WASHINGTON STATE HEALTH INSURANCE POOL (WSHIP)

Basic Plan Policy
(a Medicare-eligible plan)

WSHIP Basic Policy

This Policy is issued to You by the Washington State Health Insurance Pool in consideration of Your premium payments and the statements in Your application attached to this Policy.

INDEX

I. INTRODUCTION

A. Defined Terms. Capitalized terms in this Policy have the meanings set forth in Section IX, Definitions.

B. Relation to Medicare Coverage. This Policy generally provides coverage for expenses incurred for services and items that are not reimbursed under Part A or Part B of Medicare because of deductible or coinsurance requirements. This Policy does not, however, qualify as a Medicare Supplement Policy and is not subject to the requirements of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) or any Washington State law enacted to implement OBRA 90.

C. Eligibility. To be eligible for coverage under this Policy, You must be enrolled in both Part A and Part B of Medicare and meet the eligibility requirements under Washington State law.

D. Please Read—10-Day Right To Examine Policy. If You are not satisfied with this Policy, You may return it to Us within 10 days of Your receipt of the Policy. If You timely return the Policy, We will refund Your premium and this Policy will be void, retroactive to the Policy effective date.

E. Administrator of the Policy. The Administrator processes all claims and administers all services on Our behalf. If You have any questions about a claim or other items such as premiums, coverage or cost-sharing, You should contact the Administrator.

II. EFFECTIVE DATE, ENROLLMENT AND TERMINATION

A. Policy Effective Date. This Policy will become effective and coverage begins at 12:01 a.m. Pacific Time on the first day of the month following Our approval of Your application, provided that Your completed application and required premium payment are received by the Administrator by the 20th day of the preceding month. Under limited circumstances and after obtaining the written approval of the Administrator, You may have an earlier effective date.

B. Dependent Children. Coverage for Your Dependent Children is available under a separate policy offered by Us. You may obtain coverage for Dependent Children at the time You apply for coverage or after Your coverage begins at any time a qualifying event occurs. A qualifying event is limited to the birth or adoption of a Dependent Child or a Dependent Child's loss of health insurance coverage due to a parent's loss of such coverage. The Dependent Child must meet the eligibility requirements for coverage and benefits are subject to payment of the applicable premium and all other provisions of the applicable policy. Coverage will include the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities.

For a Dependent Child who lost coverage under a parent's policy, coverage will begin on the first day of the month following Our receipt of complete enrollment information and premium payment. Your Newborn or adopted Dependent Child will be covered automatically

for 31 days from the moment of birth for a Newborn or placement in Your home for an adopted Dependent Child. Coverage after the 31st day will be under the policy applicable to the Dependent Child and is subject to Our receipt from You within the 31-day period of: (1) written notification of the birth or adoption; (2) enrollment information for the child; and (3) the applicable premium. A child is deemed adopted when the child is physically placed, for the purpose of adoption under the laws of the state, in Your custody and You assume financial responsibility for the medical expenses of the child. Evidence of adoption will be required as a condition of enrollment of the child.

The Dependent Child's coverage will terminate upon attainment of age 19, except that coverage may be continued beyond age 19 while the Dependent Child is:

(a) incapable of self-sustaining employment by reason of developmental disability or physical handicap; and
(b) is chiefly dependent upon You for support and maintenance, provided that proof of such incapacity and dependence is furnished to Us within thirty-one (31) days of the Dependent Child's 19th birthday.

We may require proof of continuing incapacity and dependence from time to time, but not more often than annually after the two-year period following the Dependent Child's 19th birthday.

If You die during the Policy period and You have Dependent Children covered under one of Our policies, those Dependent Children may elect, if such election is done in writing within thirty (30) days of the date of Your death, to continue coverage under one of Our policies.

C. Termination of Coverage. This Policy will continue until terminated as set forth below.

1. Events of Termination. This Policy will terminate if any of the following events occur. The termination will be effective as of 11:59 p.m. Pacific Time on the date the event occurs unless a different date is specifically identified below:

(a) You send written notice of termination to the Administrator. Termination will be effective on the last day of the month that the Administrator receives the notice;
(b) You fail to pay the applicable premium within the 31-day grace period. Termination will be effective on the last day of the period for which Your premium was paid;
(c) You are no longer a Washington State Resident;
(d) You are eligible for benefits under CHAMPUS;
(e) the Individual Lifetime Maximum has been paid for You by Us;
(f) the last date upon which You are enrolled in both Parts A and B of Medicare;
(g) You fail to respond within 30 days to Our inquiry about Your eligibility or place of residence;

(h) Washington State law requires cancellation of this Policy or permits cancellation, in which case We will provide at least 90 days written notice of such cancellation;
(i) You commit a material fraudulent act upon or against Us; or
(j) We discontinue or replace this Policy as permitted by law. In such instance, We will give You at least 90 days written notice of such discontinuation or replacement.

