For plans effective January 1, 2024

WiseChoices 20

$1,000 Deductible

Benefit Booklet for Individual and Families Residing in Washington

LifeWise

016812 (01-2024)

LifeWise Health Plan of Washington

WiseChoices 20 Plan ($1,000 Deductible)

For Individuals And Families Residing in Washington

PLEASE READ THIS CONTRACT CAREFULLY This is a contract between the subscriber and LifeWise Health Plan of Washington and shall be construed in accordance with the laws of the State of Washington. Please read this contract carefully to understand all of your rights and duties and those of LifeWise Health Plan of Washington.

GUARANTEED RENEWABILITY OF COVERAGE Coverage under this contract will not be terminated due to a change in your health. Renewability and termination of coverage are described under the ELIGBILITY, ENROLLMENT AND TERMINATION section of this contract.

In consideration of timely payment of the full subscription charge, LifeWise Health Plan of Washington agrees to provide the benefits of this contract subject to the terms and conditions appearing on this and the following pages, including any endorsements, amendments, and addenda to this contract which are signed and issued by LifeWise Health Plan of Washington.

LifeWise Health Plan of Washington has issued this contract at Mountlake Terrace, Washington.

Kristin Meadows

President and CEO

LifeWise Health Plan of Washington

YOUR RIGHT TO RETURN THIS CONTRACT WITHIN TEN DAYS

If, after examining this contract, you are not satisfied with it for any reason, you may return it to LifeWise Health Plan of Washington or the producer through whom it was purchased, within ten days of delivery for a full refund of your subscription charge payment. We will consider the date of delivery to be five days from the postmark date. We will refund your payment within 30 days of the date that LifeWise Health Plan of Washington or our producer received the returned contract, or we will pay an additional ten percent penalty which will be added to your refund. If you return this contract within the ten-day period, it will be void and considered as never effective. We reserve the right to recover any benefits paid by us prior to such action, and deduct such amounts from the subscription charge refund.

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WELCOME

Thank you for choosing LifeWise Health Plan of Washington to serve your health care coverage needs.

This contract gives you information on this plan's benefits, provider network, and other information. Please read this contract to familiarize yourself with the provisions of your health care coverage. Terms that have specific meanings in this contract are defined in the ***Definitions*** section of this contract.

Should you have any questions regarding the information contained in this contract or any other aspect of your health care coverage with us, please contact our customer service. You can find the telephone numbers on the back cover of this contract.

We look forward to serving you and your family. Once again, thank you for choosing LifeWise Health Plan of Washington for your health care coverage.

LifeWise Health Plan of Washington

Your Individual Health Care Plan Contract

This is your contract. The term "contract" means this document. The terms "you" and "your" refer to the covered members under this benefit plan. The terms "we," "us," "our" and "LifeWise" refer to LifeWise Health Plan of Washington.

LifeWise Health Plan of Washington uses its expertise and judgment to reasonably construe the terms of this booklet as they apply to specific eligibility and claims determinations. This does not prevent you from exercising rights you may have under applicable law to appeal, have independent review or bring civil challenge to any eligibility or claims determinations.

Medical and payment policies we use in administration of this plan are available on lifewise.com.

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

LifeWise believes this plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of the plan lifetime maximum.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to lose its grandfathered health plan status, can be directed to the federal Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa.healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SUMMARY OF BENEFITS

LifeWise WiseChoices 20 Plan ($1,000 Deductible)

This summary provides a brief description of this plan's benefits. Please refer to the other sections of this contract for a complete description of covered services, benefits, exclusions, and limitations.

All benefits are based on the allowed amount as described in the ***Definitions*** section of this contract.

This plan uses the LifeWise Health Plan of Washington Preferred network.

Calendar Year Deductible

LifeWise Health Plan of Washington Preferred (Network) Providers…….$1,000 Individual / $3,000 Family

Non-Preferred (Non-network) Providers…….$3,000 Individual / $9,000 Family

Copays

Professional Visits (Office or Home) Copay*…….$30 per visit

Acupuncture Services / Spinal and Other Manipulative Treatment Copay*…….$25 per visit

Emergency Room Copay……...$100 per visit

* Applies to visits from LifeWise Health Plan of Washington Preferred (Network) providers. Visits from Non-preferred (Non-network) providers are subject to the calendar year deductible and coinsurance for non-preferred (non-network) providers stated above.

Prescription Drug Copays (Retail)…….$10 generic/$45 preferred brand/50% non-preferred brand

Prescription Drug Copays (Mail Order)…….$25 generic/$112.50 preferred brand/45% non-preferred brand

(Non-preferred brand-name drugs subject to coinsurance)

Coinsurance Percentage

LifeWise Health Plan of Washington Preferred (Network) Providers……..20% of the allowed amount

Non-Preferred (Non-network) Providers…….…50% of the allowed amount

Annual Coinsurance Maximum

LifeWise Health Plan of Washington Preferred (Network) Providers……...$8,500 individual / $25,500 family

Non-Preferred (Non-network) Providers…….None (Unlimited)

Copays required by this plan are not included in the annual coinsurance maximum.

Annual Out-of-Pocket Maximum

LifeWise Health Plan of Washington Preferred (Network) Providers…….$9,500 individual / $28,500 family

Non-Preferred (Non-network) Providers……...None (Unlimited)

The annual out-of-pocket maximum includes the calendar year deductible and coinsurance. Copays required by this plan are not included in the annual coinsurance maximum.

Benefits With Annual Maximums

The following benefits have annual benefit maximums.

Benefit	Maximum
Acupuncture	Up to 12 visits per calendar year
Ambulance Services	Up to $5,000 per calendar year for ground ambulance (Air ambulance unlimited)
Home Health Care	Up to 130 visits per calendar year (Visits in lieu of inpatient hospitalization unlimited)
Hospice Care	Includes 10 inpatient days and 240 hours respite care per 6-month period
Medical Equipment, Prosthetics, Orthotics, Supplies	Up to $5,000 per calendar year
Prescription Drugs	Up to $3,000 per calendar year for brand name drugs
Rehabilitation Therapy and Chronic Pain Care	Inpatient: Up to 8 days per calendar year Outpatient: Up to 20 visits per calendar year
Skilled Nursing Facility	Up to 45 days per calendar year
Spinal and Other Manipulative Treatment	Up to 12 visits per calendar year
Transplants	$7,500 for transportation and lodging
Vision Care	Exam: 1 exam every 2 consecutive calendar years Hardware: Up to $200 every 2 consecutive calendar years

ELIGIBILITY, ENROLLMENT, AND TERMINATION

General Eligibility Requirements

The individuals defined below are eligible to enroll on this contract when we approve their application:

- The subscriber (the person in whose name the application is filed and coverage is established)
- The lawful spouse of the subscriber. For purposes of the rights and benefits of this plan, the term “spouse” also means the domestic partner of the subscriber.
- All rights and benefits afforded to a “spouse” under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term “establishment of the domestic partnership” shall be used in place of “marriage.” The term “termination of the domestic partnership” shall be used in place of “legal separation” and “divorce.”
- A dependent child under 26 years of age, except as provided in the ***Continued Eligibility for a Disabled Child*** section. An eligible child is one of the following:
  - A natural offspring of either or both the subscriber or spouse
  - A legally adopted child of either or both the subscriber or spouse
  - A child "placed" with the subscriber for the purpose of legal adoption in accordance with state law. "Placed for adoption" means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child.
  - A legal dependent or foster child of the subscriber or spouse. There must be a court order signed by a judge, which grants guardianship to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
  - A child for whom the subscriber or spouse is required by a medical child support order to provide health coverage

Enrollment and maintenance of coverage on this contract is also contingent on the individuals meeting **all** of the following requirements:

- They are residents of Washington State.
- “Resident" means a person who lives in the state of Washington and intends to live in the state permanently or indefinitely. In no event will coverage be extended to a subscriber or dependent who resides in Washington State for the primary purpose of obtaining health care coverage. The confinement of a person in a nursing home, hospital, or other medical institution shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
- Their principal residence is located within our service area.
- They are not entitled to (enrolled in) Medicare on the date coverage would begin.
- They are not 65 years of age or older, and eligible for Medicare on the date coverage would begin.

When Coverage Begins

Subscriber and Existing Dependents

Upon approval of the enrollment application, coverage will become effective as follows:

- For applications received by the 5th day of the month, coverage will be effective on the 15th day of that month. In this instance, a pro-rated subscription charge will be applied for the first partial month of coverage.
- For applications received between the 6th and 20th day of the month, coverage will be effective on the first day of the following month. Applications received after the 20th of the month will be effective on the 15th of the following month.

The receipt date will be the date of postmark or the date of delivery to us, whichever is earlier.

New Dependents

You must submit your enrollment request for new dependents to us. The effective date of coverage will be determined by the receipt date of your approved application and required subscription charges.

An enrollment application isn't required when subscription charges being paid for dependents already include coverage for additional new dependent children, but we may request additional information if necessary to establish eligibility of the dependent children.

Newborn Children

The effective date will be the child's date of birth **only** if we receive a completed application within 60 days of birth. Otherwise, coverage will become effective as described under ***General Eligibility Requirements***.

Adoptive Children

The effective date will be the date of placement with the subscriber **only** if we receive a completed application within 60 days of the date of placement with the subscriber. Otherwise, coverage will become effective as described under ***General Eligibility Requirements***.

Domestic Partners and Their Children

The effective date for the domestic partner and/or their children will be the date the domestic partnership began only if we receive a completed application within 60 days of the date the domestic partnership began with the subscriber. Otherwise, coverage will become effective as described under ***General Eligibility Requirements***.

Legal Guardianship

Children who are legal dependents of the subscriber or spouse and meet all stated eligibility requirements will be accepted for coverage when we receive the completed application and copies of the final court-ordered guardianship.

The effective date will be the date of the guardianship order if the approved application is received within 60 days of that date. Otherwise, coverage will become effective as described under ***General Eligibility Requirements***.

