximum amounts, any deductible, copayment, coinsurance, limitations or other provisions of the plan.

**Skilled Nursing Facility**

If you require continuing treatment in a skilled nursing facility or a rehabilitation center following hospitalization, the plan will pay the covered percentage of your covered medical expenses for treatment in a skilled nursing facility or rehabilitation center. The plan covers room and board, routine nursing care and other services and supplies during the confinement including physical therapy, speech therapy and occupational therapy. The services must be Medically Necessary as a continuation of treatment for the condition for which you were previously hospitalized. You must be admitted to the skilled nursing facility or rehabilitation center within 24 hours following a medically necessary hospital stay.

After the quarterly deductible has been met and a $300 copay per admission for network facilities or a $400 copay for non-network hospitals, these charges are covered at 75% for network providers and 60% of allowable charges for non-network providers up to a combined maximum of 90 days per plan year for network and non-network services.

**Sterilization**

The plan covers charges for sterilization procedures. But, the plan does not cover charges for the reversal of a sterilization procedure. Services that meet the federal guidelines aren't subject any deductible, copay or coinsurance when you use, or care is coordinated through, the campus clinic. See the Preventive Care benefit.

**Transgender Medical Treatment**

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. Surgical services are covered up to a maximum $35,000 per plan year. All claims billed with transgender surgical codes apply toward the $35,000 benefit limit. However, any non-network coinsurance billed with transgender treatment codes accrue toward the $3,000 network coinsurance maximum.

**Transgender Surgical Services Criteria**

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

**Surgical Procedures**

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

**Breast Surgery**

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

**Genital Surgery**

For genital surgery all the following criteria must be met:

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

**Obtaining a Benefit Advisory**

To be advised about your eligibility to receive covered Transgender Medical Treatment, you may submit a Benefit Advisory request to LifeWise Assurance Company. The Benefit Advisory 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.

Your physician can fax this information to 800-866-4198 or mail it to:

LifeWise Assurance Company
Attn: Integrated Health Management (IHM)
P.O. Box 91059
Seattle, WA 98111-9159

Transplants

The plan covers charges the same as for any other condition for Medically Necessary services and supplies after meeting the pre-existing condition requirements relating to the following eligible organ transplants:

• Heart
• Heart/lung combined
• Kidney
• Kidney/pancreas
• Lungs – single/bilateral
• Liver
• Cornea
• Bone marrow or other form of stem cell rescue.

The plan does not cover any donor expenses.

EMERGENCY MEDICAL EVACUATION AND REPATRIATION OF REMAINS

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

Emergency Medical Evacuation

The plan will pay 100% of the actual expense up to a lifetime maximum of $10,000 to transport you to your home country or country of regular domicile. Evacuation must be recommended and approved by the attending physician. Emergency Medical Evacuation means after being treated at a local Hospital, your medical condition warrants transportation to your home country to obtain further medical treatment to recover. Covered Expenses are Expenses up to the maximum for transportation, medical services and medical supplies necessarily incurred in connection with your Emergency Medical Evacuation. All transportation arrangements made for your evacuation must be:

• By the most direct and economical conveyance
• Approved in advance by us.

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

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

Repatriation Of Remains

In the event of your death, the plan will pay the actual charges for preparing and transporting your remains to your home country up to a maximum of $7,500. This will be done in accord with all legal requirements in effect at the time your remains are to be returned to your home.

PRE-EXISTING CONDITION LIMITATION

This plan has a waiting period for pre-existing conditions for members who are 19 or older. A pre-existing condition is a medical condition that existed prior to the beginning of your coverage. It is defined as:

• The existence of symptoms within the 3 months immediately prior to your effective date under the plan, or
• Any condition that is diagnosed, treated or recommended for treatment within the 3 months immediately prior to your effective date.
Pre-existing conditions will not be covered for the first three months of coverage under the plan, unless you were insured under another similar health coverage for at least three months immediately before becoming insured under this coverage.

Credit will be given for the period of time you were covered under the immediately preceding health coverage if it was less than three months.

The pre-existing condition limitation may not apply in full or in part if you had "creditable coverage" (coverage under another similar health coverage) in the 3 months prior to your effective date of coverage in this coverage.

Any lapse in coverage means you will have to satisfy the pre-existing condition waiting period again. For example, if you do not enroll for a quarter, then re-enroll the following quarter, the pre-existing condition waiting period will have to be satisfied again.

If a claim was paid that was related to a pre-existing condition, payment will not constitute a waiver of this exclusion for that claim or for any subsequent claim if it is later determined that the condition was pre-existing.

How Waiting Periods Can Be Shortened Or Waived

This plan’s waiting period for pre-existing conditions may be reduced by periods of creditable coverage accrued under other health care plans prior to the effective date for this plan. Most medical health care coverage is considered creditable (see list below).

Credit will be given for prior creditable coverage that occurred without a break in coverage of more than 3 months. Any coverage before a break in coverage which exceeds 3 months won't be credited toward the waiting periods. Eligibility waiting periods won't be considered creditable coverage or a break in coverage.

Your prior employer or health insurance carrier will provide a certificate of health coverage that includes information about the prior health coverage. If you haven’t received a certificate, or have misplaced it, you have the right to request one from a prior employer or health carrier within 24 months of the date your coverage under that plan terminated. If you can’t get a certificate, please call Customer Service, because other kinds of proof of prior coverage are also acceptable.

