LifeWise Health Plan of Washington

LifeWise Family Dental Plan

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 your rights and duties and those of LifeWise Health Plan of Washington.

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

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

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WELCOME

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

Important Note: Pediatric dental coverage is one of the ten Essential Health Benefits that is required by the Affordable Care Act (ACA). This plan will only provide benefits for pediatric dental services to members under the age 19 (the end of the month following the member's 19th birthday).

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 dental 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 dental care coverage with us, please contact our Customer Service Department. You can find the telephone numbers on the back cover of this contract.

We look forward to serving you and your family.

LifeWise Health Plan of Washington

Your Individual Dental Care Plan Contract

This is your contract. The term "contract" means this document. LifeWise Health Plan of Washington uses its expertise and judgment to reasonably construe the terms of this contract 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 lifewisewa.com.

This coverage is issued as individual health coverage and is not sold or issued for use as a third party sponsored health plan. We do not accept direct, indirect, partial or full payment for this plan from third parties, including employers, providers, not-for-profit agencies, government agencies, or any other third party payer, unless required by law.

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

Translation Services

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

LIFEWISE FAMILY DENTAL PLAN

This plan uses the following network:

- Dental Value network

SUMMARY OF YOUR COSTS

This is a summary of your costs for covered services. Out of Network providers may bill you for amounts over the allowed amount, even when there is no coinsurance. See ***Important Plan Information*** for details.

Pediatric Dental

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

	In-Network Providers	**Out-of-Network Providers**
Individual dental deductible	$65	Shared with In-Network Deductible

	In-Network Providers	**Out-of-Network Providers**
Class I – Diagnostic and Preventive	Covered in full	Deductible, then 30%
Class II – Basic	Deductible, then 20%	Deductible, then 40%
Class III – Major	Deductible, then 50%	Deductible, then 50%
Major services include medically necessary orthodontia services for cleft lip and palate, cleft palate, cleft lip with alveolar process involvement of other craniofacial anomalies.		

	In-Network Providers	**Out-of-Network Providers**
Individual out-of-pocket maximum	$375	Unlimited

	In-Network Providers	**Out-of-Network Providers**
Family out-of-pocket maximum	$750	Unlimited

	In-Network Providers	**Out-of-Network Providers**
Calendar year maximum	Unlimited	Shared with In-Network

There are special conditions and limitations in the ***Pediatric Dental Benefits*** and in ***Exclusions.***

Adult Dental

This plan covers adult dental services for members age 19 and older when all eligibility requirements are met. Your costs are subject to the following:

	In-Network Providers	**Out-of-Network Providers**
Individual dental deductible	None	None

Covered Diagnostic and Preventive dental services aren't subject to a calendar year deductible

	In-Network Providers	Out-of-Network Providers
Class I – Diagnostic and Preventive	Covered in full	20%
Class II – Basic	40%	60%
Class III – Major	Not covered	Not covered

	In-Network Providers	Out-of-Network Providers
Calendar year maximum	$1000	Shared with In-Network

There are special conditions and limitations in ***Adult Dental Benefits*** and in ***Exclusions.***

IMPORTANT PLAN INFORMATION

Benefits are available for the services described in this plan that are furnished for a covered dental condition including treatment of an enrolled dependent child's congenital anomaly. Such services must meet all of the following requirements:

- They must be dentally necessary (see definition of "Dentally Necessary")
- They must be named in this plan as covered
- They must be furnished by a licensed dentist (D.M.D. or D.D.S.) or denturist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual such as a Registered Nurse (R.N.) or Advanced Registered Nurse Practitioner (A.R.N.P.) performing within the scope of his or her license or certification, as allowed by law. (These providers are referred to as "dental care providers.")
- They must not be excluded from coverage under this benefit

At times we may need to review diagnostic materials such as dental x-rays to determine your available benefits. These materials will be requested directly from your dental care provider. If we're unable to obtain necessary materials, we'll provide benefits only for those dental services we can verify as covered.

Coverage under this dental plan is based on allowable charges for dentally necessary covered services. See ***Definitions*** for a detailed explanation of "allowable charge."

Alternative Benefits

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

Estimate of Benefits

An estimate of benefits verifies, for the dental care provider and yourself, your eligibility and benefits. Because we consider alternative treatment at the time we review the estimate, our review may result in a lower cost of treatment and additional services under this benefit. It may also clarify, before services are rendered, treatment that isn't covered in whole or in part. This can protect you from unexpected out-of-pocket expenses.

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

Our estimate of benefits shouldn't be considered a guarantee of payment. Payment of any service will be based on your eligibility and benefits available at the time services are rendered.

Calendar Year Deductible

A calendar year deductible is the amount of expense you must incur in each calendar year for certain covered services and supplies before this plan provides benefits. See the ***Summary of Your Costs*** for your deductible amounts.

Individual Calendar Year Deductible

This plan includes an individual deductible. After you pay this amount, this plan will begin paying for your covered services.

