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 (LifeWise) 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.

GUARANTEED RENEWABILITY OF COVERAGE Coverage under this contract will not be terminated due to a change in your health. Renewability and termination of coverage are described under ***ELIGIBILITY and ENROLLMENT***.

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.

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 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 payments from third-party payers including employers, business accounts, providers, not-for-profit agencies, government agencies, or any other third-party payer, either directly or indirectly, except as required by law. We do not accept payments from business accounts, such as business credit cards or business checks, to pay for individual subscription fees.

If any provision of this Plan is superseded by state or federal law, the Plan will comply with the applicable law as it relates to those provisions.

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. The phone number is available in ***Contact Information.***

INTRODUCTION

Welcome

Thank you for choosing LifeWise Health Plan of Washington (LifeWise) for your pediatric dental care coverage. We're looking forward to taking great care of you.

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 is your health plan. It tells you what services we cover, your costs, and how to contact us. We know that health care can be complicated, and we want to help.

What your health plan can help you do

Know your plan

- What do healthcare terms mean?
- Show me real examples of what I'll pay

Find care

- How do I find doctors, facilities, and specialists near me?

Get care

- How does my plan work?
- What is covered?
- How do I keep my costs low?

Contact Information

Where To Send Claims

MAIL YOUR CLAIMS TO
LifeWise Health Plan of Washington
PO Box 21552
Eagan, MN 55121

Customer Service

Mailing Address
LifeWise Health Plan of Washington
PO Box 21552
Eagan, MN 55121

Physical Address
6707 220th St. SW
Mountlake Terrace, WA 98043

Phone Numbers
Local and toll-free number:
800-817-3056
Fax 866-903-9899

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

Complaints and Appeals

LifeWise Health Plan of Washington
Attn: Appeals Coordinator
PO Box 21552
Eagan, MN 55121

Local and toll-free number:
800-817-3056
Fax 866-903-9899

Website

Visit our website lifewise.com for information and secure online access to claims information.

Dental Estimate of Benefits

LifeWise Health Plan of Washington
Attn: P&R Dental Strategies LLC
300 American Metro Blvd Suite 190
Hamilton, MJ 08619

Fax 609-225-5432

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Quick Care Guide

Here are the most common dental care terms and how they affect what you pay for covered services. There are also examples to show how these terms fit together.

To learn more about amounts you are responsible for, visit the ***Covered Services*** section.

Allowed Amount	The maximum amount LifeWise pays for a covered service.
Alternative Treatment	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. Frequently, several alternate treatments exist to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced either with a fixed bridge or a partial denture. In all cases, we will make payment based on the allowance for the least expensive alternative treatment that is covered under this plan that meets accepted standards of dental practice. If you and your dental care provider choose the more expensive treatment, you're responsible for the additional charges beyond those for the less expensive alternative treatment.
Coinsurance	It's a percentage of the allowed amount that you pay for the service. You start paying coinsurance after you've met your deductible.
Cost shares	Your share of the allowed amount for covered services. Deductibles and coinsurance are all types of cost-shares. If you go out-of-network for care, the provider can charge additional amounts, except as prohibited by federal or state law.
Calendar Year Deductible	A calendar year deductible does apply to all pediatric dental covered services. A calendar year deductible is the amount you must pay for Class I – Diagnostic and Preventive, Class II – Basic and Class III – Major covered services per calendar year before LifeWise starts to pay for covered services. The amount credited toward the calendar year deductible won't exceed the allowed amount for the covered service.
Calendar Year Maximum	The most that LifeWise pays for adult dental benefits within a calendar year for dental covered services. After the limit is met, you pay 100% of costs out of pocket. The maximum does not apply to services and supplies for treatment of temporomandibular joint (TMJ) disorders covered under this plan. The amounts that apply to your deductible don't count toward your dollar maximums. The maximum amount applies to Basic and Major adult dental services only.
Dental Estimate of Benefit	A dental estimate of benefits verifies, for the dental care provider and you, your eligibility and benefits. It may also clarify, before services are rendered, treatment that isn't covered in whole or in part, or when alternative treatment is allowed. This can protect you from unexpected out-of-pocket expenses. A dental estimate of benefits isn't required in order for you to receive your dental benefits. However, we suggest that your dental care provider submit an estimate to us for any proposed dental services in which you are concerned about your out-of-pocket expenses. Our dental 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.

In-Network **(Contracted)**	Specific dentist or dental providers that LifeWise contracts with to provide healthcare services to members. You typically pay less when using in-network healthcare providers. Your bills will be reimbursed at a higher percentage. In-network providers will not charge you more than the allowed amount.
Out-of-Network **(Non-Contracted)**	Services from dental care providers that have not contracted with LifeWise. This could mean the service will cost more or not be paid for at all by LifeWise. Your bills will be reimbursed at a lower percentage and you may also be required to submit the claim yourself.
Out-of-Pocket Maximum	The out-of-pocket maximum is the most you pay for pediatric dental covered services in a year before LifeWise pays 100% of the allowed amount for covered services from Dental Value in-network providers. The out-of-pocket maximum includes an Individual and a Family Out-of-Pocket Maximum. However, if you get out-of-network care, you are still responsible for any charges above the allowed amount, except as prohibited by state or federal law. Expenses that do not apply to the out-of-pocket maximum include, but not limited to: • Charges above the allowed amount. • Services above any benefit maximum limit or durational limit. • Services not covered by this plan. • Services from out-of-network providers, except as prohibited by state or federal law. • Covered services that do not apply to the out-of-pocket maximum. See ***Covered Services.***
Visit or treatment or age limits	Some covered services have a maximum number of visits or treatment or age limits. After you reach this limit, you pay 100% out-of-pocket, whether or not you've met your deductible.
Year	The consecutive 12-month period that starts on your health plan's effective date. For this plan, it's a calendar year which begins January 1 and ends on December 31.

Overview

This plan is a Preferred Provider Plan (PPO). See ***Eligibility and Enrollment*** for eligibility requirements specific to subscribers and dependents. Your plan provides you benefits for covered services from providers within the Dental Value network. You have access to one of the many providers included in our network of providers for covered services included in your plan. See ***How Providers Affect Your Costs*** for more information. This plan covers pediatric dental services until the end of the month of a member's 19th birthday, when all eligibility requirements are met. This plan covers adult dental services for members age 19 and older when all eligibility requirements are met.