Creditable coverage shall mean coverage under one or more of the following types of health care coverage:

- Group health coverage (including self-funded plans and COBRA)
- Individual health coverage
- Part A or B of Medicare
- Medicaid
- Military health coverage
- Indian Health Service or tribal coverage
- State high risk pool
- Federal or any public health care plan, including state children’s health care plans
- Peace Corps Plan
- Government health coverage provided for citizens or residents of a foreign country
- Any other health insurance coverage.

Creditable coverage doesn't include coverage under a limited plan such as an accident only coverage; disability income insurance; workers’ compensation; limited scope dental or vision plans; liability insurance; automobile medical insurance; specified disease coverage; Medicare supplemental plan; or long-term care policy.

Exceptions

The pre-existing condition exclusion does not apply to any of the following:

- Abortion
- Pregnancy, including complications, if such condition is covered under this plan

Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information. (Genetic testing is not covered under the plan.)

If a claim was paid that was related to a pre-existing condition, payment will not constitute a waiver of this exclusion for that claim or for any subsequent claim if we later determine that the condition was pre-existing.
WHAT’S NOT COVERED – EXCLUSIONS AND LIMITATIONS

Here is a list of services the plan does not cover. No Benefits will be paid for services or supplies for treatment for or related to, contributed to, or resulting from the following:

- Acupuncture services, supplies and/or treatment
- Bungee jumping or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline
- Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this plan or for newborn or adopted children
- Counseling, educational or training services
  - Community wellness classes and programs that promote positive health and lifestyle choices. Examples of these classes and programs are adult, child, and infant CPR, safety, babysitting skills, back pain prevention, stress management, bicycle safety and parenting skills, except for services that meet the standards for preventive medical services in the Preventive Care benefit.
  - Counseling, education or training services, except as stated under the Alcoholism/Chemical Dependency Treatment rider, Diabetes Treatment benefit, Mental Health rider, or for services that meet the standards for preventive medical services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling; and caffeine dependency. Also not covered is family and marital psychotherapy, except when medically necessary to treat the diagnosed mental or substance use disorder or disorders of a member.
  - Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child’s language, cognitive, motor or social skills, including evaluations thereof. However, this exclusion doesn’t apply to treatment of neurodevelopmental disabilities in children age 6 and under as stated under the Neurodevelopmental Therapy rider.
  - Nonmedical services, such as spiritual, bereavement, legal or financial counseling
  - Recreational, vocational, or educational therapy; exercise or maintenance-level programs
  - Social or cultural therapy
  - Gym or swim therapy
  - Custodial care: care provided in rest homes, health resorts, homes for the aged, halfway houses or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care
  - Experimental Or Investigational Services. Any service or supply that LifeWise Assurance Company determines is experimental or investigational on the date it’s furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of Experimental Services Or Supplies (please see the “Definitions” section in this booklet). This exclusion does not apply to certain experimental or investigational services provided as part of clinical trials. Benefit determination is based on the criteria specified in the definition of “Clinical Trials” in the definitions section in this booklet.
  - Genetic testing
  - Hearing examinations or hearing aids; or other treatment for hearing defects and problems. “Hearing defects” means any physical defect of the ear that does or can impair normal hearing, apart from the disease process
  - Human growth hormone
  - Preventive medicines, except as required by law
  - Injury or sickness for which benefits are paid or payable under any Workers’ Compensation or Occupational Disease Law or Act, or similar legislation
  - Injury sustained while participating in any intercollegiate sport, contest or competition; traveling to or from such sport, contest or competition as a participant; or while participating in any practice or conditioning program for such sport, contest or competition
  - Learning disabilities (excluding ADD/ADHD) and behavioral problems, services and supplies
  - Marital and family counseling
  - Naturopathic services
  - On-Line Or Telephone Consultations. Electronic, on-line, internet or telephone medical consultations or evaluations. except for crisis/emergency evaluations, or when the member is temporarily confined to bed for
medical reasons; telehealth services that do not utilize real-time video or audio services.

- Orthotics (except for diabetes treatment)
- Over-the-counter drugs and take-home medications, except as required by law
- Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting
- Prescription drug, services or supplies as follows:
  - Products used for cosmetic purposes
  - Drugs labeled “Caution – limited by federal law for investigational use” or experimental drugs
  - Drugs used to treat or cure baldness
  - Anabolic steroids used for body building
  - Anorectics – drugs used for the purpose of weight control
  - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene or Viagra
  - Growth hormones
  - Refills in excess of the number specified or dispensed after one (1) year of the date of the prescription.
  - Prosthetic appliances and orthotic devices, except as specifically provided in the plan or as required by law
  - Reproductive/infertility services including but not limited to: fertility tests; infertility for male/female including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; impotence, organic or otherwise; reversal of sterilization procedures.
  - Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study
  - Routine or preventive care that doesn't meet the federal guidelines for preventive services described in the Preventive Care benefit. This includes services or items provided more often than stated in the guidelines. Routine or palliative foot care, including hygienic care; impression casting for foot prosthetics or appliances and prescriptions thereof; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. However, foot-support supplies, devices and shoes are covered for the treatment of diabetes.
  - Sexual dysfunction–Services, surgery or related expenses or supplies
  - Services and/or supplies that are not medically necessary
  - Services or supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.
  - Services provided normally without charge by the health service of the policyholder or services covered or provided by the student health fee
  - Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, temporomandibular joint dysfunction
  - Treatment in a governmental Hospital unless there is a legal obligation for the participant to pay for such treatment
  - War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered)
  - Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, surgery or treatment for obesity, surgery for removal of excess skin or fat.
CLAIMS
When You Need To File A Claim

Many providers will submit their bills to us directly. However, if you ever need to submit a claim to us yourself, follow these simple steps.