2. Services After Termination. If You are receiving Covered Services as a registered inpatient in a Hospital on the date of termination, You will continue to be eligible for Covered Services while You are an inpatient for the condition for which You were hospitalized, until one of the following events occurs:

(a) We determine that it is no longer Medically Necessary for You to be an inpatient at the facility;
(b) the benefits available under this Policy for hospitalization are exhausted, regardless of whether a new calendar year begins;
(c) You become covered under another policy that provides benefits for the hospitalization; or
(d) You become enrolled under an agreement with another carrier that would provide benefits for the hospitalization if this Policy did not exist.

This provision will not apply if You are covered under another policy that provides benefits for the hospitalization at the time coverage would terminate. You are responsible for payment of all charges for services and items provided after the effective date of termination, except those services covered above.

D. Reinstatement. We will not reinstate this Policy if it terminates due to nonpayment of premium. If You mail or deliver a premium to Us after the 31-day grace period, We will return it to You as soon as We determine that the premium is late. No agent is authorized by Us to accept a late premium.

You may reapply for coverage under the Policy if You again become eligible, provided at least 12 months have elapsed since the old Policy terminated.

III. BENEFITS

This section of the Policy describes the specific benefits this Policy provides. Benefits are available only for the services described below and are subject to applicable coinsurance, copays, limitations, exclusions and all other provisions of this Policy.

A. Conditions For Payment of Benefits. We provide benefits for a Covered Service, up to the Allowed Amount, only if it is:

(a) received while You are insured under this Policy;

(b) ordered by and under the direct supervision of a Physician;
(c) Medically Necessary as determined by Us; and
(d) not excluded or beyond the limitations or benefit maximums of this Policy.

B. Covered Services and Limitations. The following are Covered Services under the Policy:

1. Hospital Inpatient. Room and board at the semiprivate room rate of the Hospital, or the Hospital's most common private room rate if a private room is Medically Necessary, and other Hospital services and supplies that are furnished to You as an inpatient.

Only the first 180 days of inpatient confinement are covered in a Calendar Year.

2. Hospital Outpatient. Hospital medical services and supplies furnished on an outpatient basis.

3. Outpatient Surgery. Medical and surgical services and supplies furnished on an outpatient basis.

4. Oral Surgery. The following forms of oral surgery:

(a) fractures of facial bones;
(b) excisions of mandibular joints;
(c) excisions of lesions of the mouth, lip or tongue;
(d) excisions of tumors or cysts;
(e) incision of accessory sinuses, mouth, salivary glands or ducts;
(f) dislocation of the jaw;
(g) plastic reconstruction or repair of traumatic injuries occurring while covered under the Policy; and
(h) excision of impacted wisdom teeth.

5. Professional Services. Professional services, including surgical services, for the Treatment of Illness that are rendered by a Health Care Provider or at a Health Care Provider's direction. Professional Services do not include professional dental services, except as specifically provided under Oral Surgery above.

Coverage for the services of an assistant surgeon is limited to 20% of the Allowed Amount.

6. Medical Therapy. Chemotherapy, radioisotope, radiation and nuclear medicine therapy.

7. Breast Reconstruction Following Mastectomy. Reconstructive surgery on the breast on which the mastectomy has been performed and all stages of reconstructive breast reduction on the nondiseased breast to equal the size of the diseased breast following surgery due

to a mastectomy. The physical complications of all stages of mastectomy, including lymphademas, are also Covered Services.