A list of network providers including specialists is available by contacting customer service or accessing the LifeWise website at lifewise.com.

The services covered under this dental plan are categorized under Pediatric Dental and Adult Dental and classified as Class I - Diagnostic and Preventive, Class II - Basic, and Class III – Major services. The list of covered services that relate to each class are outlined in the following pages under ***What Are My Benefits?***

Pediatric Dental

Individual Calendar Year Deductible

	In-Network Providers	Out-of-Network Providers
Individual deductible	$65 per member	Shared with In-network

Out-of-Pocket Maximum

	In-Network Providers	Out-of-Network Providers
Individual Out-of-Pocket maximum	$400 per member	Not applicable
Family Out-of-Pocket Maximum	$800 per family	Not applicable

Individual Calendar Year Maximum

	In-Network Providers	Out-of-Network Providers
Individual maximum	Unlimited	Shared with In-network

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

Adult Dental

Individual Calendar Year Deductible

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

Individual Calendar Year Maximum

	In-Network Providers	Out-of-Network Providers
Individual maximum	$1,000 per member	Shared with In-network

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

Example: In-Network Fillings

An in-network filling costs $120, the allowed amount for the service is $100, and your coinsurance is 20% of the $100, or $20. If you've met your deductible, LifeWise pays 80% of the $100, or $80. You pay the remaining $20.

 Filling charges	 Allowed amount	 Your coinsurance	 LifeWise pays	 Your total responsibility
$120	$100	$20 (20% of the allowed amount)	$80 (80% of the allowed amount)	**$20**

Example: Out-of-Network Fillings

An out-of-network filling is $120, the allowed amount for the service is $100 and your coinsurance is 40% of the $100, or $40. If you've met your deductible, LifeWise pays 60% of the $100, or $60. You pay the remaining $40, plus any cost above the allowed amount: $20.

 Filling charges	 Allowed amount	 Your coinsurance	 LifeWise pays	 Your total responsibility
$120	$100	$40 (40% of the allowed amount)	$60 (60% of the allowed amount)	**$60**

Getting Care

No ID card yet? No problem. As long as your plan date is effective, you can get care:

- The provider's office can often look up your insurance and see that you're eligible.
- Call LifeWise customer service at 800-817-3056 for your ID number.

Discover your care choices

You can see or call	When you need	What to do
Dental care providers	Routine and specialty care	Log in to lifewise.com and click "Find Care." You can search by name, type, or location.
Emergency services	Life-threatening emergency services	**Call 911** or go to an emergency room.

Important Plan Information

Benefits are available for the services described in this section that are furnished for a covered dental condition. "Covered dental condition" means a covered member's illness, injury or disease, or a dependent child's congenital malformation. Such services must meet all of the following requirements:

- They must be medically or dentally necessary. See definition of ***Medically Necessary*** or ***Dentally Necessary***.
- They must be named in this benefit as covered.
- The expense for it must be incurred while you're covered under this plan.
- They must be furnished by a licensed dentist (DMD or DDS) 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 (RN), or an Advanced Registered Nurse Practitioner ARNP) performing within the scope of their 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.
- Some types of services may be limited or excluded under this plan.

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 the allowed amount for medically and dentally necessary covered services. The percentage of an allowed amount you're responsible for is called coinsurance. See the ***Definitions*** section in this booklet for a detailed explanation of "allowed amount."

Allowed Amount

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

In-Network

The allowed amount is the fee that we have negotiated with providers who have signed contracts with us and are in your provider network. This dental plan utilizes the Dental Value network providers.

Out-of-Network

The allowed amount is the maximum allowed amount as determined by LifeWise in the area where the services were provided, but in no case higher than the 90th percentile of provider fees in that geographic area.

How Providers Affect Your Costs

In-Network Providers

This dental plan utilizes the Dental Value network providers.

This plan provides you benefits for covered services from providers of your choice. You have access to one of the many providers included in our Dental Value network.

This plan makes available to you a sufficient number and types of providers to give you access to all covered services in compliance with applicable Washington state regulations governing access to providers. Our provider network includes dentists and a variety of other types of providers.

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

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

The Dental Value provider network directories are available any time on our website at lifewise.com. You may also request a copy of this directory by calling customer service at the number located in ***Contact Information*** or on your LifeWise ID card.

As a LifeWise member, you have access to a nationwide network of Dental Value providers who can provide preventive and specialty dental care services. When you receive services from Dental Value providers, your claims will be submitted directly to us and available benefits will be paid directly to the dental care provider. Dental Value providers agree to accept our "allowed amount" as payment in full. See the ***Definitions*** section in this booklet. You're responsible only for the calendar year deductible, coinsurance, amounts that are in excess of stated benefit maximums, and charges for non-covered services.

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

Out-of-network providers are providers that are not part of our Dental Value Network. If you decide not to use a Dental Value provider, you may choose any dental care provider. If you receive services from an out-of-network dental care provider, you're responsible for amounts above the allowable charge in addition to coinsurance, amounts that are in excess of stated benefit maximums, charges for non-covered services, and the calendar year deductible. Amounts that are in excess of the allowable charge don't accrue toward your calendar year deductible or calendar year maximum.

You may 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.

Covered Services

This section talks about the benefits that are available with this plan and your costs.

The services under this dental plan are categorized under Pediatric Dental and Adult Dental and classified as Class I - Diagnostic and Preventive, Class II - Basic, and Class III – Major services. The list of covered services that relate to each type are outlined in the following pages under ***What are My Benefits?*** These services are covered once all of the following requirements are met. It is important to understand all of these requirements so you can make the most of your dental benefits.

Related Benefit Information

- See ***Exclusions and Limitations*** for a complete description of limitations and exclusions.

Dental services must meet the standards set in our medical, dental and payment policies. The plan uses policies to administer the terms of the plan. Our policies are available to you and your provider at LifeWise or by calling customer service.

Medical and dental policies are generally used to further define medical and dental necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services.

Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS).

What Are My Benefits?

The covered services under this plan are classified as:

- Class I – Diagnostic and Preventive services.
- Class II – Basic services.
- Class III – Major services.
- Dental Care Services for Injuries

The lists of services that relate to each type are outlined in the ***Benefit Overview***.