Medical Child Support Orders

An application must be submitted to us, along with a copy of the medical child support order. The application may be submitted by the subscriber, the child's custodial parent, or a state agency administering Medicaid. The effective date will be the date of the order **only** if the application is received within 60 days of the date of the order. Otherwise, coverage will become effective as stated under ***General Eligibility Requirements***.

Due To Marriage

The effective date will be the date of marriage **only** if the approved application is received by us within 60 days of the date of the marriage. Otherwise, coverage will become effective as described under ***General Eligibility Requirements***.

Other Provisions Affecting Coverage

Term Of Contract

This contract is guaranteed renewable except as stated under ***When Coverage Ends***.

Subscription Charges And Grace Period

This contract is issued in consideration of an approved application and the payment of the required subscription charges by or on behalf of the subscriber and enrolled dependents. A government agency or any other third party may not sponsor or pay for your individual health plan, except where permitted by law.

A grace period of ten days following the due date is allowed for payment of subsequent subscription charges. If a subsequent payment is not received within this grace period, this contract will, without further notice, terminate as of the last day of the period for which subscription charges were paid rather than at the end of the

grace period.

We reserve the right to revise subscription charges annually upon written notice. Such notice may be provided to the subscriber or producer as we may elect. Such changes will become effective on the date stated in the notice, and payment of the revised subscription charges will constitute acceptance of the change.

Subscription charges will also be revised in the following situations:

- A change in the number of enrolled dependents.
- The subscriber or dependents enroll in a different LifeWise individual health plan.
- A change in government requirements affecting the health plan, including, but not limited to, a mandated change in benefits, eligibility or other plan provisions, or imposition or changes to a tax on our revenue.

Third-Party Payers

This coverage is issued as individual health coverage, is not sold or issued for use as a government or third-party sponsored health plan, and is not partially or fully paid for by third-party payers including employers, business accounts, providers, not-for-profit agencies, government agencies, or any other third-party payer, either directly or indirectly, excepted as required by law.

When Coverage Ends

Coverage under this contract is guaranteed renewable and will not be terminated, except as described below.

Termination By The Subscriber

The subscriber may terminate this contract by:

- Sending written notice to us. Cancellation will be effective on the first of the month following receipt of the request.
- Failing to pay the required subscription charges when due or within the grace period

Termination by LifeWise

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

- Nonpayment of subscription charges. Coverage will end without notice as of the last date for which subscription charges were paid.
- Violation of published policies of LifeWise that have been approved by the Washington State Insurance Commissioner
- A member no longer lives in Washington State.
- A member commits fraudulent acts as to LifeWise.
- A member materially breaches the contract which includes, but is not limited to, failure to continue to meet the provisions stated under ***General Eligibility Requirements***.
- Change or implementation of federal or state laws that no longer permit the continued offering of this contract
- We discontinue this contract to all those covered under this contract as allowed by law. In such instance you will be given at least a 90-day notification of the discontinuation. If we discontinue this contract, you may apply for any other individual plan currently offered for sale by us.
- We withdraw from a service area or from a segment of a service area as allowed by law.
- Any other reason allowed by state or federal law

In the event this coverage under this contract is terminated, LifeWise will refund any subscription charges received for dates beyond the contract termination date stated in our notice to you.

Reinstatement of Coverage

If coverage under this contract is terminated for non-payment of subscription charges, reinstatement on this contact may be permitted at LifeWise's discretion, by payment of all past due and current subscription

charges. Such reinstatement shall be limited to once every 12 consecutive months.

When reinstatement is not permitted, individuals may re-apply for this plan by completing an application.

Continuation Of Coverage

Continuity of Care

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

COC applies in these situations:

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

How you qualify for Continuity of Care If a primary care provider contract is terminated without cause, continuing care will be provided according to the details included in the member's notice of the contract termination. Additionally, you may qualify for continuing care from non-primary care providers if you are in an "active relationship" or treatment with your provider. This means that you have had three or more visits with the provider within the past 12 months and you meet one or more of these conditions with respect to a terminated provider or facility:

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

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

You can request continuity of care by contacting customer service. The contact information is on the back cover of this booklet.

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

- The 90th day after we notified you that your provider's contract ended.
- The day after you complete the active course of treatment entitling you to continuity of care.

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

Continuity of care does not apply if your provider:

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

When continuity of care ends, non-emergent care from the provider is no longer covered. If we deny your request for continuity of care, you may appeal the denial. See ***Complaints and Appeals***.

Continued Eligibility For A Disabled Child

Coverage may continue past the limiting age for an unmarried dependent child who is incapable of self-sustaining employment by reason of a developmental or physical disability and who is chiefly dependent upon the subscriber for support and maintenance. The child will continue to be eligible if all of the following are met:

- The subscriber is covered under this plan.
- The child became disabled before reaching the limiting age.
- Within 31 days of the date the child no longer meets dependent child eligibility requirements, the subscriber furnishes proof of the child's disability and dependency acceptable to us.
- The child's subscription charges, if any, continue to be paid.

The subscriber provides proof of the child's disability and dependent status when we request it. We will not ask for proof more often than once a year after the two-year period following the date the child qualifies for continuing eligibility.

Continuation Of Coverage On An Identical Contract

Dependent(s) may continue coverage on an identical contract in the following situations:

- If the subscriber terminates coverage for any reason, or in the event of death of the subscriber or divorce of the subscriber and spouse, enrolled dependents under this plan may continue under an identical contract. The dependent(s) must meet all of the eligibility requirements as specified in this contract. If the spouse continues coverage, the spouse's enrollment status will change from dependent to subscriber and any enrolled child may be covered under the spouse's continued coverage. Subscription charges will be assessed at the appropriate rate. If there is no spouse, or the spouse does not continue coverage, each enrolled child may continue coverage as a subscriber, and subscription charges will be assessed at the appropriate subscriber rate.
- A dependent child, who no longer is eligible as a dependent under this contract for reasons such as reaching the age of 26, may continue coverage on an identical contract as a subscriber, providing all eligibility requirements, as specified in this contract, are met. The child's enrollment status will change from dependent to subscriber, and subscription charges will be assessed at the appropriate subscriber rate.

To continue coverage, an enrollment application must be submitted to us prior to the date coverage would end as a dependent.

HOW DOES CHOOSING A PROVIDER AFFECT MY BENEFITS?

To help you manage the cost of health care, we've contracted with a network of health care facilities and professionals. Throughout this contract, those providers are referred to as "LifeWise Health Plan of Washington Preferred Providers." They are also known as "network" or "in-network" providers.

This plan's benefits and your out-of-pocket expenses depend on the providers you seek care from. Throughout this section you'll find important information on how to control costs and your out-of-pocket expenses, and how the providers you choose can affect this plan's 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 Washington state regulations governing access to providers. Our provider networks include hospitals, physicians, and other types of licensed or certified health care providers.

Your choice of a particular provider may affect your out-of-pocket costs because different providers may have different allowed amounts even though they have an agreement with us. You'll never have to pay more than your share of the allowed amount when you use LifeWise Health Plan of Washington Preferred Providers.

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 is a network provider. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws. If you see a non-participating provider for emergency services, you are not responsible for any amounts that exceed the allowed amount. See ***Balance Billing Protection*** under ***How Does Choosing A Provider Affect My Benefits?*** section.

When You Get Care In Washington

LifeWise Health Plan of Washington Preferred Providers

You'll always get the highest level of benefits and the lowest out-of-pocket costs when you get covered services and supplies from LifeWise Health Plan of Washington Preferred providers.

To locate a LifeWise Health Plan of Washington Preferred Provider, please refer to our printed provider directory, or visit our website at lifewise.com.

LifeWise Health Plan of Washington Preferred Providers agree to accept our allowed amount for covered services and supplies. You will not be billed for amounts over the allowed amount. You will be responsible for deductibles, coinsurance, copays, and for services not covered by this plan, as described in this contract.

Contracted Health Care Benefit Managers

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

Other Providers

If you decide not to use a LifeWise Health Plan of Washington Preferred Provider, you may choose any state-licensed or certified provider (see the ***Definitions*** section in this contract). However, if the provider you choose isn't part of our provider network (a non-preferred or non-network provider), in most cases you will receive a lower benefit level, unless otherwise stated below. You may also be responsible to pay any amounts above the allowed amount.

The following covered services and/or providers will always be covered at the highest applicable in-network benefit level applied to the allowed amount for covered services and supplies (see the ***Definitions*** section of this contract for the description of allowed amount):

- Emergency services. If you have a medical emergency (see the ***Definitions*** section in this contract), this plan provides worldwide coverage at the in-network benefit level.
- Treatment of an accidental injury, limited to services received on the day of or within two days following the date of the accidental injury
- Certain categories or types of providers for which contracting agreements are not available. These types of providers aren't included in our provider directory.
- Facility and hospital-based provider services at any of our contracted hospitals

Benefit Level Exceptions for Non-Emergency Services

LifeWise may agree to provide in-network benefits for non-emergency services from providers who are not part of our network. This is called a "benefit level exception" and will be granted when a LifeWise provider is not reasonably available to you for covered services.

You or your health care provider may request a benefit level exception. **Such requests 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 in-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 may be responsible for amounts applied towards your calendar year deductible, coinsurance, copays, amounts that exceed the benefit maximums, amounts above the allowed amount and charges for non-covered services. If we deny the request, in-network benefits won't be provided.

Please contact customer service for all benefit level exceptions for non-emergent care requests.

Note: Services from Non-preferred (Non-network) providers, even when paid at the in-network benefit level, are subject to the allowed amount. You may be responsible to pay any amounts over the allowed amount.

Other Important Information About Selecting Providers

The benefits of this plan are based on the allowed amount (see the ***Definitions*** section in this contract). **If**

you receive services from a provider who does not have a contracting agreement with us, you may be responsible to pay all amounts over the allowed amount. This is **in addition** to any applicable copays, deductibles, coinsurance, or services and supplies not covered by this plan.