8. Medical Supplies and Equipment.

(a) Purchase (or rental up to the purchase price) of Durable Medical Equipment used for therapeutic purposes with no personal use in the absence of the condition for which it is prescribed, but only if it:
  (1) is approved by the Administrator in advance;
  (2) is prescribed by Your attending Physician;
  (3) reduces or eliminates the time required for confinement in a Hospital, Skilled Nursing Facility or other facility; and
  (4) is used to serve a medical purpose other than for transportation, comfort or convenience;

(b) the initial internal breast prostheses following mastectomy;

(c) braces, crutches and prostheses (except dental prostheses) needed because of Illness that begins while covered by the Policy;

(d) colostomy bags and related supplies;

(e) catheters;

(f) syringes and needles for insulin and allergy injections; and

(g) oxygen.

9. Prescription Drugs. All Prescription Drugs that are covered under Part A or Part B of Medicare excluding drugs relating to services or supplies that are excluded under Section IV.C. The Administrator will provide You with information about Our mail order pharmacy and a list of Network Pharmacies. All Prescription Drugs and pharmacy services must be obtained at a Network Pharmacy or through Our mail order pharmacy except for:

(a) drugs dispensed by a Health Care Provider when related to Emergency services; and

(b) drugs dispensed by a non-Network Pharmacy when a Network Pharmacy is not available within a 30-mile radius of Your home or prescribing Health Care Provider.

10. Sterilization. Sterilization is a Covered Service. Reversal of sterilization is not a Covered Service.

11. Maternity Services. Maternity services are Covered Services. For covered prenatal, maternity and newborn care, Your attending Health Care Provider in consultation with You makes the following decisions:

(a) length of inpatient stay;

(b) inpatient post-delivery care; and

(c) follow-up care to include type and location, which may include Home Health Agency services and registered nurse services.

12. Emergency Ambulance. When necessary because of Your medical condition, licensed ambulance service for transportation to the nearest Hospital or SNF qualified to treat Your Illness.

13. Skilled Nursing Facility (SNF). Room and board at a SNF's lowest semiprivate room rate and the services and supplies that are furnished for medical care therein.

SNF benefits are limited to 100 days of confinement each Calendar Year. Any SNF confinement is covered only if it is in lieu of Medically Necessary Confinement in a Hospital under the supervision of a doctor of medicine or osteopathy (MD or DO).

14. Home Health Care. The following items and services are covered home health care services when ordered by a Physician and furnished: (1) in a private home, (2) by a Home Health Agency, and (3) in accordance with a Home Health Care Plan. Home health care services include:

(a) nursing care provided on a part-time (less than an eight-hour shift) or intermittent basis by a registered nurse (RN) or a licensed practical nurse (LPN);
(b) physical, occupational, respiratory or speech therapy provided by a licensed therapist; and
(c) limited home health aide services provided under the supervision of an RN.

Home health care services are covered only if You are unable to leave home due to Illness (unwillingness to travel or arrange for transportation does not constitute inability to leave home). Home health care benefits are limited to 130 visits for each Calendar Year. One home health care visit will consist of:

(i) one visit for the services listed under subsections (a) and (b) above; or
(ii) up to four consecutive hours for the home health aide services shown under subsection (c) above.

Home health care excludes Custodial Care and maintenance care, private duty and continuous nursing care, housekeeping and meal service and any care provided by or for a member of Your family and any other services that are not listed above.

15. Hospice Care. Hospice Care services received in lieu of curative Treatment for a terminal Illness during the period of time that You are participating in a Hospice Care program. Hospice Care services are limited to:

(a) those services provided under a coordinated, interdisciplinary program provided by a licensed Hospice Care agency; and

(b) respite care limited to one 5-day period for every three-month period of hospice care.

Hospice Care excludes all services not specifically listed above and does not include bereavement therapy or counseling, financial or legal counseling services, housekeeping or meal services, custodial or maintenance care, or any services provided by members of Your family.

16. Routine Mammography. Routine mammography for a woman and ordered by a Physician, an advanced registered nurse practitioner (ARNP), or a physician's assistant.

17. Rehabilitation Therapy Service. The services of a registered physical therapist, certified speech pathologist or speech therapist for the purpose of restoring lost speech function, licensed occupational therapist, and licensed respiratory therapist. Services must be provided within a Treatment plan for conditions for which significant improvement as a result of the therapy is expected.

Rehabilitation therapy services for Dependent Children under age seven with neuro-developmental disabilities with documentation from the attending Physician that such care is necessary to prevent further deterioration of the neurodevelopmental disability are Covered Services.

Maintenance care and therapy for learning and education disabilities or difficulty are not Covered Services.