PEDIATRIC DENTAL BENEFITS

Note: This plan requires all enrollees to be under 19 years of age to be covered under the Pediatric Dental plan. See *Eligibility and Enrollment* for eligibility requirements specific to subscriber and dependents.

Important things to know:

This plan does not cover services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends), except for Major services and root canals that:

- Were started after your effective date and before the date your coverage ended under this plan, and
- Were completed within 30 days after the date your coverage ended under this plan.

Class I – Diagnostic and Preventive Services

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Class I – Diagnostic and preventive services	See Benefit Overview	No charge	Deductible, then 30% coinsurance

Benefit Overview

What services are included?	• 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 Screening***s 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
What is excluded? (LifeWise pays 0%)	• See ***Exclusions and Limitations, Pediatric Non-Covered Dental Services*** for more details.

Class II – Basic Services

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Class II – Basic services	See Benefit Overview	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance

Benefit Overview

What services are included?	• 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.

What is excluded? (LifeWise pays 0%)	• See ***Exclusions and Limitations, Pediatric Non-Covered Dental Services*** for more details.

Class III – Major Services

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Class III – Major services	See Benefit Overview	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance

Benefit Overview

What services are included?	• 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 are 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 for cleft lip and palate, cleft palate, cleft lip with alveolar process involvement or other craniofacial anomalies • Services for congenital anomalies when impairment is related to or caused by congenital disease or anomaly from the moment of birth for a child afflicted with a congenital disease or anomaly.
What is excluded? (LifeWise pays 0%)	• Any replacement or repair to any orthodontic appliance • Charges beyond the month of termination of orthodontic services if such services are terminated for any reason before completion • Expenses incurred for orthodontic services or supplies when this benefit isn't in effect or when you're not covered under this benefit • See ***Exclusions and Limitations, Pediatric Non-Covered Dental Services*** for more details.
Related benefit information	• A ***Dental Estimate of Benefits*** is recommended prior to orthodontic and congenital anomaly services being received. See ***Dental Estimate of Benefits***.

ADULT DENTAL

Important things to know:

This plan does not cover services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends), except for Major services and root canals that:

- Were started after your effective date and before the date your coverage ended under this plan, and
- Were completed within 30 days after the date your coverage ended under this plan.

Class I – Diagnostic and Preventive Services

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Class I – Diagnostic and preventive services	See Benefit Overview	No charge	20% coinsurance

Benefit Overview

What services are included?	• Routine comprehensive and periodic oral evaluations, including second opinions are limited to 2 visits per calendar year. See definition of ***Comprehensive Oral Evaluation***.
	• 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

What is excluded? (LifeWise pays 0%)	• See ***Exclusions and Limitations, Adult Non-Covered Dental Services*** for more details.

Class II – Basic Services

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Class II – Basic services	See Benefit Overview	40% coinsurance	60% coinsurance

Benefit Overview

What services are included?	• 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.
What is excluded? (LifeWise pays 0%)	• See ***Exclusions and Limitations, Adult Non-Covered Dental Services*** for more details.

Class III – Major Services

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Class III – Major services	See Benefit Overview	Not Covered	Not Covered

Benefit Overview

What services are included?	• None
What is excluded? (LifeWise pays 0%)	• See ***Exclusions and Limitations, Adult Non-Covered Dental Services*** for more details.

Dental Care Services for Injuries for Pediatric and Adult

When services are related to an accidental injury, benefits are provided for the repreparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

When services or supplies listed in another benefit of this plan are performed in the treatment of accidental dental injuries as described in this section, any calendar year deductibles, or coinsurance and limitations of that other benefit apply to this benefit.

Important things to know:

These services are only covered when they're:

- Necessary as a result of an accidental injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing, and
- On the natural tooth structure and the teeth were free from decay and functionally sound when the injury happened. 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

An accidental injury doesn't include damage caused by biting or chewing, even when caused by a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the injury date. To request an extension, please have your provider contact customer service. In order for us to review an extension request, we will ask the provider to send additional information that would show the necessity for the extension; such as, the severity of the accident or other circumstances.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Dental Care Services for Injuries	See Benefit Overview	Covered as any other service	Covered as any other service

Benefit Overview

What services are included?	• Services are related to an accidental injury; benefits are provided for the repreparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.
Related benefit information	• You may have additional costs for other services such as x-rays, restorative procedures and exam charges. See those covered services for details.
What is excluded? (LifeWise pays 0%)	• See ***Exclusions and Limitations, Pediatric Non-Covered Dental Services and Adult Non-Covered Dental Services*** for more details.

Exclusions and Limitations

This section of your booklet lists services that are either limited or not covered by this plan.

Benefit or Service	Exclusion
Adult Non-Covered Dental Services	• 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
Amounts over the Allowed Amount	Costs over the allowed amount as defined by this plan for non-emergency services from a non-participating provider.
Benefits from other Sources	Services that are covered by other types of insurance or coverage, such as: • Motor vehicle medical or motor vehicle no-fault coverage • Any type of no-fault coverage, such as Personal Injury Protection (PIP), Medical Payment coverage or Medical Premises coverage • Any type of liability insurance, such as homeowners' coverage or commercial liability coverage • Any type of excess coverage • Boat coverage • School or athletic coverage
Benefits that have been exhausted	Services in excess of limitations or maximums of this plan.
Broken or missed appointments	Broken or missed appointments, including charges from providers for broken or missed appointments.
Charges for records or reports	Charges from providers for supplying records or reports that aren't requested by LifeWise for utilization review.
Complications of a non-covered service	Includes follow-up services or effects of those services.
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 that are not medically necessary. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. • Cosmetic orthodontia

Counseling, Education and Training	Counseling, education, or training in the absence of illness or injury, including but not limited to: • Job help and outreach • Social or fitness counseling • Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff • Private school or boarding school tuition • Community wellness or safety programs
Court-Ordered Services	Services that you must get to avoid being tried, sentenced, or losing the right to drive when they are not medically necessary.
Custodial Care	Custodial services that are not covered hospice care services.
Dental Services Received from a:	• Dental or medical department maintained for employees by or on behalf of an employer; or • Mutual benefit association, labor union, trustee or similar person or group.
Dietary Services	Dietary planning for the control of dental caries.
Environmental Therapy	Therapy designed to provide a changed or controlled environment.
Experimental or Investigative Services	Experimental or investigational services or supplies, including any complications or effects of such services. This does not apply to certain services that are part of an approved clinical trial.
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 or supplies that you provide to yourself. It also doesn't cover a provider who is: • Your spouse, mother, father, child, brother, or sister • Your mother, father, child, brother, or sister by marriage • Your stepmother, stepfather, stepchild, stepbrother, or stepsister • Your grandmother, grandfather, grandchild, or their spouse • A volunteer
Governmental Facilities	Services provided by a state or federal facility that are not emergency services or 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, Illegal Services, and Terrorism	Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any service that is illegal under state or federal law.
Increase of Vertical Dimensions	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, including any related civilian forces or units.
Multiple Providers	Services provided by more than one dental care provider for the same dental procedure.