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

Family Calendar Year Deductible

We also keep track of the expenses applied to the individual calendar year deductible that are incurred by all enrolled family members combined. When the total equals the family deductible, we'll consider the individual deductible of every enrolled family member to be met for the year.

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

Coinsurance

As used in this plan, "coinsurance" is a defined percentage of allowable charges for covered services and supplies you receive from non-network providers. The percentage you're responsible for, not including any applicable calendar year deductibles, is called "coinsurance."

See the ***Summary of Your Costs*** for your coinsurance amount.

Dental Benefit Maximum

A Dental Benefit Maximum is the most the plan will pay towards covered dental services. Benefits for covered services with multiple treatment dates are subject to the dental benefit maximum of the calendar year in which the services are started.

See the ***Summary of Your Costs*** for your dental benefit maximum amount.

In-Network Providers

This dental plan utilizes the Dental Value network providers.

This dental plan is designed to provide you the lowest out-of-pocket costs when you receive services from a Dental Value in-network provider when you are inside the service area. See ***Definitions*** in this contract for a definition of the service area.

When you receive services from an in-network provider, your claims will be submitted directly to us and available benefits will be paid directly to the dental care provider. In-network providers agree to accept our "allowable charge" (see ***Definitions***) as payment in full. You're responsible only for the calendar year deductible, applicable network copay, amounts that are more than stated benefit maximums, and charges for non-covered services.

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. To find an in-network provider, please refer to our website or contact Customer Service Department. You will find contact information on your LifeWise ID card.

Please Note: 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.

Out-of-Network Providers

If you decide not to use a Dental Value provider, you may choose any dental care provider. If you receive services from out-of-network dental care providers, including providers outside the United States, you'll get the lowest level of coverage under this plan for covered services. You'll also be responsible for amounts above the allowable charge in addition to the non-network coinsurance, amounts that are more than stated benefit maximums, charges for non-covered services, and any applicable calendar year deductible. Amounts that are more than the allowable charge don't accrue toward your calendar year deductible.

You may also be required to submit the dental claim yourself if your dental care provider doesn't do this for you. See ***How Do I File A Claim*** for instructions on submitting claims for reimbursement.

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.

Claim Payment

When we process your claim, we will send a written notice explaining how the claim was processed. If the claim is denied in whole or in part, we will send a written notice that states the reason for the denial, and information on how to request an appeal of that decision, however you have the right to request and obtain copies of information relevant to the claim free of charge by calling Customer Service.

PEDIATRIC DENTAL BENEFITS

This plan covers pediatric dental services until the end of the month of a member's 19th birthday, when all eligibility requirements are met. For members age 19 and older see ***Adult Dental Benefits***.

This benefit includes

Class I – Diagnostic and Preventive Services

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

Class II – Basic Services

- Limited oral evaluations – problem focused or emergent. (See definition of ***Limited Oral Evaluation-Problem Focused***)
- Other x-rays include:
  - Cephalometric film is limited to once every 24 months
  - Oral and facial photographic images and other non-routine x-rays are subject to review for dental necessity
- Fillings, consisting of amalgam and resin-based composite on any tooth surface are limited to once every 24 months. Multiple restorations on any tooth surface will be considered one surface regardless of the number or combination of restorations.
- Prefabricated stainless steel crowns including those made with porcelain, ceramic or resin material are limited to once every 36 months on permanent and primary teeth
- Repair to bridge (fixed partial denture), complete and partial dentures is limited to once in a 12 month period
- Recement or rebond permanent crown, onlay, inlay, bridge or fixed partial denture is covered for members age 12 years and older
- Repair to crowns (indirect), onlay, inlay is limited to once per tooth per lifetime

- Pulp vitality tests
- Non-surgical periodontics include:
  - Full mouth debridement is limited to once every 3 years
  - Periodontal maintenance following periodontal therapy is limited to 4 per calendar year for members age 13 and older
- Simple extractions
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- House/extended care facility call is limited to 2 per facility per day, when medically or dentally necessary
- Behavior management (behavior guidance techniques used by dental provider)
- Occlusal guard (nightguard) is covered for bruxism and other occlusal factors when dentally necessary for members age 12 and over.