18. Diabetes Education Program. A diabetes patient education program that is provided by a Health Care Provider. You must be enrolled in the diabetes education program, it must be certified by the American Association of Diabetes Educators, and the benefit is subject to a lifetime maximum amount of $250.

19. Transplant Surgery and Related Expense Benefits. Transplant surgery and related expenses for which You have obtained prior medical necessity review are Covered Services subject to all applicable limitations and exceptions including the $250,000 lifetime maximum set forth in Section IV.B. If the transplant surgery is determined to be Investigational or Experimental, no benefits are payable for such procedure or other Covered Services or supplies related to the transplant.

If You have transplant surgery for which benefits are payable under this Policy and the donor incurs charges made by a Physician for surgery or Physician visits related to the transplant, those services are Covered Services. Payment for those Covered Services is payable, however, only after payments for Your Covered Services have been made. We will not pay for Covered Services related to the donor that are paid or are payable by other insurance.

20. Mental Conditions and Chemical Dependency. Mental conditions, including nervous conditions, are Covered Services. Services of a state-approved chemical

dependency program under Chapter 70.96A RCW for alcohol, drug, or chemical dependency or abuse are Covered Services.

Limitations for Treatment for mental conditions or chemical dependency are as follows:

(a) the maximum number of days for inpatient care is limited to 30 days each Calendar Year; and

(b) the maximum number of visits for outpatient care is limited to 20 visits each Calendar Year for all conditions. Services must be provided by a Physician or community mental health professional, or at the direction of a Physician or other Health Care Provider.

21. Preventive Health Care. Preventive care services up to the maximum benefit of $200 per Calendar Year.

22. Temporomandibular Joint (TMJ) Disorders or Myofacial Pain Dysfunction (MPD). Medical services and supplies for treatment of temporomandibular joint (TMJ) disorders or Myofacial Pain Dysfunction (MPD) subject to a $1,000 lifetime maximum per individual.

23. Massage Therapy. Services of a licensed massage practitioner (LMP) when prescribed by a Physician, up to 12 visits per Calendar Year.

24. Acupuncture. Acupuncture services performed by an individual acting within the scope of their license that are Medically Necessary to relieve pain (induce surgical anesthesia) or to treat a covered Illness. The acupuncture benefit is limited to 12 visits per Calendar Year.

IV. EXCLUSIONS AND LIMITATIONS

A. Pre-Existing Condition.

1. Pre-Existing Condition Limitation. The benefits of this Policy are not payable for any pre-existing condition for the first six months following the Policy effective date. A pre-existing condition is an Illness for which medical advice was given, for which a Health Care Provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the policy effective date.

The pre-existing condition limitation does not apply to pre-natal care. Maternity, delivery and postnatal care are subject to the pre-existing condition limitation.

2. Waiver or Credit of the Pre-existing Condition Waiting Period. The pre-existing condition wait time will be waived or credited, up to the amount of time that You were covered under a previous medical plan, if You meet the requirements below. The previous coverage must not have been terminated more than 63 days before the date You applied for coverage under this Policy or, if You applied as a result of rejection by a carrier, 63 days before

You applied to the carrier. The previous coverage also must not have been an individual Catastrophic Health Plan.

The pre-existing condition wait time will be waived if You reside in a county where individual health benefit plans are not offered (other than an individual Catastrophic Health Plan) and You qualify as a HIPAA Eligible Individual under the Health Insurance Portability and Accountability Act.

B. Lifetime Maximum Benefits.

1. Individual Lifetime Maximum. Payments made by Us under this Policy and any other policy issued to You by Us will not exceed the Individual Lifetime Maximum benefit of $1,000,000.

2. Organ Transplant Lifetime Maximum. Payments made by Us under this Policy or any other policy issued to You by Us will not exceed a lifetime maximum of $250,000 for all Covered Services related to organ transplant services, including pre-surgery testing. The $250,000 organ transplant lifetime maximum will not apply to necessary post-surgery drugs or medical services, but payments made by Us related to organ transplant services, including post-surgery Covered Services, will be counted toward the $1,000,000 Individual Lifetime Maximum benefit.

3. Diabetes Education Lifetime Maximum. Payment made by Us under this Policy or any other policy issued to You by Us will not exceed a lifetime maximum of $250 for diabetes education. Payments made by Us that are subject to the diabetes education lifetime maximum will be counted toward the $1,000,000 Individual Lifetime Maximum benefit.