Non-Covered Services	Services or supplies directly related to any non-covered condition. • Ordered when this plan is not in effect or when the person is not covered under this plan • Provided to someone other than the ill or injured member • That are not listed as covered under this plan • Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay • Non-treatment charges, including charges for provider time • Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. • Doing housework or chores for the member or helping the member do housework or chores
Non-Diagnostic Testing	Testing required for employment, schooling, screening, or public health purposes.
Non-Standard Techniques	Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.
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.
Non-Treatment Facilities, Institutions or Programs	• Institutional care • Housing • Incarceration • Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions Examples are prisons, nursing homes, and juvenile detention facilities.
Not Covered Under This Plan	• Services that aren't listed in this booklet as covered 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)
Not Medically Necessary	Services or supplies that are not medically necessary even if they are court ordered.
Orthodontia Services	Orthodontia services including casts, models, x-rays, photographs, examinations, appliances, braces and retainers not covered above. This does not apply to medically necessary orthodontia services provided in ***Pediatric Dental.***
Orthognathic Surgery	Procedures to lengthen or shorten the jaw not required due to temporomandibular joint disorder, injury, sleep apnea or congenital anomaly.
Pediatric Non-Covered Dental Services	• 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
	  • 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
Personal comfort or convenience items	• Personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting • Normal living needs, such as food, clothes, housekeeping, and transport. This doesn't apply to chores done by a home health aide as prescribed in your treatment plan. • Dietary assistance, including "Meals on Wheels"
Prescription Drugs	Any prescription drugs or medicines. This includes vitamins and food supplements.
Provider's Licensing or Certification	Services that are outside the scope of the provider's license or certification or any unlicensed or uncertified providers.
Serious Adverse Events and Never Events	Serious Adverse Events are hospital injury(ies) caused by medical management that prolonged the hospitalization, and/or produces a disability at the time of discharge. Never Events are events that should never occur, such as a surgery on the wrong patient, surgery on the wrong body part or a wrong surgery. Members and this plan are not responsible for payment of services provided by in-network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. In-Network providers may not bill members for these services and members are held harmless. Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us or on the Center for Medicare and Medicaid Services (CMS) website.
Services or Supplies For Which You Don't 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 are court-ordered. This also includes places of service, such as inpatient hospital care or stays.
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	Any illness, condition, 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 HEALTH PLANS

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

If you do not know which plan 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.

COB DEFINITIONS

For the purposes of COB:

Plan	• A **plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contact or benefit to which COB doesn't apply is treated as a separate plan. • "Plan" means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law. • "Plan" **doesn't mean**: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law. • **This plan** means your plan's health care benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to coordinate other benefits. All the benefits of your LifeWise plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.
Primary Plan	Primary plan is a plan that provides benefits as if you had no other coverage.
Secondary Plan	Secondary plan is a plan that can reduce its benefits in accordance with COB rules. See ***COB's Effect on Benefits*** later in this section for rules on secondary plan benefits.
Allowable Expense	Allowable expense is a healthcare expense, including deductibles, coinsurance and copays, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that is not covered by any of your plans is not an allowable expense. The allowable expense for the secondary plan is the amount it allows for the service or supply in the absence of other coverage that is primary. This is true regardless of what method the secondary plan uses to set allowable expenses.

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

PRIMARY AND SECONDARY RULES

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

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

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

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

	If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.
Retired or Laid-off Employee	The plan that covers you as an active employee (an employee who is neither laid off nor retired) is primary to a plan covering you as a retired or laid-off employee. The same is true if you are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.
TRICARE	If you are a member of the U.S. military (active or retired) or you have dependents enrolled in the TRICARE program, this plan is the primary plan and TRICARE would be secondary, when required by federal law.
Continuation Coverage	If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that is not through COBRA or other continuation law. **Note:** The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.
Length of Coverage	The plan that covered you longer is primary to the plan that didn't cover you as long. If none of the rules above apply, the plans must share the allowable expenses equally.

COB'S EFFECT ON BENEFITS

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

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

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

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

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

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

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

RIGHT OF RECOVERY/FACILITY OF PAYMENT

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

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

THIRD PARTY LIABILITY (SUBROGATION)

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

Definitions The following terms have specific meanings in this contract:

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

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

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

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

UNINSURED AND UNDERINSURRED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

How Do I File a Claim?

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

Step 1. **Get the form**	• Complete the Claim Reimbursement Form, you can find it on lifewise.com or call customer service to request a copy. • A separate form is needed for each patient and each provider.

Step 2.
Collect required documents
	If requesting reimbursement for medical care, include:
	• Proof of payment (if applicable).
	• An itemized bill that includes:
	  • Name of the patient.
	  • Date of service.
	  • Name, address, and IRS tax ID of the provider.
	  • Diagnosis code (ICD-10) – You can get this from your provider.
	  • American Dental Association (ADA) Current Dental Terminology (CDT) procedure code or (CPT-4, HCPCS, ADA, or B-04) – You can get this from your provider.
	  • Itemized charge for each service received.
	  • Member ID number

Step 3. **Send in my claim**	To help process your claim, the form must be fully completed, signed, and returned with all required documents. Send your documents one of two ways: • **Email through your Secure Inbox** Sign into your account at and select Secure Inbox. Scan and send the completed form and any required documents back to us as a secure email attachment. • **Mail to:** LifeWise Health Plan of Washington PO Box 21552 Eagan, MN 55121 **Note:** Any highlights or modifications to your bill may delay processing your claim.