Class III – Major Services

- Diagnostic casts or study models
- Inlay, onlay, and crowns (indirect) are covered for members age 12 years and older, limited to permanent anterior teeth only, and limited to once every five years when there is significant loss of clinical crown and no other dentally appropriate restoration will restore function. For inlay, onlays, and crowns the service start date is the preparation date. The completion date is the seat date.
- Crown build-ups including pins, and cast post and core
- Endodontics Services include:
  - Direct pulp cap
  - Therapeutic pulpotomy is limited to primary teeth only
  - Pulpal debridement is limited to permanent teeth only
  - Pulpal therapy (resorbable filling) is limited to primary teeth only
  - Endodontic treatment is limited to primary posterior and permanent anterior, bicuspid, and molar teeth excluding teeth 1, 16, 17, and 32 teeth only. For root canals and retreatment of root canals, the service start date is the date the canal is opened. The service completion date is the date the canal is filled.
  - Endodontic retreatment includes the removal of post, pin, and old root canal filling material, and all procedures necessary to prepare the canal with placement of new filling material and is limited to permanent anterior, bicuspid, and molar teeth excluding teeth 1, 16, 17, and 32. Endodontic retreatment provided by the original treating provider or clinic is subject to review for medical or dental necessity.
  - Apexification for apical closures is limited to anterior permanent teeth only.
  - Apicoectomy and retrograde filling is limited to anterior teeth only
- Periodontal scaling and root planing is covered for members age 13 years and older and is limited to once per quadrant every 24 months
- Surgical periodontics include:
  - Gingivectomy and gingivoplasty is limited to once every 3 years per quadrant
  - Osseous surgery including flap entry and closure, and mucogingival surgery is limited to once every 5 years per quadrant
- Initial placement of bridges (fixed partial dentures). Replacement is limited to once every 7 years after the original was placed. For fixed partial bridgework the service start date is the preparation date. The completion date is the seat date.
- Initial placement of complete dentures, including overdentures is covered when the denture cannot be made serviceable by a less costly procedure. For dentures the service start date is the impression date. The

completion date is the delivery date.

- Includes six-months post-delivery care (e.g., adjustments, soft relines, and repairs) after placement.
- Replacement of complete denture or overdenture is limited to 1 per lifetime and at least 5 years after the original was placed.

- Initial placement of resin base partial dentures are covered when one or more anterior teeth are missing or four or more posterior teeth (excluding third molars) per arch and the remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis. For resin base partial dentures, the service start date is the impression date. The completion date is the delivery date.
  - Includes six-months post-delivery care (e.g. adjustments, soft relines, and repairs) after placement
  - Replacement of resin partials is limited to once every three years
- Denture rebase and reline is limited to once in a three year period when performed at least six-months after placement
- Denture adjustment, excluding six-months post-delivery care
- Dental implant crown and implant abutment related procedures limited to 1 every 7 years. For implant supported crowns the service start date is the preparation date. The completion date is the seat date.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Member Lifetime.
- Other oral Surgery related to the teeth and supporting structures in a dental office including:
  - Surgical extraction and removal of erupted or impacted tooth
  - Biopsy of oral tissue, hard or soft
  - Removal of odontogenic cyst or tumor
  - Alveoplasty
  - Vestibuloplasty
  - Frenuloplasty/frenulectomy is covered for members age 6 and under
  - Residual root removal
- Treatment of post-surgical complications such as dry socket by a dental provider
- Hospital call including emergency care limited to 1 per day, when dentally necessary
- Therapeutic parenteral/therapeutic drugs such as antibiotics, steroids, and anti-inflammatory medication administered in a dental office
- Anesthesia in conjunction with covered services in a dental care provider's office includes:
  - General anesthesia, deep sedation or intravenous (conscious) sedation when necessary due to age, condition or degree of difficulty
  - Non-intravenous conscious sedation
  - Nitrous oxide is limited to once per day
  - Local anesthesia and regional blocks are considered part of the global fee if billed with any covered service
- Medically Necessary Orthodontia Services

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

  An ***Estimate of Benefits*** is recommended prior to services being received. See ***Estimate of Benefits***.

Dental Care Services for Congenital Anomalies

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

Pediatric Non-Covered Services

This section of your contract explains which pediatric dental services are limited and not covered. See ***Exclusions*** for general contract exclusions. See ***Pediatric Dental Benefits*** for covered services that have own specific limitations.

This benefit does not cover:

- Application of any type of desensitizing medicament
- Cast-metal framework, flexible base, and removable unilateral partial dentures
- Cleaning of appliances
- Connector bar or stress breaker
- Coping
- Diagnostic tests and examinations including collection, preparation, analysis, viral culture, genetic and caries susceptibility tests, and adjunctive pre-diagnostic tests.
- Diagnostic tomographic surveys, cone beam, MRI, ultrasound, 3-D imaging, and posterior-anterior or lateral skull and facial bone survey films
- Duplicate appliances
- Duplicate x-rays
- Extra dentures or other duplicate appliances, including replacements due to loss or theft
- Fabrication of an athletic mouthguard
- Facility charges (hospital and ambulatory surgical center) for dental procedures
- Gold foil restorations
- Home use products. Services and supplies that are normally intended for home use such as take-home fluoride, toothbrushes, floss and toothpaste
- Immediate dentures
- Implants and implant related services including but not limited to:
  - Surgical placement of implants including endosteal, eposteal, and transosteal;
  - Interim endosseous implants;
  - Endodontic endosseous implants;
  - Sinus augmentations or lift;
  - Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
  - Radiographic/surgical implant index;
  - Unspecified implant procedures.
- Indirect pulp caps
- Labial veneers
- Localized delivery of antimicrobial agents
- Medication and supply such as take-home drugs, pre-medications, therapeutic drug injections and supplies
- Occlusion analysis and limited and complete occlusal adjustments