How To File A Claim

- Print a claim form from our website, pick one up at the campus clinic, or you can also contact Customer Service.
- Complete the claim form using the information on the itemized bill from the provider
- Send the claim form and the itemized bill to us. (Keep copies of the itemized bills for your records.)
- You should receive reimbursement for the covered percentage of the services you received.

Claims must be submitted within 120 days. Failure to give sufficient proof of your claim (for instance, itemized receipts with claim details) within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event later than one year.

YOUR IDEAS, QUESTIONS, 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.

We offer the assistance of language translation services. If you need an interpreter to help, 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 address and telephone number found on the front cover of this booklet.

When You Have Questions

Please call Customer Service with any questions you may have regarding your health plan. We suggest that you call your provider of care when you have questions about the health care services 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 Disagree With a Benefit Decision

If we declined to provide 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 requirements as necessary under state and federal laws and regulations.

What is an adverse benefit determination?

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment for a benefit, in whole or in part for services based on:
- An individual’s eligibility to participate in a plan or health insurance coverage, or rescission of coverage;
- A determination that a benefit is not a covered benefit;
- A preexisting condition exclusion, or other limitation on otherwise covered benefits;
• A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

**When You Have An Appeal**

After you are notified of an adverse benefit determination, you can request an internal appeal. Your internal appeal will be reviewed by individuals who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be provided by a health care provider. They will review all of the information relevant to your appeal and will provide a written determination.

**Who may file an internal appeal?**

You or your authorized representative, someone you have named to act on your behalf, may file an appeal. To appoint an authorized representative, you must sign an authorization form and mail or fax the signed form to the address or phone number listed below. This release provides us with the authorization for this person to appeal on your behalf and allows our release of information, if any, to them.

Please call us for an Authorization For Appeals form. You can also print a copy of the form by going to our web site at student.lifewiseac.com.

**How do I file an internal appeal?**

You or your authorized representative may file an appeal by calling Customer Service or by writing to us at the address listed below. We must receive your appeal request within 180 calendar days of the date you were notified of the adverse benefit determination.

You can mail your written appeal request to:

LifeWise Assurance Company  
Attn: Appeals Department, MS 123  
P.O. Box 91102  
Seattle, WA 98111-9202

Or, you may fax your request to:

Appeals Department  
(425) 918-5592

If you need help with filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed on the front of this booklet. You can also get a description of the appeals process by visiting our web page at student.lifewiseac.com.

We will acknowledge our receipt of your request in writing.

**What if my situation is clinically urgent?**

If your provider believes that your situation is clinically urgent under law, your appeal will be conducted on an expedited basis. A clinically urgent situation means one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. You may request an expedited internal appeal by calling Customer Service at the number listed on the front of this booklet.

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

**Can I provide additional information for my appeal?**

You may supply additional information to support your appeal at the time you file an appeal or at a later date by mailing or faxing to the address and fax number listed above. Please provide us with this information as soon possible.

**Can I request copies of information relevant to my claim?**

You can request copies of information relevant to the adverse benefit determination. We will provide this information, as well as any new or additional information we considered, relied upon or generated in connection to your appeal as soon as possible and free of charge. You will have the opportunity to review this information and respond to us before we make our decision.
What happens next?

We will review your appeal and provide you with a written decision as stated below:

- Expedited appeals, as soon as possible, but no later than 72 hours after we received your request. We will call, fax or email and will follow up with a decision in writing.
- All other appeals, within 14 days of the date we received your request. If we need additional time to review your request, we may extend the review to no more than 30 days.

If we uphold the initial decision, you will be provided information about your right to an external review.

Appeals Regarding Ongoing Care

If you do not agree with our decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer medically necessary or appropriate, you may appeal this decision. After receipt of your appeal, we will suspend our denial of benefits during the appeal period. Our provision of benefits for services received during the appeal period does not, and should not be construed to, reverse our denial. If our initial decision is upheld, you must repay us all amounts that we paid for such services. You may also be responsible for any difference between our allowable charge and the provider's billed charge.

When Am I Eligible for External Review?

If you are not satisfied with the final internal adverse benefit determination based on medical necessity, experimental or investigational care, appropriateness, health care setting, level of care or effectiveness of a covered benefit, you have the right to have our decision reviewed by an Independent Review Organization (IRO). An IRO is an independent organization of qualified 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 notifying you of your right to an external review. We must receive your written request for an external review no later than 4 months from the date you received the final internal adverse benefit determination. 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 request an expedited external review when your provider believes that your situation is clinically urgent under law. Please call Customer Service at the number listed on the front of this booklet to request an expedited external review.

We will notify the IRO of your request for an external review. The IRO will let you, your authorized representative and/or your attending physician know where additional information may be submitted directly to the IRO and when the information must be provided. We will forward your medical records and other relevant materials for your external review to the IRO. We will also provide the IRO with any additional information they request that is reasonably available to us.

How will I know when the IRO has completed the external review?

Once the external review is completed, the IRO will notify you and us in writing of their decision as stated below:

- Expedited external review, 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 external reviews, within 15 days after receiving all necessary information, or 20 days after receiving the referral, whichever is earlier.

What happens next?