Timely Filing

We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses.
- Or within 365 days of the date the expenses were incurred for any other services.

The plan won't provide benefits for claims we receive after the later of these 2 dates except when required by law.

Special Notice About Claims Procedure

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. You can call customer service to get a paper copy of an Explanation of Benefits for the service or supply.

Additional Information

Any notice we're required to send to the subscriber will be considered delivered if it's mailed to the most recent address appearing on our records.

We'll use the postmark date when determining the date of our notification. If you're required to send us a notice, it will be considered delivered 3 days after the postmark date, or if not postmarked, the date we receive it.

If you only had to pay a copay to your provider for a covered service, that is not considered a claim for benefits. To get a paper copy of an explanation of benefits call customer service. Or you can visit lifewise.com for secure online access to your claims.

Notice Required for Reimbursement and Payment of Claims

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

Complaints and Appeals

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 your questions.

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

WHAT IS A COMPLAINT?

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

How to file a complaint:	**Send the details in writing to:**
Call customer service at 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 Dental Estimate of Benefits	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials.
Enrollment canceled or not issued	No Coverage	You are not eligible to enroll or stay in the plan.

APPEAL LEVELS

You have the right to one level of 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 appeal process, call customer service
Step 2. Collect supporting documents	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your provider. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a Member Appeal Form with authorization, you can find it on lifewise.com. We can't release your information without this form.
Step 3. Send in my appeal	To help process your appeal, be sure to complete the form and return with any supporting documents. Send your documents to: LifeWise Health Plan of Washington 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 in writing within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, LifeWise representatives who have not reviewed the case before will review and make a decision. Medical review denials will be reviewed by a medical specialist.

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

All other Level 1 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 the 30 days without your informed written consent.

WHAT IF YOU HAVE ONGOING CARE?

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

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

WHAT IF IT'S URGENT?

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

Examples of urgent situations are:

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

If your situation is urgent, you may ask for an expedited appeal.

ONCE LIFEWISE DECIDES

For urgent appeals, LifeWise will inform you immediately.

If LifeWise decides to:

- Reverse our initial decision, we will apply the decision quickly.
- Stand 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

800-562-6900

E-mail: cap@oic.wa.gov

Eligibility And Enrollment

This section outlines who is eligible for coverage and who can be covered under this plan. Only members enrolled on this plan can receive its benefits.

General Eligibility Requirements

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

- The subscriber must enroll and maintain enrollment on a LifeWise individual medical plan to qualify for enrollment on this individual dental plan.
- They must have completed a LifeWise enrollment application that includes appropriate signatures and initials or

have enrolled through the Washington Health Benefit Exchange (The Exchange).

- 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 healthcare coverage. The confinement of a person in a nursing home, hospital, or other medical institution shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
- Their principal residence is located within our service area.
- They are not entitled to (enrolled in) Medicare on the date coverage would begin.

The individuals defined below are eligible to enroll on this contract.

Subscriber	• Individuals can only apply during an open enrollment or special enrollment period. See ***Open Enrollment*** and ***Special Enrollment***.

Dependents	To be a dependent under this plan, the family member must be:
	• The lawful spouse of the subscriber. For purposes of the rights and benefits of this plan, the term “spouse” also means the domestic partner of the subscriber.
	  • All rights and benefits afforded to a “spouse” under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term “establishment of the domestic partnership” shall be used in place of “marriage;” the term “termination of the domestic partnership” shall be used in place of “legal separation” and “divorce.”
	• An eligible child who is under 26 years of age, except as provided for in the ***Continued Eligibility for a Disabled Child*** section. An eligible child is one of the following:
	  • A natural offspring of either or both the subscriber or spouse
	  • A legally adopted child of either or both the subscriber or spouse
	  • A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
	  • A legally placed dependent or foster child of the subscriber or spouse. There must be a court or other order signed by a judge or state agency, 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.

OPEN ENROLLMENT

Families and individuals who wish to enroll in a LifeWise plan and or to enroll for coverage as a dependent on an existing plan may apply only during an open enrollment period. The only exception is for existing dependents transferring to an identical contract as stated in ***Continuation of Coverage on an Identical Contract*** or if you are enrolling a natural newborn or adoptive child whose date of birth or date of placement is after the subscriber's effective date of coverage on this plan. In this instance, you must submit the application within 60 days of birth or placement for adoption, or a qualifying loss of coverage event.

We must receive a completed enrollment application before the end of the open enrollment period. See ***When Coverage Begins*** for information on effective dates. If the application is not received within the open enrollment period, applicants cannot apply for enrollment until the next open enrollment period.

SPECIAL ENROLLMENT

Qualifying Events

Individuals who don't 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, 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

Enrollment is subject to verification at the time of application. See lifewise.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 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 date of the qualifying event, see ***Open Enrollment.***

WHEN COVERAGE BEGINS

Subscriber and Existing Dependents	If you enrolled through The Exchange, your coverage will begin as of the effective date established by The Exchange. If you enrolled directly with us, initial coverage on this plan will become effective as follows: • For applications received by the 14th day of the month, coverage will be effective on the 15th day of that month. In this instance, a pro-rated subscription charge will be applied for the first partial month of coverage. • For applications received between the 15th and the last day of the month, coverage will be effective on the first day of the following month. The receipt date will be the date of postmark or the date of delivery to us, whichever is earlier.
New Dependents	You must submit your enrollment request for new dependents to us 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.