- Oral pathology laboratory including collection of tissue samples, cultures and specimens
- Oral surgery treating fracture of the mandible (jaw)
- Pin retention in addition to restoration
- Plaque control programs (dietary instruction and home fluoride kits)
- Precision attachments, replacement of replaceable parts for semi-precision or precision attachments and personalization of appliances
- Provisional Splinting
- Sedative fillings
- Surgical procedures including:
  - Exfoliative cytology sample collection or brush biopsy
  - Incision and drainage of abscess-extra oral soft tissue
  - Radical resection of maxilla or mandible
  - Removal of non-odontogenic cyst, tumor or lesion
  - Surgical stent
  - Surgical procedures for isolation of a tooth with rubber dam
- Temporary, interim or provisional services for crowns, bridges or dentures
- Tobacco cessation and nutritional counseling for control of dental disease
- Tooth preparation, acid etching, all adhesives, and liners
- Tooth transplantation including re-implantation from one site to another and splinting and/or stabilization

ADULT DENTAL BENEFITS

This plan covers adult dental services for members age 19 and older when all eligibility requirements are met. For members under age 19 see ***Pediatric Dental Benefits***.

Class I – Diagnostic and Preventive Services

- Routine comprehensive and periodic oral evaluations including second opinions, are limited to 2 per calendar year.
- Limited oral evaluations – problem focused (including emergency evaluations) are not limited. See the ***Definitions*** section for the definition of a Dental Emergency.
- Comprehensive periodontal evaluations, re-evaluations, and detailed and extensive oral evaluations are limited to 2 per calendar year.
- Prophylaxis (cleaning) is limited to 2 per calendar year
- Periodontal maintenance, as a follow-up to active periodontal treatment is limited to 4 visits per calendar year
- X-rays include:
  - Either a complete series (full-mouth) x-ray or panoramic films, once every 5 calendar years, but not both
  - Bitewing x-rays, once per calendar year
  - Periapical x-rays
- Topical application of fluoride is limited to one treatment per calendar year
- Sealants or preventive resin restorations are limited to once every 2 calendar years, for posterior permanent teeth only

Class II – Basic Services

- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once every 2 calendar years.
- Periodontal scaling and root planing is limited to once per quadrant every 3 calendar years
- Localized delivery of antimicrobial agents
- Emergency palliative treatment. We require a written description and/or office records of services provided.

Adult Non-Covered Services

This section of your contract explains which pediatric dental services are limited and not covered. See ***Exclusions*** for general contract exclusions. See ***Adult Dental Benefits*** for covered services that have own specific limitations.

This benefit does not cover:

- Pre-diagnostic services such as screening or assessments
- Oral pathology laboratory
- Cone beams, MRI and ultrasounds
- Tests and examinations such as genetic, caries, pulp vitality, diagnostic casts and risk assessment
- Lab collection, testing, processing and analysis
- Nutritional and tobacco counseling
- Oral hygiene instructions
- Preventive resin restorations or interim carries arresting medicament application

- Space maintainers, including recement or removal
- Resin infiltration and resin-based composite crowns
- Resin infiltration
- Gold foils, inlay and onlay restorations
- Crowns and provisional crowns including re-cement, re-bond and repair of crowns
- Crown core buildups including any pins/posts
- Veneers
- Endodontic services including root canals, apexification/recalcification, pulpal regeneration, and apicoectomy/periradicular services
- Periodontal surgery
- Provisional splinting
- Full mouth debridement
- Complete and partial dentures including adjustments, repairs, rebase, reline, and tissue conditioning. This includes inspection and removal
- Interim complete and partial dentures
- Overdentures
- Precision attachments
- Maxillofacial prosthetics including fluoride, medicament and radiation carriers
- Implant and implant related services
- Fixed partial dentures or bridges including re-cement and re-bond
- Temporary partial dentures or bridges
- Precision attachments
- Oral and maxillofacial surgery including extraction and removal of teeth
- Alveoloplasty and vestibuloplasty
- Excision of lesions and bone tissue
- Surgical incisions
- Treatment of fractures
- Sutures and other repair procedures such as skin grafts
- Bone grafts
- Collection and application of blood
- Frenulectomy and frenuloplasty
- Salivary surgical procedures
- Tracheotomy/coronoidectomy
- Temporomandibular Joint (TMJ) Disorders including any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and aftereffects
- Orthognathic Surgery including procedures to lengthen or shorten the jaw not required due to temporomandibular joint disorder, injury, sleep apnea or congenital anomaly
- Orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.
- Adjunctive general services such as anesthesia, drugs

- Application of desensitizing medicament
- Occlusal guard (nightguard) and athletic mouthguards, including repair and reline
- Occlusal analysis
- Occlusal adjustment (limited and complete)
- Enamel microabrasion, odontoplasty, and bleaching

DENTAL CARE SERVICES FOR INJURIES

When services are related to injuries, benefits are available for covered services as listed in the ***Summary of Your Costs***. For a list of covered services for under this plan, please refer to the ***Pediatric Dental Benefits*** or the ***Adult Dental Benefits***.