LifeWise is bound by the decision made by the IRO. If the IRO overturned our final internal adverse benefit determination, 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 internal appeals or external review process. However, you may have other remedies available under state or federal law, such as filing a lawsuit.

Other resources for help

If you have questions about a claim or your appeal rights, you can contact LifeWise customer service for assistance at the number listed on the front of this booklet. If you are not satisfied with our decisions and wish to make a complaint or need help filing an appeal or external review, 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
Call: 1-800-562-6900
Email: cap@oic.wa.gov

OTHER INFORMATION ABOUT MY PLAN

This section tells you about how this plan is administered. It also includes information about federal and state requirements we must follow and other information we must provide to you.

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 this contract or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict this 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 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 Assurance Company 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 the company.

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 health care providers. No benefits will be available if the proof isn't provided or acceptable to us.

EXCESS PROVISION

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

This plan pays secondary when you also have other valid and collectible insurance that are:

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

This plan pays secondary when you also have other valid and collectible insurance that are:

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

REPRESENTATIONS
A copy of the eligible student’s enrollment form, if any, can be obtained upon request. All statements made by an insured person are deemed representations and not warranties (except in the case of fraud), and no statement made by an individual insured person shall be used in any contest unless a copy of the statement has been furnished to them.

MATERIAL MISREPRESENTATIONS
If this plan’s benefits are paid in error due to an insured person's or provider's commission of fraud or providing any material misrepresentation, we'll be entitled to recover these amounts. Please see the Right Of Recovery provision later in this section.

And, if an insured person commits fraud or makes any material misrepresentation on any enrollment form that affects the insured person's acceptability for coverage, we may, at our option:
• Deny the insured person's claim
• Reduce the amount of benefits provided for the insured person's claim
• Void the insured person'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 form required by us, that affect the risks to be assumed by us, may cause the University of Washington contract for this plan to be voided.

Please Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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, health care providers, insurance companies, or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:
• Underwriting and determining your eligibility for benefits and paying claims
• Coordinating benefits with other health care plans
• Conducting quality reviews
• Fulfilling other legal obligations that are specified under the 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.

NOTICES
Any notice we’re required to submit to the university or insured person will be considered to be delivered if it’s mailed to 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 the university 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.

**SUBROGATION**

The plan shall be subrogated to all rights of recovery which any participant has against any person, firm or corporation to the extent of payments for benefits made by the plan to or for benefits of a participant. The participant (you) shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the plan. The plan shall recover only that portion paid by the plan which is in excess of the amount necessary to fully compensate the participant (you) for all expenses incurred as a result of your loss. The participant (you) shall be permitted to recoup his/her general damages which is not limited to medical expenses, from the tort-feasor before subrogation provided that in so doing, the participant (you) does not prejudice the rights of the plan.

**RIGHT OF RECOVERY**

Payments made by the plan which exceed the covered medical expenses (after allowance for deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the plan from or among any persons, firms or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered injury or sickness as their liability may appear.

**RIGHT TO AND PAYMENT OF BENEFITS**

Benefits of this plan are available only to insured persons. Except as required by law, we won’t honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, insured persons 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 to:

- The insured
- A provider
- Another health insurance carrier
- The insured student’s covered dependents, if dependents are covered
- Another party legally entitled under federal or state medical child support laws, if dependent children are covered
- Jointly to any of the above

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

**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.

**VENUE**

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

- Within 3 years of the date we denied, in writing, the rights or benefits claimed under this contract, or of the completion date of the independent review process if applicable
- In the state of Washington

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.

**YOUR 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.

**DEFINITIONS**

**AFFORDABLE CARE ACT**

The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care
ALLOWABLE CHARGE

The allowable charge shall mean one of the following:

Network Providers:
The allowable charge is the amount that these providers have agreed to accept as payment in full for medically necessary covered services under the terms of their network contracts.

Network providers agree not to bill you for any charges above the amount agreed upon by the provider, except for any cost-shares, amounts in excess of stated benefit maximums, and charges for noncovered services for which you are responsible.

Your cost-shares and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.

Non-Network Providers:
When you receive services from non-network providers, the allowable charge shall be the lesser of the provider's billed charge, or one of the following:

- For covered services received in Washington, Alaska or Oregon:
  
  **Services From Professional Providers:** The allowable charge is derived from Lifewise's standard fee schedule used for negotiations with network physicians. This standard fee schedule is developed using Medicare Relative Value Units (RVUs) multiplied by a conversion factor. For some services, our allowable charge is a percentage of Medicare’s allowable or the Solvay Average Wholesale Price. The conversion factor and the percentage of Medicare incorporate information including, but not limited to, trends in Medicare RVUs, geographic differences in provider costs, and overall medical price inflation.

  **Services From Ambulatory Surgical Centers:** The allowable charge will be based on the weighted average of rates that we have negotiated with our network ambulatory surgical centers.

  **Services From Hospitals (Acute Facilities):** The allowable charge will be equivalent, on a weighted average basis, to similar services received from contracted hospitals. In making this determination, we review claims experience from our network hospitals. As charges, services and patients' severities vary from hospital to hospital, we apply a "case mix and severity" adjustment to neutralize these differences, using weights which have been developed for this purpose. These weights are from external independent sources.

  **Services From Skilled Nursing Facilities, Extended Care Facilities, Birthing Centers, Kidney Dialysis Centers, Rehabilitation Facilities, And Others Sub-Acute Facilities** The allowable charge will either be based on our standard fee schedule for network facilities of that type, a percentage of the billed charge or on the weighted average of rates we have negotiated with network providers of the same type.