Balance Billing Protection

Non-participating providers are either (1) providers that are not part of your network (out-of-network) or (2) providers that do not have a contract with us (non-contracted). Non-participating providers have the right to charge you more than the allowed amount for a covered service. This is called "surprise billing" or "balance billing." However, Washington state and federal law protects you from balance billing for:

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

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

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

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

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

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

When You Get Care Outside Washington

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

Providers who are located outside Washington state and are **not** contracted with the nationwide network are paid at the **non-preferred** (out-of-network) benefit level.

The only exceptions are:

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

When you receive services from providers located outside Washington state, you are responsible for all amounts above the allowed amount if the provider is not contracted.

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

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

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

This section of your contract explains the types of expenses this plan requires you to pay. To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for.

Copays

"Copays" are a fixed dollar amount you are required to pay for certain services. Copays do not apply toward this plan's calendar year deductible, coinsurance, coinsurance maximum, or out-of-pocket maximum. This plan requires a copay for the following services:

- **Professional Visits (Home and Office)** You pay a copay of **$30** for each professional visit (home or office) received from LifeWise Health Plan of Washington Preferred (Network) Providers.
- **Acupuncture Services** You pay a copay of **$25** for each visit from LifeWise Health Plan of Washington Preferred (Network) Providers.
- **Spinal and Other Manipulative Treatment** You pay a copay of **$25** for each visit from LifeWise Health Plan of Washington Preferred (Network) Providers.

Professional visits, acupuncture or spinal and other manipulative treatment from Non-preferred (Non-network) providers are subject to the out-of-network calendar year deductible and coinsurance stated in this contract.

- **Emergency Room Visits** You pay a **$100** copay for each visit to a hospital emergency room. This copay is in addition to the plan's in-network calendar year deductible and coinsurance.

  The emergency room copay is waived if you are admitted to the hospital as an inpatient directly from the emergency room.

- **Prescription Drugs** You pay the following copays per prescription or refill:

  Participating Retail Pharmacies
  Generic Drugs $10
  Preferred Brand Name Drugs $45
  Non-Preferred Brand Name Drugs 50%

  Medco By Mail/Mail-Order Pharmacy
  Generic Drugs $25
  Preferred Brand Name Drugs $112.50
  Non-Preferred Brand Name Drugs 45%

(Non-preferred brand-name drugs are subject to coinsurance)

Calendar Year Deductible

The "calendar year deductible" is the amount of the allowed amount incurred for covered services for which each member is responsible each calendar year before this plan provides certain benefits.

The calendar year deductible is subject to the following provisions:

- There are separate deductible amounts for service from LifeWise Health Plan of Washington Preferred (Network) providers and Non-preferred (Non-network) providers.
- Family members will be required to meet the family deductible. Once the family deductible is met, the calendar year deductible is met for all enrolled family members. As with the individual deductible, the family deductible only applies to services from Non-Preferred (Non-network) Providers.
- Amounts credited to the calendar year deductible during the last three months of a calendar year will be credited toward the calendar year deductible requirement for the next calendar year
- Amounts credited to the calendar year deductible will accrue to the annual benefit maximums for those benefits which have a day or visit maximum. Benefits with a dollar-based benefit maximum will not accrue

until the calendar year deductible has been met.

- The following do not accrue toward the calendar year deductible:
  - Copays
  - Coinsurance
  - Amounts that exceed the allowed amount
  - Amounts for services or supplies not covered by this plan

This plan requires the following calendar year deductibles:

LifeWise Health Plan of Washington Preferred (Network) Providers

The individual calendar year deductible is **$1,000**. The maximum family deductible is **$3,000**

Non-Preferred (Non-network) Providers

The individual calendar year deductible is **$3,000** per member. The maximum family deductible is **$9,000.**

Coinsurance

"Coinsurance" is a defined percentage of the allowed amount for covered services and supplies you are responsible to pay. Coinsurance does not include deductibles or copays required by this plan.

This plan has different coinsurance levels for preferred (network) and non-preferred (non-network) providers:

LifeWise Health Plan of Washington Preferred (Network) Providers

Coinsurance is **20%** of the allowed amount.

Non-Preferred (Non-network) Providers

Coinsurance is **50%** of the allowed amount.

Coinsurance Maximum

The "coinsurance maximum" is the maximum amount of coinsurance an individual or family will have to pay each calendar year for covered services from LifeWise Health Plan of Washington Preferred (network) providers.

Once the coinsurance maximum has been met, benefits covered services from LifeWise Health Plan of Washington Preferred (network) Providers are provided at 100% of the allowed amount for the remainder of the calendar year.

The coinsurance maximum for this plan is as follows:

LifeWise Health Plan of Washington Preferred (Network) Providers

The coinsurance maximum is **$8,500** per individual per calendar year. The maximum family coinsurance maximum is **$25,500** per calendar year.

Copays required by this plan will continue to apply even when the coinsurance maximum has been met.

Note: Coinsurance required in the ***Prescription Drugs*** benefit does not accrue toward the coinsurance maximum.

Non-Preferred (Non-network) Providers

There is no coinsurance maximum for services of non-preferred (non-network) providers.

Out-of-Pocket Maximum

The "out-of-pocket maximum" is the maximum amount an individual or family will have to pay each calendar year for covered services from LifeWise Health Plan of Washington Preferred (network) providers. It consists of the calendar year deductible and coinsurance applicable to services from LifeWise Health Plan of Washington Preferred (Network) providers.

The out-of-pocket maximum for this plan is as follows:

LifeWise Health Plan of Washington Preferred (Network) Providers

The out-of-pocket maximum is **$9,500** per individual per calendar year. The maximum family out-of-pocket maximum is **$28,500** per calendar year.

Copays required by this plan will continue to apply even when the out-of-pocket maximum has been met.

Note: Coinsurance required in the Prescription Drugs benefit does not accrue toward the out-of-pocket maximum.

Non-Preferred (Non-network) Providers

There is no out-of-pocket maximum for services of non-Preferred (non-network) providers.

BENEFIT DESCRIPTION

This section of the contract describes the specific benefits this plan provides, and your cost shares (amounts you are required to pay) for each type of service. Benefits are available only for the covered services stated in this section. Benefits are subject to applicable deductibles, coinsurance, copays, limitations, exclusions, and all other provisions stated in this contract.

All benefits of this plan are based on the allowed amount.

Conditions For Payment Of Benefits

We provide benefits for covered services and supplies, up to the allowed amount, received in the treatment of injury, illness, or disease when such services or supplies meet **all** of the following conditions:

- They must meet our definition of "medically necessary." (See ***Definitions***.) Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- They are received on or after your effective date under this contract.
- They must not be listed as an exclusion, exceed the benefit maximums, or be listed as a limitation as described in this contract.

Care Facilitation

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

This plan's benefits do not require preauthorization for coverage. You must be eligible on the dates of service and services must be medically necessary. We encourage you to call customer service to verify that you meet the required criteria for benefits and to help us identify inpatient admissions which might benefit from case management, described below.

Case Management

Case Management works cooperatively with you and your physician to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of this plan's benefits. Your participation in a treatment plan through Case Management is voluntary. If an agreement is reached, you or your legal representative, your physician and other providers participating in the treatment plan will be required to sign written agreements which set forth the terms under which benefits will be provided.

Specific Benefits

This plan's benefits are provided only for the following services, supplies or drugs described in this section.

Acupuncture Services

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

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to a copay of **$25** per visit.

Non-Preferred (Non-Network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits are provided for acupuncture services up to a maximum of **12** visits per member per calendar year. Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury, or condition.

Ambulance Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of $**1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-Network) Providers: Benefits are subject to the calendar year deductible of $**1,000** and coinsurance of **20%** of the allowed amount.

Benefits for ground ambulance services are provided up to a maximum of **$5,000** per calendar year for all services combined. Benefits for air ambulance services are not subject to an annual limit.

Benefits are provided for medically necessary services and supplies, including licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition.

This benefit only covers the member that requires transportation.

Ambulatory Surgical Centers

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits are provided for services and supplies furnished by an ambulatory surgical center.

Blood and Blood Derivatives:

- Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider.
- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury.

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits are provided for the cost of blood and blood derivatives.

Contraceptive Management Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Your deductible (if any) and

coinsurance does not apply to this benefit.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

See ***Professional Visits*** for benefits for office visits.

Covered services include the following:

- Exams, treatment, prescription and over-the-counter drugs and supplies you get at your provider's office, including all FDA approved contraceptives. FDA approved contraceptives include but are not limited to emergency contraceptives and contraceptive devices (insertion and removal). Tubal ligation and vasectomy are also covered.
- Prescription and over-the-counter drugs, devices and supplies dispensed by a pharmacy are covered under the ***Prescription Drug*** benefit. See that benefit for more information.
- Up to a 12-month supply of oral contraceptives (including emergency contraception) dispensed by a licensed pharmacy are covered on the same basis as other covered prescription drugs. See the ***Prescription Drug*** benefit elsewhere in the contract for provisions regarding pharmacy-dispensed drugs.

This benefit doesn't cover:

- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

Dental Injury Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

See ***Professional Visits*** for benefits for office visits.

Benefits are limited to dental services that are necessary due to an injury to teeth gums, or jaw. Benefits are limited to the repreparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

These services are only covered when all of the following are true:

- They're necessary as a result of an injury.
- They're performed within the scope of the provider's license.
- They're not required due to damage from biting or chewing.
- They're rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth don't have:
  - Extensive restoration, veneers, crowns or splints
  - Periodontal disease or other condition that, in our judgment, would cause the tooth to be in a weakened state prior to the injury

Note: An injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the injury date.

Diabetes Health Education

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are provided at **100%** of the allowed amount. The calendar year deductible and coinsurance are waived.

Non-Preferred (Non-network) Providers: Benefits are provided at **100%** of the allowed amount. The

calendar year deductible and coinsurance are waived.

Benefits are available for outpatient self-management training and education for diabetes.