Benefits will be provided for repreparation or repair of the natural tooth structure when it is required because of an injury to that structure, and such repair is performed within 12 months of the injury.

These services are only covered when they're:

- Necessary because of an injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing
- Performed within 12 months of the injury
- 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 would cause the tooth to be in a weakened state prior to the injury

If you have a medical plan with LifeWise then dental care services related to accidental injury are covered under your LifeWise medical plan. Please refer to the ***Dental Accidents*** section of your LifeWise medical plan contract.

Please Note: An injury doesn't include damage caused by biting or chewing, even if due to a foreign object in food.

Extension Requests for Injury Services

If the 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.

EXCLUSIONS

This section lists the services that are either limited or not covered by this plan. Benefits can also be affected by your eligibility. Some benefits may also have their own specific limitations.

Amounts Over the Allowed Amount

Costs over the allowed amount as defined by this plan including services from a non-contracted provider.

Benefits from Other Sources

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

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

- School or athletic coverage

Benefits That Have Been Exhausted

Services more than benefit limitations or maximums of this plan.

Broken or Missed Appointments

Charges for Records or Reports

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

Comfort or Convenience

- Personal services or items like meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport.
- Meal or dietary assistance, including “Meals on Wheels”

Complications

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

Conditions from Professional Sports

Any condition related to semiprofessional or professional athletics, including practice. Semiprofessional athletics are athletics requiring a high level of skill, for which you are paid, even if the activity is not your full-time occupation.

Cosmetic Services

- Drugs, services or supplies for cosmetic services.
- Cosmetic orthodontia

Counseling, Education and Training

Counseling, education or training in the absence of illness including:

- 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

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.

Dental Services Received From:

- A dental or medical department maintained for employees by or on behalf of an employer; or
- A mutual benefit association, labor union, trustee, or similar person or group.

Dietary Services

Dietary planning for the control of dental caries, oral hygiene instruction and training in preventive dental care.

Experimental or Investigational Services

Experimental or investigative services or supplies, see Definitions. This plan also does not cover any complications or effects of such services.

Extra or Replacement Items

Extra dentures or other duplicate appliances, including replacements due to loss or theft.

Facility Charges

Hospital and ambulatory surgical center care for dental procedures.

Family Members or Volunteers

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

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

Government Facilities

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

Home-Use Products

Services and supplies that are normally intended for home use such as take-home fluoride, toothbrushes, floss and toothpaste.

Illegal Acts and Terrorism

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt.

Increase of Vertical Dimension

Any service to increase or alter the vertical dimension.

Military Service and War

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, National Guard or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law.

Multiple Providers

Services provided by more than one dental care provider for the same dental procedure.

No Charge or You Don't Legally Have to Pay

- Services for which no charge is made, or for which none would have been made if this plan weren't in effect
- Services for which you don't legally have to pay, unless benefits must be provided by law

Non-Covered Services

Services or supplies:

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

Non-Diagnostic Testing

Testing required for employment, schooling, screening or public health purposes.

Non-Treatment Charges

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

Non-Treatment Facilities, Institutions or Programs

Benefits are not provided for:

- 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.

Non-Standard Techniques

Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.

Not Covered Under This Plan

- Services that aren't listed as covered in this booklet, or that are directly related to any condition, service or supply that isn't covered under this plan.
- Services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends)

Orthognathic Surgery

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

Prescription Drugs

Any prescription drugs or medicines. This includes vitamins and food supplements.

Provider's Licensing or Certification

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

Serious Adverse Events and Never Events

Members and this plan are not responsible for payment of services provided by in-network providers for

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

Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.

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

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed in the front of this booklet or on the Centers for Medicare and Medicaid Services (CMS) website at {**www.cms.hhs.gov**.}

Services or Supplies for which You Do Not Legally Have to Pay

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

Services or Supplies Not Dentally Necessary

Services that are not dentally necessary

Services or Supplies Not Medically Necessary

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

Temporomandibular Joint (TMJ) Disorders

Any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and aftereffects thereof.

Testing and Treatment Services

Testing and treatment for mercury sensitivity or that are allergy-related.

Work-Related Illness or Injury

This plan does not cover 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 Dental Care Plans

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

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

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

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

Definitions

For the purposes of COB:

- A **plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the 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 dental 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 dental 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 dental care expense, including deductibles, coinsurance and copayments, 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.

  An example of an expense that is **not** allowable is any amount over the highest of the expense amounts allowed by either the primary or secondary plan. This is true regardless of what method the plans use to set allowable expenses. However, when Medicare is primary to your other coverage, Medicare's allowable expense must be treated as the highest allowable.
- **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.

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, unless the group coverage 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 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 they were ever married:
  - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. This rule and the court decree rules below apply 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 health care expenses, the plan of the parent with financial responsibility is primary.
  - If a court decree makes both parents responsible for the child's health care 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 health care expenses or coverage, the birthday rule determines which plan is primary.
  - If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
    - The plan covering the custodial parent, first
    - The plan covering the spouse of the custodial parent, second
    - The plan covering the non-custodial parent, third
    - The plan covering the spouse of the non-custodial parent, last
  - If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

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

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

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

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

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

COB's Effect on Benefits

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

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a 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 they are normally covered.