- For services received outside Washington, Alaska and Oregon

  The allowable charge will be the lesser of the provider’s billed charge or what Medicare would have allowed for the same services."

  When you receive services from non-network providers, you’re responsible for any amount above the allowable charge, and for any cost-shares, amounts in excess of stated maximums, and charges for non-covered services.

We reserve the right to determine the amount allowed for any given service or supply.

CHILDREN

Your children, step-children, children for whom responsibility was assumed through domestic partner registration, foster children, adopted children from the date of placement in your home and who depend on the participant for their support, children which you have been granted legal custody, and children which you have legal obligation to provide coverage due to a court order.

When a court ordered guardianship or foster care terminates or expires, the child is no longer an eligible child. Court ordered guardianship and foster care expires at the child’s age of majority.

The attainment of the limiting age of 26 will not operate to terminate the coverage of such child while the child is and continues to be both:

- Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and,
- Chiefly dependent upon you for support and maintenance.
COINSURANCE
See Understanding Your Health Insurance Plan.

CONTRACTED PROVIDERS
See Network Providers.

COPAYMENT
The specified dollar amount you must pay for specified charges. The copayment is separate from and not a part of the deductible or coinsurance.

COVERED CHARGE OR COVERED MEDICAL EXPENSE
Are reasonable charges that are:
• Not in excess of the allowable charge
• Not in excess of the maximum benefit amount payable per service as specified
• Made for services and supplies not excluded under the plan
• Made for services and supplies which are a Medical Necessity
• Made for services included in the plan
• In excess of the amount stated as a deductible, if any.

COVERED MEDICAL EXPENSES
Will be considered “incurred” only:
• When the covered services are provided; and
• When a charge is made to you for such services.

COVERED PERCENTAGE
The part of a covered charge that is payable by the plan after the deductible or copayment has been met.

CUSTODIAL CARE
Any portion of a service, procedure or supply that is provided primarily:
• For ongoing maintenance of your health and not for its therapeutic value in the treatment of an illness or injury
• To assist you in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

DEDUCTIBLE
An amount to be subtracted from the amount or amounts otherwise payable as covered medical expenses before payment of any benefit is made. The deductible will apply per quarter as specified in the plan.

DOCTOR
See Physician.

DOMESTIC PARTNER
Domestic partners who have registered with the Washington state domestic partner registry or the registry of another jurisdiction.

EMERGENCY CARE
A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department.

Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities or, if necessary, to make an appropriate transfer to another medical facility. “Stabilize” means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.
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 SERVICES OR SUPPLIES

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria as determined by us:

- A drug or device that can’t be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn’t been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet the standards set in the definition of "Clinical Trials" below in this section will not be deemed experimental or investigational.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes but is not limited to reports and articles published in authoritative peer reviewed medical and scientific literature as determined by LifeWise Assurance Company.

FORMULARY/NON-FORMULARY

A formulary prescription included on the approved list of drugs most commonly utilized by Lifewise’s network pharmacies. A non-formulary prescription is not included on this list, and would need to be special-ordered.

HOSPITAL

A licensed or properly accredited general hospital which:

- Is open at all times
- Is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients
- Is under the supervision of a staff of one or more legally qualified physicians available at all times
- Continuously provides on the premises 24-hour nursing service by Registered Nurses
- Provides organized facilities for diagnosis and major surgery on the premises, and
- Is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating mental disorders.

INJURY

A Bodily injury that is:

- Directly and independently caused by specific accidental contact with another body or object
- Unrelated to any pathological, functional, or structural disorder
- A source of loss
- Treated by a Physician within one year after the date of accident, and
- Sustained while you are covered under this plan.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered medical expenses incurred as a result of an injury that occurred prior to this plan’s effective date will be considered a sickness under this plan.
INSURED
A student of the university who is eligible and insured for coverage under this plan.

INSURED PERSON
An insured student and his or her covered dependent(s), if dependents are covered under this plan, while insured under this plan.

INTERNATIONAL STUDENT
A student classified as a Non-Immigrant. For example, students holding visa types: “F” (Student), “J” (Exchange Visitor), “B” (Tourist), or “A” (Diplomat).

LOSS
A medical expense covered by this plan as a result of injury or sickness as defined in this plan.

MAXIMUM PER CONDITION
The total amount of benefits payable for each injury or sickness under this plan.

MEDICAL EMERGENCY
A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

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

MEDICALLY NECESSARY
Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

• In accordance with generally accepted standards of medical practice;
• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
• Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to 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 generally 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.

NETWORK PROVIDERS
Healthcare providers that have a contractual arrangement with LifeWise Assurance Company.

NON-NETWORK PROVIDERS
Healthcare providers that do not have a contractual arrangement with LifeWise Assurance Company.

CLINICAL TRIALS
Treatment that is part of a scientific study of therapy or intervention in the treatment of a disease, syndrome or condition being conducted at-phases 1, 2, 3 or 4 level in a national clinical trial sponsored by a national body; for example, the National Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

The clinical trial must also be to treat a condition that is either life-threatening or severely and chronically disabling, has a poor chance of a positive outcome using current treatment, and the treatment subject to the
clinical trial has shown promise of being effective.