Newborn Children	Newborn children are automatically covered for the first 3 weeks from birth when the mother is covered on the plan. Beyond the first 3 weeks, you must submit an application to us or contact The Exchange to enroll the child. The child may be enrolled as a dependent under a current subscriber or on their own plan as a single subscriber. The effective date will be the child's date of birth **only** if we receive a completed application within 60 days of birth. Otherwise, coverage will become effective as described under ***Eligibility and Enrollment***.
Adoptive Children	The effective date will be the date of placement with the subscriber **only** if application to us or The Exchange is received timely. Otherwise, coverage will become effective as described under ***Eligibility and Enrollment***.
Domestic Partners and Their Children	Coverage will be effective for the domestic partner and/or their children upon our acceptance and approval of the completed application or notification of enrollment through The Exchange and payment of required subscription charges as described under ***When Coverage Begins***.
Legal Guardianship	Children who are legal dependents of the subscriber or spouse and meet all stated eligibility requirements will be accepted for coverage when we receive the completed application or notification of enrollment through The Exchange and copies of the final court-ordered guardianship. The effective date will be the date of the guardianship order if the approved application is received within 60 days of that date. Otherwise, coverage will become effective as described under ***Eligibility and Enrollment***.
Medical Child Support Orders	An application must be submitted to us or enrollment through The Exchange, along with a copy of the medical child support order. The application may be submitted by the subscriber, the child's custodial parent, or a state agency administering Medicaid. The effective date will be the date of the order **only** if the application is received within 60 days of the date of the order. Otherwise, coverage will become effective as stated under ***Eligibility and Enrollment***.
Due to Marriage	The effective date will be the date of marriage **only** if the approved application is received or enrollment is done through The Exchange within 60 days of the date of the marriage. Otherwise, coverage will become effective as described under ***Eligibility and Enrollment***.

OTHER PROVISIONS AFFECTING COVERAGE

Term of Contract	This contract is guaranteed renewable except as stated under ***Events That End Coverage***.
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, except as 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	For members whose subscription charges are not subsidized by the federal government, you have a 1-month grace period to pay subsequent subscription charges. If a payment is not received by the end of the grace period, your coverage will terminate as of the last day of the period for which subscription charges were paid. Claims for services received after the termination date will be denied. Providers can seek reimbursement directly from you for those services. 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 also 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 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

EVENTS THAT END COVERAGE

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

Termination by the Subscriber

The **subscriber** may terminate this contract by:

- Contacting us or The Exchange, (if you enrolled through The Exchange). For coverage purchased directly from us, termination will be effective on the last day for which subscription charges were paid.
- Failing to pay the required subscription charges when due or within the grace period

Termination by Us

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

- Nonpayment of subscription charges. Coverage will end without notice as of the last date for which subscription charges were paid.
- Violation of published policies of LifeWise that have been approved by the Washington State Insurance Commissioner
- A member no longer lives in Washington State
- A member commits fraudulent acts as to LifeWise

- A member materially breaches the contract which includes, but is not limited to, failure to continue to meet the provisions stated under ***Eligibility and Enrollment***
- Change or implementation of federal or state laws that no longer permit the continued offering of this contract
- We discontinue this contract to all those covered under this contract as allowed by law. In such instances, you will be given at least a 90-day notification of the discontinuation. If we discontinue this contract, you may apply for any other individual plan currently offered for sale by us or The Exchange.
- 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. See ***Notice***.

Continuation of Coverage

There are specific requirements, time frames and conditions which must be followed in order to be eligible for continuation of coverage and which are generally outlined below.

Continued Eligibility for a Disabled Child	Coverage may continue beyond the limiting age for a child who cannot support themselves because of a developmental or physical disability. See ***Dependent Eligibility.*** The child will continue to be eligible if all the following are met: • The child became disabled before reaching the limiting age. • The child is incapable of self-sustaining employment by reason of developmental or physical disability and is chiefly dependent upon the subscriber for support and maintenance. • The subscriber is covered under this plan. • The child's subscription charges, if any, continue to be paid. • Within 31 days of the child reaching the limiting age, the subscriber furnishes us with a Request for Certification of Disabled Dependent form. We must approve the request for certification for coverage to continue. • The subscriber provides us with proof of the child's disability and dependent status when we request it. We won't ask for proof more often than once a year after the 2-year period following the child's attainment of the limiting age.
Continuation of Coverage on an Identical Contract	Dependent(s) may continue coverage on an identical contract in the following situations: • If the subscriber terminates coverage for any reason, or in the event of death of the subscriber or divorce of the subscriber and spouse, enrolled dependents under this plan may continue under an identical contract. The dependent(s) must meet all of the eligibility requirements as specified in this contract. If the spouse continues coverage, the spouse's enrollment status will change from dependent to subscriber and any enrolled child may be covered under the spouse's continued coverage. Subscription charges will be assessed at the appropriate rate. If there is no spouse, or the spouse does not continue coverage, each enrolled child may continue coverage as a subscriber, and subscription charges will be assessed at the appropriate subscriber rate. • A dependent child, who no longer is eligible as a dependent under this contract for reasons such as reaching the maximum dependent age, 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 or you must contact The Exchange prior to the date coverage would end as a dependent.

Other Plan Information

This section tells you about how this plan is administered. It also includes information about federal and state requirements we must follow and other information we must provide to you. If you have any questions about your plan or want to request additional information or forms, please call customer service or go to our website at LifeWise. Information about your plan is provided to you free of charge.

Benefit Modifications	From time to time, we may change the terms of this contract. You will receive prior written notice of any changes, and 30 days prior written notice of changes to subscription charges. See ***Notice***. If the terms of this contract change, those changes will not affect benefits to a member during confinement in a facility. Benefit changes will take effect when you leave the facility, or from any other facility you are transferred to, as long as you are still covered under this plan. No producer or agent of LifeWise or any other person, 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 with the signature of an officer of LifeWise.
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	The contract is issued and delivered in the State of Washington and is governed by the laws of the State of Washington, except to the extent pre-empted by federal law. If any provision of the contract or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.
Entire Contract	The entire contract between you and us consists of all of the following: • The contract • All applications used to apply for coverage • All attachments, endorsements, and riders included or issued hereafter No representative of LifeWise Health Plan of Washington 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 Health Plan of Washington. If there is a language conflict in the contract, the benefit booklet (as amended by any attachments, endorsements or riders) will govern.
Evidence of Medical or Dental Necessity	We have the right to require proof of medical or dental necessity for any services or supplies you receive before we provide benefits under this plan. This proof may be submitted by you, or on your behalf by your providers. No benefits will be available if the proof isn't provided or acceptable to us.
Health and Dental Care Providers - Independent Contractors	All health and 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.
ID Card	If you need a replacement LifeWise ID card, call our customer service or visit our website at lifewise.com. If coverage under the contract terminates, your LifeWise ID card will no longer be valid.
Independent	The subscriber hereby expressly acknowledges the understanding that this contract

Corporation	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.
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 Statements	If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, we'll be entitled to recover these amounts. See ***Right of Recovery*** later in this section. And, if a member commits fraud or makes any intentionally false or misleading statements on any application or enrollment form that affects the member's acceptability for coverage, we may, at our option: • Deny the member's claim. • Reduce the amount of benefits provided for the member's claim. • Void the member's coverage under this plan (void means to cancel coverage back to its effective date, as if it had never existed at all). Finally, statements that are fraudulent, intentionally false or misleading on any form required by us, that affect the acceptability of the Member or the risks to be assumed by us, may cause the contract for this plan to be voided. **Note:** We cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.
Limitations 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	You're under a duty to cooperate with us in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us in the event of a lawsuit.