Certain facts about your other health care 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 the “Right of Recovery/Facility of Payment” provision in the plan.

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

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

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 compliant is when you are not satisfied with customer service, quality, or access to medical service, and you want to share it with LifeWise.

How to file a complaint:	**Send the details in writing to:**
Call customer service at 1-800-817-3056	LifeWise Health Plan of Washington
Send a fax to 844-903-9899	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

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 or device was denied or partially denied. This includes prior authorization denials.
Enrollment canceled or not issued	No Coverage	You are not eligible to enroll or stay in the plan

The rest of this section will explain the appeal process. If you still have questions, please call Customer Service. Contact information is on the back of your LifeWise ID card.

APPEAL LEVELS

You have the right to appeal:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	LifeWise will review your appeal.	180 days from the date you were notified of our decision.

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 at 800-817-3056
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on **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 Attn: Appeals Coordinator 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

Attn: Appeals Coordinator
PO Box 21552
Eagan, MN 55121

Fax: 866-903-9899

Appeal Response Time Limits

We'll review your appeal and send a decision 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

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 HAPPENS WHEN YOU HAVE ONGOING CARE

Ongoing care is continuous treatment you are currently receiving.

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. Please see the table above. 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 care that you are currently receiving

Once LifeWise decides

If LifeWise:

- 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**

ELIGIBILITY AND ENROLLMENT

General Eligibility Requirements

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

- The subscriber. A subscriber must enroll and maintain enrollment on a LifeWise individual medical plan to qualify for enrollment on this individual dental plan.
- The lawful spouse of the subscriber, unless legally separated.
- 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.”
- The Subscriber’s state-registered domestic partner (as required by Washington state law).
- A dependent child who is 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 biological 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 of the subscriber or spouse. There must be a court order signed by a judge, which grants guardianship of the child 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

  Please Note: Foster children are not eligible for coverage.

Enrollment and maintenance of coverage on this contract is also contingent on the individuals meeting **all** 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 enough 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. See ***Definitions***.
- 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

Special Enrollment Period

Qualifying Events

Individuals who do not enroll in this plan during a designated open enrollment period may later enroll in this plan outside of an open enrollment period only if one of the following is met:

- Birth of a newborn child
- Marriage or entering into a domestic partnership, including eligibility as a dependent
- Placement for adoption of a child of the subscriber or enrolled spouse, this also applies to children placed in foster care
- Loss of employer sponsored coverage
- A loss of Medicaid or other public program providing health benefits
- A loss of coverage due to a dissolution of marriage or termination of domestic partnership
- A loss of coverage due to a change in residence and your existing health plan does not provide coverage in your new area
- Loss of COBRA benefits
- Loss of coverage on The Exchange, due to an error by The Exchange, the issuer or HHS
- The loss of coverage under a Student Insurance plan (involuntary or voluntary)
- Experience an exceptional circumstance that prevented enrollment in coverage
- Victims of domestic abuse/violence or spousal abandonment and their dependents
- A situation in which the loss of coverage in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual
- If the person discontinues coverage under a health plan offered pursuant to chapter 48.41 RCW

Enrollment is subject to verification at the time of application. Please see lifewisewa.com or if you enrolled through The Exchange, contact The Exchange for information on required documentation for your qualifying event.

When we receive your completed enrollment application, required documentation and any required subscription charges within 60 days of the date of the qualifying event, coverage under this plan will become effective on the first of the month following receipt of your enrollment application or we are notified of enrollment by The Exchange.

If we don't receive your completed enrollment application within 60 days of the qualifying event, please ***see Open Enrollment Period***.

When Coverage Begins

You must submit your enrollment request for new dependents to us or The Exchange timely. 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 dependent children.

Coverage under this dental plan is dependent on your enrollment in a LifeWise individual medical plan. When the subscriber enrolls on this dental plan, any dependents including spouse, domestic partner, or dependent children currently enrolled under the LifeWise individual medical plan will also be enrolled at the same time under this dental plan. Coverage will begin on the first day of the month following receipt of an approved application. The receipt date will be the date of postmark or the date of delivery to us, whichever is earlier.

New Dependents

Dependents must be concurrently enrolled on a LifeWise individual medical plan. When adding new dependents, completed applications must be submitted within the stated time frames below.

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. If we don't receive the enrollment application within 60 days of birth, refer to the "When Coverage Begins" section.

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 dependent children.

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. If we don't receive the enrollment application within 60 days of the date of placement with the subscriber, refer to the "When Coverage Begins" section.

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 dependent children.

Legal Dependents

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. If we don't receive the enrollment application within 60 days of the date legal guardianship began, refer to the "When Coverage Begins" section.

Children Covered by A Medical Child Support Order

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. If we don't receive the enrollment application within 60 days of the date of order, refer to the "When Coverage Begins" section.

New Dependents 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. If we don't receive the enrollment application within 60 days of the date of marriage, refer to the "When Coverage Begins" section.