A “clinical trial” does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
- Services, supplies or pharmaceuticals that would not be charged to the member, were there no coverage.
- Services provided in a clinical trial that are fully funded by another source

The member for whom benefits are requested must be enrolled in the trial at the time of treatment for which coverage is being requested. We encourage you, your provider, or the medical facility to ask us for a benefit advisory to determine coverage before you enroll in the clinical trial.

PARTICIPANTS

An insured student and his or her covered dependent(s) eligible for and enrolled in this plan.

PHYSICIAN

A legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license.

PLAN YEAR

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

PRE-EXISTING CONDITION

- The existence of symptoms within the 3 months immediately prior to your effective date under the plan, or
- Any condition that is diagnosed, treated or recommended for treatment within the three months immediately prior to your effective date under the plan.

PRESCRIPTION DRUGS

Prescription drugs include the following:

- Prescription legend drugs
- Compound medications when at least one ingredient is a prescription legend drug
- Any drugs which may dispensed under federal law by written prescription
- Injectable insulin.

PROVIDER

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 physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Denturist
- Midwife
- Optometrist (O.D.)
- Physician Assistant
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)

Care must be provided to an insured person, other than a member of the Physician’s immediate family. The term “member of the immediate family” means any person related to an insured person’s within the third degree by the laws of consanguinity or affinity.
SICKNESS
A sickness, illness or disease that causes loss, and originates while the insured person is covered under this plan. All related conditions and recurrent symptoms of the same or similar condition will be considered one sickness. Covered medical expenses incurred as a result of an Injury that occurred prior to this plan’s effective date will be considered a sickness under this plan.

SKILLED CARE
Care that’s ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

STUDENT PARTICIPANT
A student of the Bothell campus of the University of Washington who is eligible and insured for coverage under this plan.

US, OUR, THE COMPANY
LifeWise Assurance Company

YOU, YOUR OR YOURS
Means the insured person.
ALCOHOLISM/CHEMICAL DEPENDENCY TREATMENT RIDER

BENEFIT HIGHLIGHTS

The Alcoholism/Chemical Dependency Treatment Rider covers medically necessary inpatient and outpatient services. Benefits are subject to all deductibles, copayment, coinsurance, limitations, or any other provisions of the plan, including but not limited to the maximum benefit of $500,000 per plan year.

This chart provides an overview of benefits.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>NETWORK PROVIDER</th>
<th>NON-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Alcoholism/Chemical Dependency Treatment</td>
<td>$300 copay per admission</td>
<td>$400 copay per admission</td>
</tr>
<tr>
<td></td>
<td>100% of the allowable charge after deductible</td>
<td>100% of the allowable charge after deductible</td>
</tr>
<tr>
<td>Outpatient Alcoholism/Chemical Dependency Treatment</td>
<td>100% of the allowable charge after deductible</td>
<td>100% of the allowable charge after deductible</td>
</tr>
</tbody>
</table>

Benefits will include medically necessary treatment and supporting services provided by a state approved treatment program in an approved treatment facility. Medically necessary detoxification must also be covered as a medical emergency as long as you are not yet enrolled in a chemical dependency treatment program. Detoxification benefits are in addition to the alcoholism/chemical dependency benefits and are paid as any other condition.

Definitions

Alcoholism/Chemical Dependency

A condition characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user’s health is substantially impaired or endangered or his or her societal or economic function is substantially disrupted.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.
MATERNITY RIDER

BENEFIT HIGHLIGHTS

Benefits are subject to all deductibles, copayment, coinsurance, limitations, or any other provisions of the plan, including but not limited to the maximum benefit of $500,000 per plan year.

This chart provides an overview of benefits.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>NETWORK PROVIDER</th>
<th>NON-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>Paid as any other condition</td>
<td>Paid as any other condition</td>
</tr>
<tr>
<td>Prenatal Testing</td>
<td>Paid as any other condition</td>
<td>Paid as any other condition</td>
</tr>
<tr>
<td>Preventive Prenatal Testing*</td>
<td>100% of the allowable charge</td>
<td>Paid as any other condition</td>
</tr>
<tr>
<td></td>
<td>(waive deductible)</td>
<td></td>
</tr>
<tr>
<td>Midwifery and Birth Center</td>
<td>75% of the allowable charge after deductible</td>
<td>75% of the allowable charge after deductible</td>
</tr>
</tbody>
</table>

*Preventive diagnostic services that meet the guidelines for preventive care are covered for all insured persons as stated in the Preventive Care benefit.

Maternity

The plan will pay benefits for the insured student and their spouse or domestic partner’s medically necessary maternity care, including hospital, surgical and medical care. However, benefits are provided for complications of pregnancy on the same basis as any other condition for all insured persons.

The plan will cover the first two ultrasounds per pregnancy. Additional ultrasounds will be covered if medically necessary. The plan covers charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending physician in consultation with the mother, makes an alternative decision on the length of inpatient stay. The decision must be based on accepted medical practice. For a mother and newborn child who remain in the hospital for the minimum length of time stated above, the plan will pay for post-delivery care as ordered by the attending physician, in consultation with the mother. For a mother and newborn child, at the time of discharge, the attending physician in consultation with the mother will make a determination of the type and location of follow-up care based on accepted medical practice, including in-person care, services of a midwife and home health care.

The plan also covers routine nursery care furnished to a baby after its birth and routine well-baby examination by a physician furnished to the baby before the participant mother is discharged from the hospital. In addition, the newborn child will have the same coverage as the participant for the first three weeks after birth.

These charges are treated the same way covered medical expenses for any other injury or sickness are treated.