Nonwaiver	No delay or failure when exercising or enforcing any right under this contract shall constitute a waiver or relinquishment of that right and no waiver or any default under this contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this contract shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.
Notice	We may be required to send you certain notices. We will consider such a notice to be delivered if we mail it to your most recent address in our records. The date of the postmark is the delivery date. If you are required to send notice to us, the postmark date will be the delivery date. If not postmarked, the delivery date will be the date we receive it.
Notice of Information Use and Disclosure	We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources. This information is collected, used or disclosed for conducting routine business operations such as: • Determining your eligibility for benefits and paying claims. Genetic information is not collected or used for underwriting or enrollment purposes. • Coordinating benefits with other healthcare plans. • Conducting care management, case management, or quality reviews. • Fulfilling other legal obligations that are specified under the contract. This information may also be collected, used or disclosed as required or permitted by law. To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it. If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization. You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our customer service department and ask a representative to mail a request form to you.

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

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

	entity. We agree to guarantee that all transferred obligations will be performed by the successor corporation or entity according to the terms and conditions of this contract. In consideration for this guarantee, the subscriber consents to the transfer of this contract to such corporation or entity.
Right of Recovery	We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of their dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us. In addition, if this contract is voided as described in ***Intentionally False or Misleading Statements***, we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.
Right to and Payment of Benefits	Benefits of this plan are available only to members. Except as required by law, we won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan. At our option only and in accordance with the law, we may pay the benefits of this plan to: • The subscriber. • A provider. • Another health insurance carrier. • The member. • Another party legally entitled under federal or state medical child support laws. • Jointly to any of the above. Payment to any of the above satisfies our obligation as to payment of benefits.
Severability	Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.
Venue	All suits or legal proceedings brought against us by you or anyone claiming any right under this plan must be filed: • Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan; 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.
Additional Information About Your Coverage	Your benefit booklet provides you with detailed information about this plan's benefits, limitations and exclusions, how to obtain care and how to appeal our decisions. You may also ask for the following information: • Your right to seek and pay for care outside of this plan. • The plan's drug list, (also called a "formulary"). • How we pay providers. • How providers' payment methods help promote good patient care. • A statement of all benefit payments in each year that have been counted toward this plan's benefit limitations, visit, day, or dollar benefit maximums or other overall limitations.

	• How to file a complaint and a copy of our process for resolving complaints. • How to access specialists. • Obtaining a prior authorization when needed. • Accreditation by national managed care organizations. • Use of the health employer data information set (HEDIS) to track performance. If you want to receive this information, please go to our website at lifewise.com. If you don't have access to the web, please call customer service.

Definitions

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

Accidental Injury	Physical harm caused by a sudden, unexpected event at a certain time and place. Accidental injury does not mean any of the following: • An illness, except for infection of a cut or wound • Dental injuries caused by biting or chewing • Over-exertion or muscle strains
Adverse Benefit Determination	An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes: • A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage • A limitation on otherwise covered benefits • A clinical review decision • A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective • A decision related to compliance with protections against balance billing as defined by federal and state law
Affordable Care Act	The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
Allowed Amount	The allowed amount shall mean one of the following depending on whether the dental care provider is in-network or out-of-network: • **Dental Care Providers Who Have Agreements with Us** The amount for medically 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 will be responsible only for any applicable calendar year deductibles, coinsurance, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under this plan.

	Your liability for any applicable calendar year deductibles, coinsurance and amounts applied toward benefit maximums will be calculated on the basis of the allowed amount. • **Dental Care Providers Who Don't Have Agreements with Us** The allowed amount will be the maximum allowed amount as determined by LifeWise 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 allowed amount, and for any calendar year deductibles, coinsurance, amounts that are in excess of 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.
Ambulatory Surgical Center	A healthcare facility that's licensed or certified by the state it operates in and that meets all of the following: • It has an organized staff of physicians. • It has permanent facilities that are equipped and operated mainly for the purpose of performing surgical procedures. • It does not provide inpatient services or accommodations.
Benefit	What this plan provides for a covered service. The benefits you get are subject to this plan's cost shares.
Benefit Booklet	Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.
Calendar Year	The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on December 31 at midnight.
Claim	A request for payment from us according to the terms of this plan.
Coinsurance	The amount you pay for eligible services after you meet your deductible. Coinsurance is always a percentage of the allowed amount.
Congenital Anomaly	A marked difference from the normal structure of an infant's body part that's present from birth.
Contract	Contract describes the benefits, limitations, exclusions, eligibility, and other coverage provisions included in this plan.
Cosmetic Services	Services that are performed to reshape normal structures of the body in order to improve your appearance and self-esteem and not primarily to restore an impaired function of the body.
Cost Share	The part of healthcare costs that you have to pay. These are deductibles, coinsurance, and copayments.
Covered Service	A service, supply or drug that is eligible for benefits under the terms of this Plan.
Dental Emergency	A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected injury, acute infection or similar occurrence.
Dentally Necessary and Dental Necessity	Those covered services which are determined to meet all of the following requirements: • Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan. • Appropriate and consistent with authoritative dental or scientific literature.