Other Provisions Affecting Coverage

Term of Contract

The contract is guaranteed renewable except as stated under Termination of Coverage. No rights are vested under this contract.

Subscription Charges and Grace Period

This contract is issued in consideration of an accepted application or notification of enrollment through The Exchange and the payment of the required subscription charges. Subscription charges are not accepted from third party payers including employers, providers, non-profit or government agencies, unless required by law.

Federal Government Assistance with Subscription Charges: If the federal government is paying a portion of your subscription charge as an advance payment of the premium tax credit, you have a different grace period to pay your portion of the subscription charges. If we receive an advance payment of premium tax credit from the government for you, you have up to a three month grace period to pay all outstanding subscription charges.

- For the first month of the three month grace period, we will continue to process and pay claims for covered services under this plan.
- Beginning on the first day of the second month and through the last day of the third month, we will pend all your claims.

  If we have not received all outstanding subscription charges by the last day of the third month, this contract will, without further notice, terminate as of the last day of the first month of the grace period. We will also deny all pended claims for services you received in the second and third months of the grace period. Note that providers can then seek reimbursement directly from you for those services, and they would not be considered covered under this plan.

  If after termination you wish to re-enroll on an individual plan offered by us or one of our related companies, we reserve the right to require you to pay any unpaid subscription charges that were due during the 12 month period prior to your re-application for coverage.

No Federal Government Assistance with Subscription Charges: If the federal government is not paying any portion of your subscription charges, the 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.

Consistent with state law, we reserve the right to revise subscription charges annually upon written notice (see ***Notice***). Such notice will be provided to the subscriber. 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 be revised in the following situations:

- A change in the number of enrolled dependents, except when subscription charges being paid for dependent children already include additional dependent children.
- The subscriber enrolls in a different LifeWise individual dental 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 an assessment or tax on our revenue.

Subscription charges may also be adjusted outside of the plan renewal when the federal or state government requirements that affect the plan are changed, such as the government ceasing payments to us for advance premium tax credits, cost share reduction payments, or other monies owed to LifeWise.

TERMINATION OF COVERAGE

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.

- Coverage under the subscriber's LifeWise individual medical plan is terminated.
- 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.
- 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 contract 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 coverage with any LifeWise individual dental plan by submitting a completed application but only at the next dental add-on period, after a period of 12 consecutive months of no enrollment on a LifeWise individual dental plan. Existing subscribers may apply for coverage on a LifeWise individual dental plan annually. This is called the add-on period.

Continuation of Coverage

Continued Eligibility for A Disabled Child

Coverage may continue past the limiting age for a 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 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

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

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 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.

OTHER PLAN INFORMATION

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, unless 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.

Entire Contract

The entire contract between you and LifeWise Health Plan of Washington consists of all the following:

- The contract booklet
- All applications used to apply for coverage
- All attachments and endorsements included now or issued later

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

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

Evidence of Dental Necessity

We have the right to require proof of dental 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.

Dental Care Providers - Independent Contractors

All dental 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 Do I 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 by contacting Customer Service.
- Attach the itemized bill. This bill must include the name of the subscriber and patient, dates of service, American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes for each service provided and itemized charges for each service.

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.

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 he or she has 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.

ID Card

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

Individual Dental Plan

This contract is sold and issued in Washington State as an individual dental 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 any intentionally false or misleading statement, we will be entitled to recover these amounts. See Right of Recovery below.

And, if you make any intentionally false or misleading statement on any application for enrollment under this plan that affect your acceptability for coverage, we may, at our option, deny your claim, reduce the amount of benefits provided for your claim, or rescind your coverage under this plan. ("Rescind" means to cancel coverage back to its effective date, as if it had never existed at all.) We reserve the right to refund subscription charges previously paid and recover claims and administrative costs from the subscriber, person responsible for the intentionally false information, or any person receiving care.

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.

Notice

Any notice we are required to submit to you will be considered delivered if mailed to the subscriber or the producer, as we may elect, at the most recent address appearing on our records. We will use the date of

posting in determining the date of our notification. If the subscriber is required to submit notice to us, we will determine our receipt of such notice based on the earlier of postmark or date received at our offices.

Notice of Information Use and Disclosure

We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include dental information, or personal data such as your address, telephone number or Social Security Number. We may receive this information from, or release it to, dental 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 dental 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 his or her dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

In addition, if this contract is 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.

Subrogation and Reimbursement

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

Definitions The following terms have specific meanings in this contract:

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

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

Agreement to Arbitrate Any disputes that arise as part of this provision will be resolved by arbitration. Both you and we will be bound by the decision of the arbitration proceedings.

Disputes will be resolved by a single arbitrator. Either party may demand arbitration by serving notice of the demand on the other party. Each party will bear its own costs and share equally in the fees of the arbitrator. Arbitration proceedings pursuant to this provision shall take place in King County, Washington.

This agreement to arbitrate will begin on the effective date of the contract and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

Venue

All 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; 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.