Benefits for nutritional counseling and therapy related to diabetes are provided under the ***Nutritional Therapy*** benefit.

Diagnostic Services And Mammography

Benefits are provided for diagnostic and mammography services, including administration and interpretation. This benefit covers the following services:

- Laboratory and pathology services for preventive or diagnostic purposes
- Imaging and scans (such as X-rays and EKGs) for preventive or diagnostic purposes
- Cervical and prostate cancer screening procedures when recommended by a health care provider
- Colorectal cancer examinations and screening when recommended by a health care provider
- Diagnostic and screening mammography when recommended by a health care provider

Preventive Diagnostic Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are provided at **100%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Preventive diagnostic services are laboratory tests and imaging done for preventive or screening purposes, as determined by LifeWise, based on U.S. Preventive Services Task Force (USPSTF) guidelines. These guidelines are available by contacting us. Examples are pap smears, prostate-specific antigen (PSA) testing and cholesterol screening.

Other Diagnostic Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Mammography

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to coinsurance of **20%** of the allowed amount. The calendar year deductible is waived.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

The ***Diagnostic Services and Mammography*** benefit doesn't cover allergy testing.

Diagnostic surgeries and scope insertion procedures, such as an endoscopy, are covered under the ***Surgical Services*** benefit.

When covered outpatient diagnostic services are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services benefits are provided under the ***Hospital Outpatient Care*** or ***Emergency Room Services*** benefits.

Diagnostic services included in a global maternity billing are covered under the ***Maternity Care*** benefit.

Non-diagnostic testing or screening required for employment, schooling, or public health reasons that are not for the purpose of treatment is not covered.

Emergency Room Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the

emergency room copay of **$100** plus the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount for each visit.

Non-Preferred (Non-network) Providers: Benefits are subject to the emergency room copay of **$100** plus the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount for each visit.

The emergency room copay will be waived if a hospital admits you as an inpatient directly from the emergency room.

This benefit is provided for emergency room facility services, including related services and supplies, such as surgical dressings and drugs, furnished by and used in the emergency room. Also covered under this benefit are medically necessary detoxification and mental health services.

A "medical emergency" is the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

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

Home and Hospice Care

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Home health and hospice benefits are provided as described below, or when provided as an alternative to inpatient hospitalization or other institutional care.

Home health and hospice care must be part of a written plan of care prescribed, periodically reviewed, and approved by a physician (MD or DO).

Benefits are provided up to the maximums shown below for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Covered employees of a home health agency and hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a social worker. Also included in this benefit is medical equipment and supplies provided and billed by the home health or hospice agency. (Such equipment and supplies are not subject to the benefit maximums stated in the ***Medical Equipment and Supplies benefit***.)

Home Health Care This benefit provides up to **130** intermittent home visits per member each calendar year by a home health care provider or one or more of the home health agency employees above. Home health care provided as an alternative to inpatient hospitalization or other institutional care is not subject to this limit. Other therapeutic services, such as respiratory therapy and phototherapy provided by a home health agency, are also covered under this benefit.

Hospice Care Benefits for a terminally ill member are 6 months of covered hospice care. Benefits may be provided for an additional 6 months of care in cases where the member is facing imminent death or is entering remission. This limit does not apply to hospice care furnished as an alternative to inpatient hospitalization or other institutional care. The initial 6-month period starts on the first day of covered hospice care. Covered hospice services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. These services don't count toward the 130 intermittent home visit limit shown above under ***Home Health Care***.

- **Inpatient hospice care** up to a lifetime maximum of **10** days. This benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.
- **Respite care** up to a lifetime maximum of **240** hours, to relieve anyone who lives with and cares for the terminally ill member

Insulin and Other Home and Hospice Care Provider Prescribed Drugs Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice.

This benefit doesn't cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care
- Nonmedical services, such as spiritual, bereavement, legal or financial counseling
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance
- Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family or member to provide care without oversight by a home health agency. The care may be skilled, supportive or respite in nature.

Hospital Inpatient Care

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits are provided for the following services:

- Room and board expenses, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Diagnostic and therapeutic services

For inpatient hospital maternity care and newborn care, see the ***Maternity Care*** and ***Newborn Care*** benefits.

This benefit doesn't cover:

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is, in our judgment, medically necessary to treat your condition

Hospital Outpatient Care

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

This benefit is provided for operating, procedure and recovery rooms; plus services and supplies such as surgical dressings and drugs furnished by and used while at the hospital.

Infusion Therapy

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

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

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

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

Mastectomy and Breast Reconstruction Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits are provided for mastectomy necessary due to disease, illness or injury. For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses (not subject to the benefit maximum stated in the Medical Equipment and Supplies benefit)
- Physical complications of all stages of mastectomy, including lymphedemas

Services are to be provided in a manner determined in consultation with the attending physician and the patient.

Medical Equipment and Supplies

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits are provided up to a maximum of **$5,000** per member each calendar year. This maximum does not apply to equipment, supplies, foot orthotics or therapeutic shoes prescribed for the treatment of diabetes. This benefit does not include medical equipment or supplies provided as part of home health care. See the ***Home Health*** and ***Hospice Care*** benefit for coverage information.

Covered items include:

Medical and Respiratory Equipment Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. We may also provide benefits for the initial purchase of equipment, in lieu of rental.

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

In cases where an alternative type of equipment is less costly and serves the same medical purpose, we'll provide benefits only up to the lesser amount.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.

Medical Supplies, Orthotics (Other Than Foot), and Orthopedic Appliances Covered items include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

For hypodermic needles, lancets, test strips, testing agents and alcohol swabs benefit information, see the ***Prescription Drugs*** benefit.

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

Note: This benefit does not include prosthetics prescribed or purchased as part of mastectomy or breast reconstruction procedure. See the ***Mastectomy and Breast Reconstruction Services*** benefit for coverage information.

Foot Orthotics and Therapeutic Shoes Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses when medically necessary for the treatment of diabetic conditions. Benefits are provided for one pair each of orthotics and therapeutic shoes each calendar year.

This benefit doesn't cover:

- Supplies or equipment not primarily intended for medical use
- Disability modifications or renovations to vehicles or buildings, specialized equipment or services provided primarily for disabled access or accommodation
- Special or extra-cost convenience features
- Items such as exercise equipment, weights and whirlpool baths
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Foot orthotics or therapeutic shoes for non-diabetic conditions
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the ***Hospital Inpatient Care*** or ***Hospital Outpatient Care*** benefits.

Mental Health Care and Substance Use Disorder

Inpatient Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Outpatient Professional Visits

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to a copay of **$30** per visit.

Non-Preferred (Non-Network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

This plan covers mental health care and treatment for alcohol and drug dependence. This plan will also cover

alcohol and drug services from a state-approved treatment program. You must also get these services in the lowest cost type of setting that can give you the care you need. This plan will comply with federal mental health parity requirements. Benefits and cost sharing for covered mental health and substance use disorder services will be provided on the same basis as medical services.

For your cost shares, see ***Hospital Inpatient Care*** for inpatient services or ***Hospital Outpatient Care*** for outpatient facility services. For office visits, see ***Professional Visits***. Emergency detoxification treatment is covered under ***Emergency Room Services***.

Mental Health Care

This plan covers all of the following services:

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

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

Substance Use Disorder

This plan covers all of the following services:

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

This benefit does not cover:

- Mental health tests that are not used to assess a covered mental condition or plan treatment. This plan does not cover tests to decide legal competence or for school or job placement.
- Testing that is not used to assess a covered substance use disorder or plan treatment. This plan does not cover drug or alcohol testing done for school or employment.
- Halfway houses, quarterway houses, recovery houses and other sober living residences

Newborn Care

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

The benefits of the plan will be provided for newborn care on the same basis as any other covered care, subject to the cost share, limitations and exclusions specified in this contract.

Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

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

To continue benefits beyond the 3-week period, or if the mother isn't eligible for maternity care benefits under this plan, see the dependent eligibility and enrollment guidelines outlined under ***Eligibility, Enrollment and Termination***.

Benefits include the following:

- Hospital care, including hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury. (See the ***Emergency Room Services*** benefit for information on emergency room benefits.)
- Professional care, including inpatient professional services, and follow-up care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse.
- Circumcision

See the ***Hospital Inpatient Care, Hospital Outpatient Care, Preventive Medical Care*** and ***Professional Visits*** benefits for more information.

Note: Attending provider as used in this benefit means a physician (MD or DO), a physician's assistant, a certified nurse midwife (CNM), a licensed midwife or an advanced registered nurse practitioner (ARNP).

Nutritional Therapy

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury, including diabetes.

Maternity Care

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits are provided on the same basis as any other covered care, subject to the cost share, limitations and exclusions specified in this contract.

Abortion is also covered at no charge.

Maternity care benefits include:

Facility Care

Inpatient hospital, birthing center, outpatient hospital and emergency room services, including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

Plan benefits are also provided for medically necessary supplies related to home births.

Professional Care Including the following services:

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus
- Delivery, including cesarean section, in a medical facility, or delivery in the home
- Postpartum care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse.

Note: Attending provider as used in this benefit means a physician (MD or DO), a physician's assistant, a certified nurse midwife (CNM), a licensed midwife or an advanced registered nurse practitioner (ARNP). If the

attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. See the ***Surgical Services*** benefit for details on surgery coverage.

This benefit does not cover donor breast milk.

Phenylketonuria (PKU) Dietary Formula

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits are provided for dietary formula that's medically necessary for the treatment of phenylketonuria (PKU).

Prescription Drugs

This plan provides benefits for prescription drugs dispensed by a licensed pharmacy for use outside a medical facility, provider's office or clinic. A "prescription drug" (See ***Definitions***) is any medical substance that under federal law must be labeled, "Caution: Federal law prohibits dispensing without a prescription."

To encourage use of safe and effective generic drugs, this benefit requires use of appropriate generic drugs when available. Generic alternatives are FDA-approved as safe and effective as brand name drugs but are more cost effective.