	• Not primarily for the convenience of the member, the member's family, the member's dental care provider or another provider.
Dependent	The subscriber's spouse or domestic partner and any children who are on this plan.
Doctor (also called "Physician")	A state-licensed: • Doctor of Medicine and Surgery (MD) • Doctor of Osteopathy (DO) In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of their state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a doctor as defined above: • Chiropractor (DC) • Dentist (DDS or DMD) • Optometrist (OD) • Podiatrist (DPM) • Psychologist. • Nurse (RN and ARNP) licensed in Washington State
Effective Date	The date your coverage under this plan begins.
Emergency Medical Condition (also called "Emergency")	A medical condition, mental health, or substance use disorder condition which manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the member's health or the unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part. Examples of an emergency medical condition are severe pain, suspected heart attacks and fractures. Examples of a non-emergency medical condition are minor cuts and scrapes.
Emergency Services	• A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary services given in an emergency department. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health. • Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical, mental health, or substance use disorder treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant member in active labor, to perform the delivery. • Ambulance transport, as needed, in support of the services above
Endorsement	A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.
Essential Health Benefits	Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health

	and substance use disorders services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.
Experimental/Investigative Services	A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria: • A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided. • It is subject to oversight by an Institutional Review Board. • There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition. • It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. • Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies. Reliable evidence means only published reports and articles in authoritative medical and scientific literature.
Explanation of Benefits	An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.
Facility (Medical Facility)	A hospital, skilled nursing facility, approved treatment facility for substance use disorder, state-approved institution for treatment of mental or psychiatric conditions, or hospice. Not all health care facilities are covered under this contract.
Health Care Benefit Managers	Health Care Benefit Managers (HCBM). A person or entity that specializes in managing certain services for a health carrier or employee benefits programs. An HCBM may also make determinations for utilization of benefits and prior authorization for health care services, drugs, and supplies. These include pharmacy, radiology, laboratory, and mental health benefit managers.
Hospital	A healthcare facility that meets all of these criteria: • It operates legally as a hospital in the state where it is located. • It has facilities for the diagnosis, treatment and acute care of injured and ill persons as inpatients. • It has a staff of providers that provides or supervises the care. • It has 24-hour nursing services provided by or supervised by registered nurses. A facility is not considered a hospital if it operates mainly for any of the purposes below: • As a rest home, nursing home, or convalescent home • As a residential treatment center or health resort • To provide hospice care for terminally ill patients • To care for the elderly • To treat substance use disorder or tuberculosis
Illness	A sickness, disease, or medical condition.
Injury	Physical harm caused by a sudden event at a specific time and place. It is

	independent of illness, except for infection of a cut or wound.
Medically Necessary and Medical Necessity	Services a provider, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must: • Agree with generally accepted standards of medical practice • Be clinically appropriate in type, frequency, extent, site and duration. They must also be considered effective for the patient's illness, injury or disease. • Not be mostly for the convenience of the patient, physician, or other healthcare provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.
Member (also called "You" or "Your")	A person covered under this plan as a subscriber or dependent.
Non-Contracted Provider	A provider that does not have a contract with us or with any of the other networks used by this plan.
Non-Participating Provider	A provider that is not in one of the provider networks stated in the ***How Providers Affect Your Costs*** section.
Orthodontia	The branch of dentistry which specializes in tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).
Outpatient Surgical Center	A facility that's licensed or certified as required by the state it operates in and that meets all of the following: • It has an organized staff of physicians. • It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures. • It doesn't provide inpatient services or accommodations.
Plan	The benefits, terms, and limitations stated in this contract.
Prior Authorization	Prior authorization is a process that requires you or a provider to follow to determine if a service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care or effectiveness. You must ask for prior authorization before the service is delivered. See ***Prior Authorization*** for details.
Provider	A person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care-related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of their employment. Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the State of Washington and other such facilities are included as required by state and federal law. Covered categories of providers regulated under Title 18 and Chapter 70.127

	RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met: The providers are: • Acupuncturists (LAc.) (In Washington also called “East Asian Medicine Practitioners” (EAMP)) • Audiologists • Chiropractors (DC) • Counselors • Dental Hygienists (under the supervision of a DDS or DMD) • Dentists (DDS or DMD) • Denturists • Dietitians and Nutritionists (D or CD, or CN) • Gynecologists (MD) • Home Health Care, Hospice and Home Care Agencies • Marriage and Family Therapists • Massage Practitioners (LMP) • Midwives • Naturopathic Physicians (ND) • Nurses (RN, LPN, ARNP, or NP) • Nursing Homes • Obstetricians (MD) • Occupational Therapists (OTA) • Ocularists • Opticians (Dispensing) • Optometrists (OD) • Osteopathic Physician Assistants (OPA) (under the supervision of a DO) • Osteopathic Physicians (DO) • Pharmacists (RPh) • Physical Therapists (LPT) • Physician Assistants (PA) (under the supervision of an MD) • Physicians (MD) • Podiatric Physicians (DPM) • Psychologists (PhD) • Radiologic Technologists (CRT, CRTT, CRDT, CNMT) • Respiratory Care Practitioners • Social Workers • Speech-Language Pathologists The following healthcare facilities and other providers will also be considered providers for the purposes of this plan when they meet the requirements above. • Ambulance Companies • Ambulatory Diagnostic, Treatment and Surgical Facilities • Audiologists (CCC-A or CCC-MSPA) • Birthing Centers • Blood Banks

	• Board Certified Behavior Analyst (BCBA), certified by the Behavior Analyst Certification Board, and state-licensed in states that have specific licensure for behavior analysts • Community Mental Health Centers • Drug and Alcohol Treatment Facilities • Medical Equipment Suppliers • Hospitals • Kidney Disease Treatment Centers (Medicare-certified) • Psychiatric Hospitals • Speech Therapists (Certified by the American Speech, Language and Hearing Association) In states other than Washington, "provider" means healthcare practitioners and facilities that are licensed or certified consistent with the laws and regulations of the state in which they operate. This plan makes use of provider networks as explained in ***How Providers Affect Your Costs***.
Reconstructive Surgery	Is surgery: • That restores features damaged as a result of injury or illness. • To correct a congenital deformity or anomaly.
Service Area	The service area 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.
Services	Services are procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies or places of service.
Specialist	A provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
Spouse	• An individual who is legally married to the subscriber. • An individual who is a domestic partner of the subscriber or who meets the requirements for domestic partner coverage under this plan.
Subscriber	The person in whose name the plan is issued.
Subscription Charge	The monthly rates we establish as consideration for the benefits offered under this contract.
Visit	A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.
We, Us and Our	LifeWise Health Plan of Washington

Notice of availability and nondiscrimination **800-817-3056 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
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Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાઓ અને ઉચિત સહાયિક ચીજો અને સેવાઓ વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໃຫ້ເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. LifeWise does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. LifeWise provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.

LifeWise