Prenatal Testing

The plan covers charges for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy when such services are determined to be medically necessary as determined by Washington State Board of Health Standards. The plan covers these charges the same as covered medical expenses for any other condition.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.
**Midwifery And Birth Center**
The plan also covers charges for midwifery and birth center expenses.

**What The Maternity Rider Does Not Cover**
Maternity care benefits aren’t covered for enrolled children except for complications of pregnancy.

**Complications Of Pregnancy**
Complications of pregnancy are covered for all insured persons. Complications of pregnancy is a condition which falls into one of the 3 categories listed below that requires covered, medically necessary services which are provided in addition to, and greater than, those usually provided for antepartum care, normal or cesarean delivery, and postpartum care, in order to treat the condition.

- Diseases of the mother which are not caused by pregnancy, but which coexist with and are adversely affected by pregnancy
- Maternal conditions caused by the pregnancy which make its treatment more difficult. These conditions are limited to:
  - Ectopic pregnancy
  - Hydatidiform mole/molar pregnancy
  - Incompetent cervix requiring treatment
  - Complications of administration of anesthesia or sedation during labor or delivery
  - Obstetrical trauma uterine rupture before onset or during labor
  - Ante- or postpartum hemorrhage requiring medical/surgical treatment
  - Placental conditions which require surgical intervention
  - Preterm labor and monitoring
  - Toxemia
  - Gestational diabetes
  - Hyperemesis gravidarum
  - Spontaneous miscarriage or missed abortion
  - Fetal conditions requiring in utero surgical intervention

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.
MENTAL HEALTH RIDER

BENEFIT HIGHLIGHTS

The Mental Health Rider covers medically necessary inpatient and outpatient mental health services. Benefits are subject to all deductibles, copayment, coinsurance, limitations, or any other provisions of the plan, including but not limited to the maximum benefit of $500,000 per plan year.

This chart provides an overview of benefits.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>NETWORK PROVIDER</th>
<th>NON-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mental Health</td>
<td>$300 copay per admission; 75% of the allowable charge after deductible</td>
<td>$400 copay per admission; 60% of the allowable charge after deductible</td>
</tr>
<tr>
<td>Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>75% of the allowable charge after deductible (deductible is waived at Hall Health)</td>
<td>60% of the allowable charge after deductible</td>
</tr>
<tr>
<td>Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(there are no fees at the Counseling Center for registered students)</td>
<td></td>
</tr>
</tbody>
</table>

**Inpatient Mental Health** After the quarterly deductible has been met and a $300 copay per admission for network facilities or a $400 copay per admission for non-network facilities, these charges are covered at 75% of the allowable charge for network providers and 60% of the allowable charge for non-network providers up to the maximum benefit of $500,000 per plan year.

**Outpatient Mental Health** After the quarterly deductible has been met, the plan will pay 75% of the allowable charge for network providers and 60% of the allowable charges for non-network providers. There is no visit limit up to the maximum benefit of $500,000 plan year.

Prescription drugs to treat mental disorders will be treated the same as other prescription drugs under the plan.

Treatment must be provided by a properly licensed physician, psychologist, psychiatrist, certified social worker and counselor and credentialed nurse practitioner or other provider as required by state law.

**What The Mental Health Rider Does Not Cover**

- Marital and family counseling.

**Definitions**

Mental health services means medically necessary inpatient and outpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, with the exception of the following categories, codes and services:

- Substance related disorders;
- Life transition problems, currently referred to as “v” codes, and diagnostic codes 302 through 302.9 as found in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 4th edition, published by the American Psychiatric Association; and
- Skilled nursing facility services, home health care, residential treatment, and custodial care.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.
How to Find a Mental Health Provider

Help is available right on campus:

For the Counseling Center: The staff includes Psychologists and Licensed Mental Health Counselors as well as pre-doctoral interns who are in the final year of their graduate training in Clinical or Counseling Psychology. **THERE IS NO CHARGE FOR SERVICES FOR ENROLLED UW STUDENTS.** The Center provides confidential short-term counseling; staff will facilitate referrals for students needing extended or specialized care.

For Hall Health: The staff includes a Psychiatrist, Psychologist, Advanced Psychiatric Nurse Practitioner, Social Worker, Mental Health Counselors, and Crisis Intervention Specialists. Many staff members are bi- or multilingual and speak Spanish, Dutch, Filipino, Japanese, and Malayalam.

To find a network provider off-campus, visit the UW Medicine website and click on Find a Provider. Answer the questions to find a list of providers.
NEURODEVELOPMENTAL THERAPY RIDER

BENEFIT HIGHLIGHTS

The Neurodevelopmental Therapy Rider covers medically necessary neurodevelopmental therapy treatment to restore and improve function for children age 6 and under. This benefit includes maintenance services where significant deterioration of the child’s condition would result without the service. Benefits are subject to all deductibles, copayment, coinsurance, limitations, or any other provisions of the plan.

This chart provides an overview of benefits.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>NETWORK PROVIDER</th>
<th>NON-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurodevelopmental Therapy Services</td>
<td>75% of the allowable charge after deductible</td>
<td>60% of the allowable charge after deductible</td>
</tr>
</tbody>
</table>

Benefits will be provided as follows:

- Physical therapy, speech therapy and occupational therapy will be covered on an outpatient basis, and
- Inpatient Hospital and skilled nursing facility benefits will be covered for a neurodevelopmental therapy admission when care cannot be safely provided on an outpatient basis.