What's Covered

Benefits are provided for the following items:

- Prescription drugs (Federal Legend Drugs) prescribed by a licensed provider. Included is off-label use of FDA-approved drugs, as described in the definition of "Prescription Drug."
- Compounded medications of which at least one ingredient is a covered prescription drug
- Oral and self-administered injectable drugs for controlling blood sugar levels
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable medications. Also covered are disposable diabetic testing supplies such as test strips, testing agents and lancets.
- Glucagon and allergy emergency kits
- Preventive drugs as defined by federal regulations
- Contraceptives and devices
- Oral chemotherapy medications as described below.

Participating Pharmacies

Prescription drug benefits (including drugs dispensed by retail pharmacies, Mail Order Pharmacy, and Specialty Pharmacy Program) are limited to prescription drugs dispensed by participating pharmacies. **Benefits are not provided for drugs received from non-participating pharmacies, except for drugs dispensed for treatment of a medical emergency.** To find a participating pharmacy, contact customer service, or call the toll-free Pharmacy Locator Line found on the back of your LifeWise ID card.

Prescription Drug Cost Shares

All prescription drugs are subject to the medical plan calendar year deductible and the following coinsurance for each new prescription or refill. The calendar year plan maximum, coinsurance maximum and out-of-pocket maximums apply to all prescription drug benefits unless otherwise specified.

- The copays, deductible and coinsurance for participating pharmacies do not apply to contraceptive drugs, devices and supplies that are purchased from a participating pharmacy.
- Cost-shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug and the deductible does not apply. Cost-shares for covered prescription insulin drugs apply towards the deductible.

For each new prescription or refill, you pay the following copay or coinsurance:

Participating Retail Pharmacies

Generic Drugs **$10**
Preferred Brand Name Drugs **$45**
Non-Preferred Brand Name Drugs **50%**

Dispensing Limit Benefits are provided for up to a 30-day supply of covered medication unless the drug maker's packaging limits the supply in some other way.

Be sure to present your identification card at the participating pharmacy all prescription drug purchases. If you do not show your card, you will pay the full retail price of the drug, but reimbursement will be at the allowable charge.

Mail-Order Pharmacy

Generic Drugs **$25**
Preferred Brand Name Drugs **$112.50**
Non-Preferred Brand Name Drugs **45%**

Dispensing Limit Benefits are provided for up to a 90-day supply of covered medication unless the drug maker's packaging limits the supply in some other way.

The mail order pharmacy benefit is limited to our contracting mail order pharmacy.

Specialty Pharmacy Program

"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

Specialty drugs are subject to the cost shares listed above under Retail Pharmacies and are limited to a 30-day supply.

This plan will only cover specialty drugs dispensed by our participating specialty pharmacies. Contact customer service for details on which drugs are included in the Specialty Pharmacy Program or visit our website.

Oral Chemotherapy Medications

This benefit covers self-administered oral drugs that are dispensed by a pharmacy and can be used to kill or slow the growth of cancerous cells. These drugs are covered for medically necessary uses at 100% of the allowable charge. You pay no deductible or coinsurance.

Prescription Drug Benefit Maximum

Benefits for all brand name prescription drugs (preferred brand or non-preferred brand) are limited to a maximum of **$3,000** per member per calendar year. Once this benefit maximum is met, no further benefits are available for the calendar year for any brand name drug, regardless of diagnosis or condition.

This calendar year benefit maximum does not apply to:

- Generic drugs
- Drugs, testing supplies, needles, syringes, and injection aids necessary for the treatment of
- diabetes
- Anti-rejection drugs prescribed for use following a solid organ, bone marrow or stem cell transplant
- Oral chemotherapy drugs, and selected anti-nausea/anti-emetic drugs (brand name drugs for which there are no generic alternative) used in conjunction with chemotherapy or radiation therapy. (Contact customer service for details on which drugs are included in this classification).
- Prescription and over-the-counter contraceptive drugs, devices and supplies

Prescription Drug Formulary

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

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

Non-formulary medications may be covered on an exception basis for members meeting medical necessity criteria. See ***Prior Authorization Program*** below for more information.

Prior Authorization Program

To promote appropriate medication use, this plan uses a formulary and certain formulary drugs are also subject to pre-dispensing medical necessity review. Non-formulary medication may be covered on an exception basis for members meeting medical necessity criteria through a pre-dispensing medical necessity review. Formulary drugs subject to pre-dispensing medical necessity reviews, may require additional medical information from the prescribing provider, or substitution of equivalent medication. If you choose to purchase the medication before the review has been completed, you will pay the full price for the drugs. If the review verifies the medicine use is medically necessary, then you may submit a claim for reimbursement. See the ***How To File A Claim*** section in this booklet for more information.

Benefits for some prescription drugs may be limited to one or more of the following:

- A set number of days' supply
- A specific drug or drug dose that is appropriate for a normal course of treatment
- A specific diagnosis
- You may need to get a prescription drug from an appropriate medical specialist.
- You may have to try a generic drug or a specified brand name drug first.

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

Contact customer service for details on which drugs are included in the Prior Authorization Program or see the Pharmacy section on our website.

Exclusions

This benefit does not cover any of the following:

- Drugs, medicines, or other devices that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner. The exceptions are drugs meeting the federal definition of preventive care drugs or as otherwise required by law.
- Vitamins (including prescription vitamins) food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements such as infant formulas or protein supplements. Benefits for formula for treatment of phenylketonuria (PKU) are provided under this plan's medical benefits.
- Drugs for cosmetic use, or to promote or stimulate hair growth
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility, provider's office or clinic, or take-home drugs dispensed and billed by these providers.
- Infusion or parenteral therapy drugs or solutions

- Drugs for treatment of idiopathic short stature without growth hormone deficiency.
- Replacement of lost or stolen medication
- Drugs for treatment of sexual dysfunction
- Drugs for treatment of infertility or for fertility enhancement
- Drugs for weight management or treatment of obesity
- Medical equipment or supplies, except for disposable diabetic supplies
- Drugs dispensed by non-participating pharmacies, except for drugs for treatment of a medical emergency

Prescription Drug Volume Discount Program

Your prescription drug benefit program is administered for LifeWise by Express Scripts. This program includes rebates on the cost of certain covered drugs that are received by LifeWise. Rebates are used in connection with the operations of LifeWise such as in the determination of future subscription charge rates and the administration by LifeWise of its health plans and the prescription drug program. If your prescription drug plan includes copayments or coinsurance calculated on a percentage basis, or a deductible, rebates are not reflected in your cost share.

Your Right To Safe And Effective Pharmacy Services

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

If you want to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

Questions And Answers About Your Prescription Drug Benefits

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

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

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

   See ***Prior Authorization Program*** described above for additional details.

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

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

3. **What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?**

   The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can't be changed.

   You can appeal any decision you disagree with. See the ***Complaints and Appeals*** section in this contract or call our customer service for information on how to initiate an appeal.

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

   The amount you pay for covered drugs is described above.

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

   Yes. You only receive benefits when you have your prescriptions filled by participating pharmacies. The majority of pharmacies in Washington are part of our pharmacy network. Your benefit does not cover prescription drugs dispensed from a non-participating pharmacy, except for drugs dispensed for treatment of a medical emergency.

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

   The dispensing limits/days' supply for drugs is described in the ***Dispensing Limit*** provisions above.

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

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

Preventive Medical Care

Benefits are provided for routine and preventive services performed on an outpatient basis.

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to a copay of **$30** per visit.

Non-Preferred (Non-Network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Covered services include:

- Routine physical exams
- Immunizations. Benefits for immunizations are provided at 100% of the allowed amount. **Benefits are limited to immunizations received from LifeWise Health Plan of Washington Preferred (Network) providers.**
- Well-baby and newborn exams
- Physical exams related to school, sports, and employment

For outpatient routine or preventive diagnostic services (including x-ray), screening and diagnostic mammography, and laboratory services benefit information, see the ***Diagnostic Services and Mammography*** benefit.

For contraceptive services, drugs or devices benefit information, see the ***Contraceptive Management*** and ***Prescription Drugs*** benefits.

Services that are related to a specific illness, injury or definitive set of symptoms are covered under the non-preventive care medical benefits of this plan.

This benefit doesn't cover:

- Services not named above as covered
- Charges for preventive medical services that exceed what's covered under this benefit
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations
- Routine vision or hearing exams
- Immunizations received from Non-Preferred (Non-network) Providers

Professional Visits

Office, Home and Urgent Care Center Visits

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to a copay of **$30** per visit.

Non-Preferred (Non-Network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits include the following:

- Professional home and office visits
- Second opinion consultations from any qualified provider
- Urgent care center visits
- Contraceptive management-related office visits. Your copay does not apply to contraceptive management office visits to a LifeWise **Health Plan of Washington** Preferred (network) provider.
- Office visits related to dental injuries.

Other Professional Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

This benefit includes the following professional services:

- Therapeutic injections
- Allergy testing and injections
- Diabetic foot care
- Inpatient professional visits

For benefits for professional surgical procedures performed in a provider's office, surgical suite or other facility benefit information, see the ***Surgical Services*** benefit.

For diagnostic imaging and laboratory services benefit information, see the ***Diagnostic Services and Mammography*** benefit.

For home health or hospice care benefit information, see the ***Home Health*** and ***Hospice Care*** benefit.

This benefit doesn't cover:

- Hair analysis or non-prescription drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- Preventive medical care or immunizations
- Acupuncture
- Spinal and other manipulative treatment

Radiation and Chemotherapy

Treatment which uses powerful chemicals (chemotherapy) or high-energy beams (radiation) to shrink or kill cancer cells.

Chemotherapy and radiation must be prescribed by a provider and approved by LifeWise to be covered. *See **Prior Authorization.***

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and

coinsurance of **50%** of the allowed amount.

Benefits are provided for chemotherapy and radiation therapy services received in a hospital or provider's office. See ***Transplants*** for benefits for radiation and chemotherapy services provided in conjunction with a transplant.