DEFINITIONS

This section of the contract explains definitions that have specific meaning in this plan. 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 dental judgment and expertise of Dental Directors to determine whether claims for benefits meet the definitions below of "Dental Necessity" or "Experimental/Investigative Services." This does not prevent you from exercising your rights you may have under applicable law to appeal or bring a civil challenge to any eligibility or claims determinations.

Affordable Care Act

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

Allowable Charge

The allowable charge shall mean one of the following depending on whether the dental care provider is participating or non-participating:

- **Dental Care Providers Who Have Agreements with Us**

  The amount for dentally necessary services and supplies these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges more than the stated benefit maximums, and charges for services and supplies not covered under this plan.

  Your liability for any applicable calendar year deductibles, copays, coinsurance and amounts applied toward benefit maximums will be calculated based on the allowable charge.

- **Dental Care Providers Who Don't Have Agreements with Us**

  The allowable charge will be the maximum allowable charge as determined by LifeWise Health Plan of Washington in the area where the services were provided, but in no case higher than the 90th percentile of provider fees in that geographic area.

  When you receive services from dental care providers that don't have agreements with us, your liability is for any amount above the allowable charge, and for any calendar year deductibles, coinsurance, amounts that are more than stated benefit maximums and charges for non-covered services and supplies.

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

- **Emergency Services**

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

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

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

If you have questions about this information, please call our Customer Service Department.

Calendar Year

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

Child

A child is defined as one of the following:

- The biological offspring of either or both the subscriber or spouse
- The 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. "Place 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 child designated by a court of appropriate jurisdiction as the legal dependent of the subscriber or spouse
- A child for whom the subscriber or spouse is required by a medical child support order to provide health coverage

A child must be under age 26 to be eligible for coverage, except as provided in the ***Continued Eligibility for a Disabled Child*** section.

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.

Comprehensive Oral Evaluation

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

Contract

The contract consists of all the following:

- This document
- All endorsements, amendments and addenda attached to or issued to become part of this contract
- Any application required to obtain coverage

Covered Services

Services, including supplies furnished incident to those services, which are specified in this contract and for which benefits will be provided subject to any applicable deductible, coinsurance, stated benefit maximums, and all terms, conditions, limitations, and exclusions of this contract. The fact that a service is a covered service does not mean that it is dentally necessary.

Deductible

The amount of the allowable charges incurred for covered services for which you are responsible before we provide benefits. Amounts more than the allowable charge do not accrue toward the deductible.

Dental Care Provider

A state-licensed:

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

The benefits of this plan are available if professional services are provided by a state-licensed denturist, a dental hygienist under the supervision of a licensed dentist, or other individual such as a Registered Nurse (R.N.) or Advanced Registered Nurse Practitioner (A.R.N.P.) performing within the scope of his or her license or certification, as allowed by law and this plan's benefits would be payable if the covered service were

provided by a "dental care provider" as defined above.

Dentally Necessary and Dental Necessity

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

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

Dependent

The subscriber's spouse and/or children enrolled for coverage under this contract.

Domestic Partner

The person who is in a domestic partnership with the subscriber and is enrolled for coverage under this contract.

Effective Date

The date on which your coverage starts under this contract. This date is established by us and appears on our records.

Emergency Dental Condition

A dental condition with acute symptoms including severe pain or infection without immediate dental attention could result in the following:

- Placing the health of the individual, a pregnant woman or unborn child in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part

Exclusion

A provision that states that we have no obligation under this contract to provide any benefits, unless stated within the specific exclusions.

Experimental and Investigative Service

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

- It is a drug or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date that it is provided
- The service is subject to oversight by an Institutional Review Board
- Reliable evidence does not demonstrate the efficacy of the service, nor does it define a specific role for the service in clinical evaluation, management, or treatment
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

"Reliable evidence" includes, but is not limited to, reports and articles published in authoritative medical and scientific literature.

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.

Injury

Physical harm caused by a sudden and unforeseen event at a specific time and place. It is independent of illness, unless infection of a cut or wound. **Please Note:** An injury doesn't include damage caused by biting or chewing, even if due to a foreign object in food.

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.

Limitation

A restriction to a specific benefit.

Limited Oral Evaluation – Problem Focused

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

Member

The subscriber and/or dependents enrolled under this contract. Also referred to as "you."

Orthodontia

The branch of dentistry which specializes in tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Plan

The benefits, terms, and limitations set forth in this contract.

Service Area

The service area is the geographic area in Washington state in which an individual must live in order to be eligible for this health plan. The service area for this plan are the following counties:

Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman and Yakima.

Spouse

The person who is legally married to the subscriber and is enrolled for coverage under this contract.

Subscriber

The individual who has met the eligibility and residency requirements of this plan and in whose name the application is filed and the coverage established.

Subscription Charge

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

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

Visual Oral Screenings or Assessments

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

Washington Health Benefit Exchange ("The Exchange")

The state authorized entity which determines eligibility to enroll in this plan.

CONTACT INFORMATION

CUSTOMER SERVICE

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

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 1-844-990-0262]

[www.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.