The child’s physician must submit, for advance approval and periodic review, a written treatment plan, that specifically describes the services to be provided.

The care must be furnished and billed by a hospital, skilled nursing facility, physician, physical, occupational, or speech therapist, or chiropractor.

No benefits will be provided for custodial care, maintenance (except as specified), non-medical self-help, recreational, educational or vocational therapy, gym, or swim therapy.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with the terms of the rider.
PHENYLKETONURIA TREATMENT RIDER

Benefits shall be provided on the same basis as any other condition for the mineral and vitamin-enriched formulas necessary for the treatment of phenylketonuria. Benefits are subject to all deductible, coinsurance, limitations and any provisions of the plan, including but not limited to the maximum benefit of $500,000 per plan year.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.
DENTAL RIDER

DENTAL HIGHLIGHTS

This chart provides an overview of the dental benefits. You may see any licensed dentist. Benefits are paid at 100% of allowable charges after the dental deductible is met up to the plan year maximum benefit.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual maximum benefit</td>
<td>$300 per plan year for preventive and restorative services</td>
</tr>
</tbody>
</table>
| Deductible | • $25 per plan year per participant.  
• $75 per plan year per family. |

**Eligible Services** (these are things that are eligible to be covered under your annual maximum benefit)

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFITS</th>
</tr>
</thead>
</table>
| Dental X-Rays | Yes  
Covered dental x-rays include either a complete series or panoramic x-ray once in any 36 consecutive months, but not both. Supplemental bitewing and periapical x-rays are covered twice per plan year. |
| Oral Examinations | Yes  
Routine oral examinations are limited to 2 per plan year. Initial consultations, second opinion consultations and office visits count toward the limit for oral examinations.  
Emergency oral examinations are not limited, subject to the annual maximum benefit. However, services that are determined to be routine will be limited to 2 per plan year. (Please see the “Definitions” section for the definition of a Dental Emergency.) |
| Oral Hygiene Instruction | Yes  
Three sessions per lifetime |
| Fissure Sealants for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface (children to age 13 only) | Yes  
Limited to use on permanent teeth, once every three year period per tooth. |
| Prophylaxis (cleaning, scaling and polishing of teeth) | Yes  
2 treatments per plan year |
| Space maintainers when used to maintain space for eruption of permanent teeth (children under age 12 only) | Yes |
| Topical application of fluoride (children to age 18 only) | Yes  
Two treatments per plan year |

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.
Restorative services
(including extractions, fillings, root canals, crowns, periodontal (gum) treatment, and all services defined as "restorative services" by the American Dental Association)

Orthodontia

Not covered

Injury to Teeth
The plan will pay, after a $100 deductible per injury, 70% of allowable charges incurred, up to a $3,000 dental maximum per injury, arising as a direct result of an accidental bodily injury to sound, natural teeth. The accidental bodily injury must occur while you are eligible. An accidental bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 12 months of the date of the accident.

What’s Not Covered—Dental Exclusions
No benefits will be paid for the following:

- All other services not specifically included in the Dental Rider as covered dental benefits.
- Behavior management.
- Caries susceptibility tests.
- Charges above the usual and customary charge as determined by us.
- Charges by any person other than a licensed dentist (D.M.D or D.D.S), licensed denturist, dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of their license or certification, as allowed by law.
- Charges for any services in excess of the percentage and maximums listed.
- Charges for failure to keep scheduled appointments or for filling out claim forms.
- Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements.
- Charges that would not have been made, or that the participant would have had no obligation to pay in the absence of this plan.
- Cleaning of a prosthetic appliance.
- Consultations.
- Local anesthesia, sterilization, and supplies billed as separate charges.
- Materials not approved by the American Dental Association.
- Oral hygiene instruction (except as listed above), dietary instruction and home fluoride kits.
- Plaque control program.
- Prescription drugs, medications, or supplies provided by a dental office not related to covered dental care. For prescriptions dispensed by a pharmacy please see the medical prescription drug benefit.
- Replacement of a space maintainer previously paid for by the plan.
- Restorative services including extractions, fillings, root canals, crowns, and periodontal (gum) treatment.
- Services to the extent that they are not recommended and approved by the licensed dentist attending the participant.
- Services for temporomandibular joint disorder (TMJ) including diagnostic services and X-rays related to temporomandibular joints (jaw joints).
- Study and diagnostic models.
- Orthodontia.
- Orthognathic and/or maxillofacial surgery. Jaw augmentation or reduction regardless of origin of the condition, including any direct or indirect complications and after effects thereof.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.
Definitions

Dental Care Provider

A state-licensed:

- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)

The benefits of this plan are available if professional services are provided by a state-licensed denturist, 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 and this plan’s benefits would be payable if the covered service were provided by a “dental care provider” as defined above.

Dental Emergency

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

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.
VISION RIDER
VISION HIGHLIGHTS

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine eye exam</td>
<td>100% up to a maximum of $150 per plan year</td>
</tr>
<tr>
<td>Vision hardware</td>
<td>Not covered</td>
</tr>
<tr>
<td>(frames, lenses, contacts, contact lens fitting fee)</td>
<td></td>
</tr>
</tbody>
</table>

You can see any licensed vision services provider. You are responsible for any charges above the maximums. These services are not subject to the quarterly deductible.

This rider takes effect and expires at the same time as the plan to which it is attached. This rider is subject to all the terms and conditions of the plan that are not inconsistent with its terms.