Note: See the ***Prescription Drugs*** for benefit information for prescription drugs dispensed through a pharmacy. This plan has an annual limit for brand-name prescription drugs dispensed through a pharmacy.

Rehabilitation Therapy and Chronic Pain Care

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Rehabilitation Therapy Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary 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.

- **Inpatient Care** Benefits for inpatient facility and professional care are available up to **8** days per member each calendar year. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting.

  When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.
- **Outpatient Care** Benefits for outpatient care are subject to all of the following provisions:
  - You must not be confined in a hospital or other medical facility
  - Services must be furnished and billed by a hospital, rehabilitation facility approved by us, physician, or other licensed or certified provider.

  When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of **20** visits per member each calendar year. This benefit includes physical, speech, and occupational assessments and evaluations related to rehabilitation.

  For the purposes of counting outpatient visits, "visit" means a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

Chronic Pain Care Rehabilitation Therapy benefits are also available for medically necessary treatment of intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit maximums stated above. However, inpatient services for chronic pain care aren't subject to the 24-month limit.

This benefit doesn't cover:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Inpatient rehabilitation received more than 24 months from the date of onset of your injury or illness, or from the date of your surgery that made the rehabilitation necessary.
- Neurodevelopmental therapy or treatment of neurodevelopmental disabilities

Skilled Nursing Facility Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and **coinsurance of 50% of the allowed amount**.

This benefit is only provided when you're at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided up to **45** days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a:

- Skilled nursing facility that is a LifeWise Health Plan of Washington Preferred (network) provider
- Medicare-approved skilled nursing facility

This benefit doesn't cover:

- Acute nursing care
- Skilled nursing facility stay not immediately following hospitalization or inpatient stay
- Skilled nursing care outside of a hospital or skilled nursing facility
- Care or stay provided at a facility that is not qualified per our standards

Spinal and Other Manipulative Treatment

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to a copay of **$25** per visit.

Non-Preferred (Non-Network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Benefits for spinal and other manipulations are provided up to a combined maximum benefit of 12 visits per member each calendar year. Services must be medically necessary to treat a covered illness, injury or condition.

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

Surgical Services

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

This benefit includes all professional surgical services when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office.

Also included in this benefit are anesthesia and postoperative care, cornea transplantation, skin grafts and the transplanting of blood or blood derivatives, cosmetic surgery for the repair of functional disorders and gender affirming surgery if medically necessary. Benefits are provided for all gender affirming surgical services which meet the criteria of the LifeWise medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from customer service, or at lifewise.com.

For organ, bone marrow or stem cell transplant procedure benefit information, see the ***Transplants*** benefit. Benefits for mastectomy and related services are described in the ***Mastectomy and Breast Reconstruction Services*** benefit.

Transplants

LifeWise Approved Transplant Centers:
Benefits are subject to the calendar year deductible of **$1,000** and coinsurance of **20%** of the allowed amount.

Transplant services are only covered when provided by an "Approved Transplant Center." See *Covered Transplants* below.

Covered Transplants Solid organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (See the ***Definitions*** section in this contract for the definition of "experimental/investigational services.") We reserve the right to base coverage on all of the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

  The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our criteria for coverage are:

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

  Note: For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure (see the ***Surgical Services*** benefit).
- You've satisfied the transplant exclusion period.
- Your medical condition must meet our written standards.
- The transplant or reinfusion must be furnished in an Approved Transplant Center. ("Approved Transplant Center" is a hospital or other provider that's developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion, and is approved by us.) We have agreements with Approved Transplant Centers in Washington and Alaska, and we have access to a special network of Approved Transplant Centers around the country. Whenever medically possible, we'll direct you to an Approved Transplant Center that we've contracted with for transplant services. Please call customer service.

  Of course, if none of our centers or the network centers can provide the type of transplant you need, this benefit will cover a transplant center that meets written approval standards set by us.

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

This benefit also provides coverage for anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs This benefit covers donor or procurement expenses for a covered transplant. Covered donor services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor

acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

Transportation and Lodging Expenses

If you are getting a transplant, this benefit covers costs for your travel and lodging. The plan will not pay more than $7,500 for travel and lodging per transplant. You must live more than 50 miles from the Approved Transplant Center, unless medically necessary treatment protocols require you to stay closer to the transplant center. The plan covers travel and lodging up to the limits set by the IRS for the date you had the expense.

Travel Allowances: Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll costs are reimbursed. Mileage expenses will be based on the current IRS medical mileage reimbursement on the date(s) the expenses were incurred.

Lodging Allowances: Expenses incurred by a transplant patient and companion for hotel lodging away from home is reimbursed based on current IRS guidelines on the date(s) the expenses were incurred.

Companions: Companion travel and lodging expenses are only covered if the companion must, as a matter of medical necessity, accompany the member. If the member receiving the transplant is a child (up to age 19), one companion is automatically permitted, however a second companion will only be permitted if medically necessary.

Limits: The plan covers travel and lodging costs up to the IRS limits in place on the date you had the expense. The per day limits and requirements can change if IRS regulations change. Please go to the IRS website, www.irs.gov, for details. This summary is not and should not be assumed to be tax advice.

The per day limits and requirements can change if IRS regulations change. Please go to the IRS website, www.irs.gov, for details. This summary is not and should not be assumed to be tax advice.

Non-Covered Expenses

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

Virtual Care

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are subject to a copay of **$30** per visit.

Non-Preferred (Non-Network) Providers: Benefits are subject to the calendar year deductible of **$3,000** and coinsurance of **50%** of the allowed amount.

Your plan covers access to medical care for low level medical conditions using virtual methods like secure chat, text, voice or video chat from a remote location (e.g. home) or an originating site. Services delivered via virtual methods are subject to office visit cost shares and other provisions as stated in this booklet.

Originating site: Hospital, rural health clinic, federally qualified health center, physician's or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center

See ***Professional Visits***, ***Mental Health Care*** and ***Substance Use Disorder*** benefits for real-time visits with you and your provider via online and telephonic methods (telemedicine).

Vision Exams

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are provided at **100%** of the allowed amount.

Non-Preferred (Non-network) Providers:
Benefits are provided at **100%** of the allowed amount.

This benefit covers **one** routine vision exam per member each **2** consecutive calendar years.

Covered routine exam services include:

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

Vision Hardware

LifeWise Health Plan of Washington Preferred (Network) Providers: Benefits are provided at **100%** of the allowed amount.

Non-Preferred (Non-network) Providers:
Benefits are provided at **100%** of the allowed amount.

This benefit covers vision hardware up to **$200** per member each **2** consecutive calendar years.

Benefits for the vision hardware items listed below are provided when they meet all of these requirements:

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

What's Covered:

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

The Vision Hardware benefit doesn't cover:

- Services or supplies that aren't named above as covered, or that are covered under other provisions of this plan
- Nonprescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), or non-prescription sunglasses or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
  - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under

this benefit or plan ended

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

EXCLUSIONS AND LIMITATIONS

In addition to services listed as not covered under ***Covered Services***, this section of the contract lists those services, supplies or drugs that are not covered under this plan.

Amounts Over the Allowed Amount

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

Assisted Reproduction

Assisted reproduction technologies, including but not limited to:

- Drugs to treat infertility or that are required as part of assisted reproduction procedures
- Artificial insemination or assisted reproduction methods, such as in-vitro fertilization. It does not matter why you need the procedure
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

Benefits from other sources

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

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

Benefits that have been exhausted

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

Broken or missed appointments

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

Caffeine Dependency

Charges for records or reports

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

Complications of a non-covered service

Includes follow-up services or effects of those services.

Cosmetic Services

Drugs, services, and supplies for cosmetic services that are not medically necessary. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not

primarily to restore an impaired function of the body. This does not apply to services that are determined to be medically necessary for Gender Affirming Care.

Counseling, Education and Training

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

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

Court-Ordered Services

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

Custodial Care

Custodial services that are not covered hospice care services.

Dental Care

Dental care or supplies, that are not covered under any dental benefits. EEG biofeedback or neurofeedback services

Environmental Therapy

Therapy to provide a changed or controlled environment.

Experimental or Investigational Services

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

Family Members or Volunteers

Services or supplies that you provide to yourself. It also doesn't cover a provider who is:

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

Government Facilities

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

Hair Analysis

Hair Loss

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

Hearing Exams

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

Hearing Hardware

Hearing aids and devices used to improve hearing sharpness and any associated service or supply.

Hospital Admission Limitations

Hospital stays solely for diagnostic studies, physical examinations, checkups, medical evaluations, or observations, unless:

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

Illegal Acts, Illegal Services, and Terrorism

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

Low-level laser therapy

Learning Disorders and Neurodevelopmental Therapy

Services, therapy and supplies related to the treatment of learning disorders, cognitive disabilities, dyslexia, developmental delay or neurodevelopmental disabilities.

Military Service And War

Illness or injury that is caused by or arises from:

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

Nicotine Dependency

Smoking cessation services, nicotine dependency cessation treatment, drugs or devices.

Non-Covered Services

Services or supplies directly related to any non-covered condition

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

Non-Treatment Facilities, Institutions or Programs

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

Examples are prisons, nursing homes and juvenile detention facilities.

Orthodontia

Orthodontic services, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.

Orthognathic Surgery

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

Personal comfort or convenience items

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges, and babysitting
- Normal living needs, such as food, clothes, housekeeping and transport. This does not apply to chores done by a home health aide prescribed in your treatment plan.
- Dietary assistance, including “Meals on Wheels”
- Disability modifications or renovations to vehicles or buildings, specialized equipment or services provided primarily for disabled access or accommodation

Prescription Drug Benefit

- Over-the-counter or non-prescription drugs and medications (other than oral chemotherapy drugs and contraceptive drugs, supplies and devices); herbal, naturopathic, or homeopathic medicines or devices; Dietary supplements, except for PKU formula
- Prescription or non-prescription vitamins
- Drugs prescribed for infertility or fertility enhancement
- Drugs for treatment of sexual dysfunction
- Anorectics (appetite suppressant drugs); drugs for weight management or treatment of obesity
- Any claim or demand for injury or damage arising in connection with the manufacturing, compounding, or dispensing or use of any drug; prescription drugs prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice
- Drugs prescribed for cosmetic purposes including, but not limited to, drugs for treatment of skin changes due to aging
- Any prescription dispensed in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician's original order
- Brand name drugs dispensed by a pharmacy in excess of the calendar year benefit maximum as stated under the Prescription Drugs benefit

Preventive Care

Services and supplies, such as examinations, testing (including drug and alcohol testing), and vaccinations which are primarily for non-treatment purposes not covered under the Preventive Medical Care benefit. Also excluded are immunization from Non-preferred (Non-network) providers.

Provider’s Licensing or Certification

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

Recreational, Camp and Activity Programs

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

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

Routine Foot Care

Routine foot care, orthopedic shoes, and foot orthotics or shoe inserts not specifically provided for treatment of complications of diabetes.

Serious Adverse Events and Never Events

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

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

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

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

Services or Supplies Not Medically Necessary

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

Sexual Dysfunction

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

Temporomandibular Joint (TMJ) Disorder Treatment

Any services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders.

Vision Care Services

- Routine vision exams, contact lenses, corrective lenses, eyeglasses, and associated services not covered above. Also excluded are nonprescription glasses or other special-purpose vision aids.
- Orthoptics, pleoptics, visual analysis therapy and/or training; and surgeries or other procedures performed to improve or change the refractive character of the cornea, including any direct or indirect complications thereof

Voluntary Support Groups

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

Weight Loss (Surgery or Drugs)

Surgery, drugs or supplements for weight loss or weight control.

Work-Related Illness or Injury

Any illness or injury for which you get benefits under:

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

OTHER COVERAGE

Coordinating Benefits With Other Plans

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

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

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

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

DEFINITIONS

For the purposes of COB:

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

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

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

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

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

Primary and Secondary Rules

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

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

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

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

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

expenses or coverage, the birthday rule determines which plan is primary.

- If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
  - The plan covering the custodial parent, first
  - The plan covering the spouse of the custodial parent, second
  - The plan covering the non-custodial parent, third
  - The plan covering the spouse of the non-custodial parent, last
- If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

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

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

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

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

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

COB's Effect on Benefits

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

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a calendar year are not more than the total allowable expenses incurred in that year. **The total amount paid by the secondary plan in combination with the primary plan payment will not be more than one hundred percent of the highest total allowable expense of either plan in addition to any savings accrued from prior claims incurred in the same calendar year.**

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

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

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

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

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

Right of Recovery/Facility of Payment If your other plan makes payments that this plan should have made, we have the right, at our reasonable discretion, to remit to the other plan the amount we determine is needed to comply with COB. To the extent of such payments, we are fully discharged from liability under this plan. We also have the right to recover any payment over the maximum amount required under COB. We can recover excess payment from anyone to whom or for whom the payment was made or from any other issuers or plans. This plan has the right to appoint a third party to act on its behalf in recovery efforts.

Questions about COB? Contact our customer service or the Washington Insurance Department.

THIRD PARTY LIABILITY (SUBROGATION)

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

Definitions The following terms have specific meanings in this contract:

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

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

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

GENERAL PROVISIONS

Benefit Modifications

From time to time, we may revise the provisions of this contract. You will receive prior written notice of any revisions to this contract, and 30 days prior written notice of changes to subscription charges.

If the provisions of this contract are amended, modifications will not affect the benefits provided under this contract to a member during confinement in a facility. Benefit modifications will take effect upon final discharge from the facility, or from any other facility to which you are transferred, provided coverage is still in effect.

No producer or agent of LifeWise or any other entity is authorized to make any changes, additions, or deletions to this contract or to waive any provision of this contract. Changes, alterations, additions, or exclusions can only be done over the signature of an officer of LifeWise. We will only make such changes if we make changes to all contracts issued on this contract's form number.

Benefits Not Transferable

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

Conformity With The Law

This contract is issued and delivered in the state of Washington and is governed by the laws of the state of Washington, except to the extent preempted by federal law. In the event any provision of the contract or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Evidence Of Medical Necessity

We have the right to require proof of medical necessity from a member receiving benefits under this contract. You or your providers may submit such proof. No benefits will be available under this contract if the proof is not provided or acceptable to us.

Health Care Providers - Independent Contractors

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

How To File A Claim

Most providers will submit claims to us directly. However, on occasion, you may find it necessary to submit a claim yourself. To do so should follow these steps:

- Complete a Subscriber Claim Form for each provider. Subscriber Claim Forms are available from by contacting customer service.
- Attach the itemized bill. This bill must include the name of the subscriber and patient, dates of service, procedure codes or English nomenclature of each service provided, diagnosis, and itemized charges for each service.

Prescription Drug Claims

Prescription Drug Claims To make a claim for prescription drugs that are covered as required by law (such as oral chemotherapy medications), please follow these steps:

- **Participating Pharmacies**

  For retail pharmacy purchases, you don't have to send us a claim. Just show your LifeWise ID card to the pharmacist, who will bill us directly. If you don't show your ID card, you'll have to pay the full cost of the prescription and submit the claim yourself as described below for reimbursement.

- **Non-participating Pharmacies**

  You'll have to pay the full cost for retail pharmacy purchases of oral chemotherapy medications that are covered by this plan. You'll need to fill out a prescription drug claim form, attach your prescription drug receipt(s) and submit the information to the address shown on the claim form.

If you need prescription drug claim forms, contact our customer service at the numbers shown on the back cover of this contract.

Most claims for members who are entitled to Medicare will be automatically submitted to us. However, if you submit the claim to us, a copy of the Explanation of Medicare Benefits must be included.

Submit claims to the address shown on the back cover of this contract.

Timely Filing Of Claims You should submit all claims within 30 days after the service is completed. We **must** receive all claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date services or supplies were provided
- If you have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, or as indicated above, whichever is later

We will not provide benefits for claims we receive after the later of these two dates, nor will we provide benefits for claims which were denied by Medicare because they were received past Medicare's submission deadline.

ID Card

If you need a replacement LifeWise ID card, call our customer service or visit our website at lifewise.com. If coverage under the contract terminates, your LifeWise ID card will no longer be valid.

Independent Corporation

The subscriber hereby expressly acknowledges the understanding that this contract constitutes a contract solely between the subscriber and LifeWise Health Plan of Washington.

The subscriber further acknowledges and agrees that they have not entered into this contract based upon representations by any person other than us, and that no person, entity, or organization other than us shall be held accountable or liable to the subscriber for any of our obligations to the subscriber created under this contract. This provision shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this contract.

Individual Medical Plan

This contract is sold and issued in Washington State as an individual medical plan. It is not issued for use as an employer-sponsored or group health plan. LifeWise specifically disclaims any liability for state or federal group plan requirements.

This contract does not replace, affect, or supplement any state or federal requirement for worker's compensation, employer's liability, or similar insurance. When an employer is required by law to provide or has the option to provide worker's compensation or similar insurance and does not provide such coverage for its employees, the benefits available under this plan will not be provided for conditions arising out of the course of employment which are or would be covered by such insurance.

Intentionally False Or Misleading Information

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

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

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

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

Note: We cannot void your coverage (in other words, cancel back to its effective date as if it had never existed at all) based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Limitation of Liability

We are not legally responsible for any of the following:

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

Member Cooperation

All members are under a duty to cooperate in a timely and appropriate manner with us in our administration of benefits or in the event of a lawsuit. Failure to cooperate may constitute a material breach of this contract.

Notices

We may be required to send you certain notices. We will consider such a notice to be delivered if we mail it to your most recent address in our records. The date of the postmark will be the delivery date.

If you are required to send notice to us, the postmark date will be the delivery date. If it is not postmarked, the delivery date will be the date we receive it.

Notice Of Information Use And Disclosure

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

This information is collected, used or released 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 care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the contract
- This information may also be collected, used or released 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 is not 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 also have the right to request inspection and/or amendment of records retained by us that contain your PPI. Please contact customer service and ask that a request form be mailed to you.

Notice Of Other Coverage

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

- Any legal action or claim against another party for a condition or injury for which we provided benefits, and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides personal injury protection (PIP), underinsured motorist, uninsured motorist, or any other insurance under which you are or may be entitled to recover compensation
- The name of any other group insurance plan(s) under which you are covered

Rights Of Assignment

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

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

Right Of Recovery

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

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

Right To And Payment Of Benefits

All rights to the benefits of this contract are available only to you. They may not be transferred or assigned to anyone else. We will not honor any attempted assignment, garnishment, or attachment of any right of this contract.

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

Venue

All lawsuits, and legal proceedings, including arbitration proceedings, brought against us by you or anyone claiming any right under this plan must be filed:

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

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

COMPLAINTS AND APPEALS

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

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

What is a Complaint?

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

How to file a complaint

Call customer service at 1-800-817-3056

Send a fax to 866-903-9899

Send the details in writing to:
LifeWise Health Plan of Washington
PO Box 21552
Eagan, MN 55121

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

What is an Appeal?

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

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

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

What you can appeal

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

Appeal Levels

You have the right to two levels of appeals:

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

How to Submit an Appeal in Writing

Step 1. **Get the form**	• Complete the **Member Appeal Form**, you can find it on lifewise.com or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service.
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your provider. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on lifewise.com. We can't release your information without this form.
Step 3. **Send in my appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** LifeWise Health Plan of Washington PO Box 21552 Eagan, MN 55121 Fax to 866-903-9899

Note: You may also call customer service to verbally submit an appeal.

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

LifeWise Health Plan of Washington

PO Box 21552
Eagan, MN 55121

Fax: 866-903-9899

Appeal Response Time Limits

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

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

If we need more time

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

What if you have ongoing care?

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

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

What if it's urgent?

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

Examples of urgent situations are:

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

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

How to ask for an external review

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

Step 1. **Get the form**	**We'll tell you about your right to an external review with the written decision of your internal appeal.** • Complete the Independent Review Organization (IRO) Request form, you can find it on lifewise.com or call customer service to request a copy. You may also write to us directly to ask for an external appeal.
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.
Step 3. **Send in my external review request**	To help process your external review, be sure to complete the form and return with any supporting documents. **Send your documents to:** LifeWise Health Plan of Washington PO Box 91102 Seattle, WA 98111-9202 Fax to 844-990-0262

Note: You may also call customer service to verbally submit an external review request.

Once the IRO decides

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

If the IRO:

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

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

Washington Consumer Assistance Program
5000 Capitol Blvd.
Tumwater, WA 98501

1-800-562-6900

E-mail: cap@oic.wa.gov

DEFINITIONS

The information here will help you understand what these words mean. We have the responsibility and authority to use our expertise and judgment to reasonably construe the terms of this contract as they apply to

specific eligibility and claims determinations. For example, we use the medical judgment and expertise of Medical Directors to determine whether claims for benefits meet the definitions below of “Medical Necessity” or “Experimental/Investigative Services.” We also have medical experts who determine whether care is custodial care or skilled care and reasonably interpret the level of care covered for your medical condition. This does not prevent you from exercising your rights you may have under applicable law to appeal, have independent review or bring a civil challenge to any eligibility or claims determinations.

Adverse-Benefit Determination

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

- A member’s or applicant’s eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

Affordable Care Act

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

Allowed Amount

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

Covered Medical Services Received in the Service Area

In-Network

The allowed amount is the fee that we have negotiated with providers who have signed contracts with us and are in the LifeWise Health Plan of Washington Preferred provider network.

Out-of-Network

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

For non-contracted providers, the allowed amount is the last of the following (unless a different amount is required under applicable law):

- An amount that is not less than the lowest amount is the fee that we have negotiated with providers who have signed contracts with us.
- 125% of the fee schedule determined by the Centers of Medicare and Medicaid Services (Medicare) as implemented by LifeWise.
- The provider’s billed charges

Non-Emergency Services Protected From Balance Billing

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

Dialysis Due To End Stage Renal Disease

In-Network

The allowed amount is amount explained above in this definition.

Out-of-Network

The amount we pay for dialysis will be no less than 125% of the Medicare-approved amount and no more than 90% of billed charges.

Emergency Services

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

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

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

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

Air Ambulance

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

Ambulatory Surgical Center

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

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

Benefit

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

Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on December 31 at midnight.

Claim

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

Clinical Trials

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

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

Coinsurance

A cost-sharing requirement under this contract which requires the subscriber and/or members to pay a percentage of the cost of covered services.

Confined (Confinement)

Consecutive days of care received as an inpatient in a facility, or successive admissions due to the same or related causes when discharge from a facility and re-admission to the same or different Facilities occurs within a 72-hour period.

Congenital Anomaly

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

Contract

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

Cost Share

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

Covered Services

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

Custodial Care

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

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

Deductible

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

Dependent

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

Detoxification

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

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

Doctor (also called "Physician")

A state-licensed:

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

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 their state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would

be payable if the service were provided by a doctor as defined above:

- Chiropractor (DC)
- Dentist (DDS or DMD)
- Optometrist (OD)
- Podiatrist (DPM)
- Psychologist
- Nurse (RN and ARNP) licensed in Washington State

Effective Date

The date your coverage under this plan begins.

Emergency Services

- 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. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health.
- 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, mental health, or substance use disorder treatment of the 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.
- Ambulance transport as needed in support of the services above.

Endorsement

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

Essential Health Benefits

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

Exclusion

A provision that states that we have no obligation under this contract to provide any benefits.

Experimental and Investigative Service

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

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided
- It is subject to oversight by an Institutional Review Board.

- There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies.

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

Facility (Medical Facility)

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

Health Care Benefit Managers

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

Home Health Agency

An organization which is approved by us to provide approved home health services to a member.

Hospice

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

Hospital

A healthcare facility that meets all of these criteria:

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

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

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

Illness

A sickness, disease, or medical condition.

Injury

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

Inpatient

Confined in a medical facility as an overnight bed patient.

Lifetime Maximum

The maximum amount that your insurance benefit will provide during your lifetime.

LifeWise Health Plan of Washington

A health care service contractor licensed in the State of Washington that underwrites and maintains this health care plan. Also referred to as “we,” “us,” “our” and “LifeWise” in this contract.

LifeWise Health Plan of Washington Preferred (Network) Provider

A provider who, at the time services are received, has a preferred contract in effect with us to furnish covered services to members.

Important Note: Our network of LifeWise Health Plan of Washington Preferred (network) providers, as well as provider contracting status, are subject to change at any time. Please confirm the status of your provider before services are received by calling our customer service at the telephone numbers listed on the back cover of this contract.

LifeWise Non-Preferred (Non-Network) Provider

A provider that at the time services are received has not signed a preferred provider contract with us. Since there are no contracts in effect with these providers, you are responsible for amounts above the allowed amount, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for noncovered services and supplies.

Limitation

A restriction to a specific benefit.

Long-term Care Facility

A nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.025, or assisted living facility licensed under chapter 18.20 RCW.

Maternity Care

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

Medical 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 member, the health of the member or their 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 nonmedical emergency are minor cuts and scrapes.

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 and Medical Necessity

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

- Agree with generally accepted standards of medical practice
- Be clinically appropriate in type, frequency, extent, site and duration., They must also be considered effective for the patient's illness, injury or disease

- Not be mostly for the convenience of the patient, physician, or other healthcare provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.

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

Member (also called “You” or “Your”)

The subscriber and/or dependents enrolled under this contract.

Mental Health Conditions

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

Non-Participating Provider

A provider that is not in your provider network or does not have a contract with us.

Orthotic

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

Outpatient

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

Participating Pharmacy

A licensed pharmacy which contracts with us or our designated pharmacy benefits administrator to provide prescription drug benefits under this plan.

Pharmacy Benefits Administrator

An entity which contracts with us to administer the prescription drug benefits under this plan.

Plan

The benefits, terms, and limitations stated in this contract.

Prenatal Care

Medical services provided during a pregnancy until the onset of labor. Prenatal care does not include services provided during labor, obstetrical delivery, or postpartum care.

Prescription Drug

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

One of the following standard reference compendia:

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

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

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

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

Provider

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

Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the State of Washington and other such facilities are included as required by state and federal law.

Covered licensed or certified categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

The providers are:

- Acupuncturists (LAc) (In Washington also called “East Asian Medicine Practitioners” (EAMP))
- Audiologists
- Chiropractors (DC)
- Counselors
- Dental Hygienists (under the supervision of a DDS or DMD)
- Dentists (DDS or DMD)
- Denturists
- Dietitians and Nutritionists (D or CD, or CN)
- Gynecologists (MD)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (LMP)
- Midwives
- Naturopathic Physicians (ND)
- Nurses (RN, LPN, ARNP, or NP)
- Nursing Homes
- Obstetricians (MD)
- Occupational Therapists (OTA)

- Ocularists
- Opticians (Dispensing)
- Optometrists (OD)
- Osteopathic Physician Assistants (OPA) (under the supervision of a DO)
- Osteopathic Physicians (DO)
- Pharmacists (RPh)
- Physical Therapists (LPT)
- Physician Assistants (PA) (under the supervision of an MD)
- Physicians (MD)
- Podiatric Physicians (DPM)
- Psychologists (PhD)
- Radiologic Technologists (CRT, CRTT, CRDT, CNMT)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

The following health care facilities and other providers will also be considered providers for the purposes of this plan when they meet the requirements above.

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Board Certified Behavior Analyst (BCBA), certified by the Behavior Analyst Certification Board, and state-licensed in states that have specific licensure for behavior analysts
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

In states other than Washington, "provider" means healthcare practitioners and facilities that are licensed or certified consistent with the laws and regulations of the state in which they operate.

Rehabilitation Therapy

Rehabilitation therapy or devices are medical services or devices provided when medically necessary for restoration of bodily or cognitive functions lost due to a medical condition.

Rehabilitation therapy includes physical therapy, occupational therapy, and speech-language therapy when

provided by a state-licensed or state-certified provider acting within the scope or their license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.

Service Area

All counties located in the State of Washington.

Skilled Care

Care which is ordered by a physician, and requires the medical knowledge and technical training of a registered nurse.

Skilled Nursing Facility

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

Spouse

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

Subscriber

The person in whose name the plan is issued.

Subscription Charge

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

Substance Use Disorder Conditions

Substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance use disorder is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance use disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

Temporomandibular Joint (TMJ) Disorder

Those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint

Urgent Care

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

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member-initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused.

Originating site: Hospital, rural health clinic, federally qualified health center, physician's or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center.

Visit

A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.

We, Us and Our

LifeWise Health Plan of Washington

CONTACT INFORMATION

CUSTOMER SERVICE

6707 220th St. SW

Mountlake Terrace, WA 98043

Toll Free 1-800-817-3056

Toll-Free TTY for the deaf and hard of hearing..... 711

MAILING ADDRESS AND CLAIMS SUBMISSION

LifeWise Health Plan of Washington

PO Box 21552

Eagan, MN 55121

COMPLAINTS AND APPEALS

LifeWise Health Plan of Washington

PO Box 21552

Eagan, MN 55121

Fax 866-903-9899

lifewise.com

LifeWise

Discrimination is Against the Law

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

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-817-3056 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-817-3056（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-817-3056 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-817-3056 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-817-3056 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-817-3056 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-817-3056 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-817-3056 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-817-3056（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-817-3056 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-817-3056 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-817-3056 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-817-3056 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-817-3056 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-817-3056 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-817-3056 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-817-3056 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-817-3056 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-817-3056 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-817-3056 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-817-3056 (TTY: 711) تماس بگیرید.