4. Temporomandibular Joint Disorders and Myofacial Pain Dysfunction Lifetime Maximum. Payment made by Us under this Policy or any other policy issued to You by Us will not exceed a lifetime maximum of $1,000 for TMJ and/or MPD services. Payments made by Us that are subject to the TMJ/MPD lifetime maximum will be counted toward the $1,000,000 Individual Lifetime Maximum benefit.

C. Exclusions. No benefits will be paid or credit given for services or supplies that are not Covered Services or that exceed the Allowed Amount. No payment will be made or credit given for any services, supplies or drugs relating to:

1. Communication or Travel. Communication, transportation or travel except for emergency ambulance services described in Section III.B.12;

2. Cosmetic and Reconstructive. Reconstructive or cosmetic services or plastic surgery except:

   (a) as provided in Section III.B.7, Breast Reconstruction Following Mastectomy;

(b) treatment of congenital defects or birth abnormalities for function repair or restoration of any body part when necessary to achieve normal body functioning; or

(c) reconstructive surgery when incidental to or following surgery resulting from trauma, infection or other disease that occurs during the coverage period;

3. Counseling. Marital, family, sexual, vocational or outreach counseling or job training;

4. Custodial Care. Custodial Care as defined in Section IX;

5. Dental. Dental treatment of any kind except as provided in Section III.B.4, Oral Surgery;

6. Education and Training. Special education or training except diabetes education as described in Section III.B.18;

7. Fertility. Fertility or infertility diagnosis or enhancement and any related direct or indirect complications. Examples of excluded items are genetic testing, artificial insemination, in vitro fertilization, embryo transfer, hormone therapy related to fertility, and reversal of sterilization;

8. Foot Care. Routine foot care or treatment for fallen arches or flat feet;

9. Governmental Facilities. Treatment provided by a state or federal hospital or facility that is not a Network Provider unless payment of the charge is legally required;

10. Investigational or Experimental. Treatment that is Investigational and/or Experimental;

11. Medically Necessary. Treatment that We determine is not Medically Necessary;

12. Military Service and War Related. Illness caused by or related to military or war-related acts;

13. Obesity and Weight Control. Treatment of obesity or weight management and any direct or indirect complications from such treatment;

14. Services for Which You Do Not Have to Pay. Treatment for which no charge is made, no charge would have been made if this Policy were not in effect or for which You are not legally required to pay;

15. Sex or Gender Reassignment. Sex transformation or gender reassignment or the direct or indirect complications of such treatment, supplies or drugs;

16. Sexual Dysfunction. Treatment or diagnosis of sexual dysfunction and any direct or indirect complications of such treatment;

17. Vision and Hearing. Eye exams, vision analysis, contact lenses, eyeglasses or hearing aids, or surgery or other procedure or training intended to improve or correct vision or hearing, except:

(a) when due to an accidental injury to the eyes or ears; or

(b) for the initial contact lenses or eyeglasses after a covered cataract surgery without intra-ocular lens implant;

18. Work or Employment Related. Treatment or diagnosis for Illness caused by or related to employment regardless of whether a claim has been made for workers compensation.

D. Last Payer of Benefits. This Policy is the last payer of benefits whenever any other benefit is available, even if a claim for such benefits is not properly submitted or pursued. Benefits otherwise payable under this Policy shall be reduced by all amounts paid or payable through any other health insurance or health benefit plans, including but not limited to self-insured plans and by all hospital and medical expense benefits paid or payable under any workers compensation coverage, automobile medical payment or liability insurance and any hospital or medical benefit paid or payable under or provided pursuant to any state or federal law or program.

V. PREMIUMS, COST SHARING AND PAYMENTS

A. Premiums. Your premiums must be paid on or before the due date or during the 31-day grace period that follows. If Your premium is not received before the end of the grace period, Your coverage ends at the end of the period for which Your premium was paid.

Premium changes will be based on Your age. We will notify You at least 30 days before any premium change.

B. Deductible. Benefits under this Policy are not subject to a deductible.

C. Coinsurance. Coinsurance is the percentage of the Allowed Amount for Covered Services that You are required to pay. The coinsurance percentage is 20%. Coinsurance does not apply to services that are covered under Part A or Part B of Medicare.

D. Network Pharmacies. All Prescription Drugs must be obtained at a Network Pharmacy except for the following:

1. drugs dispensed by an Emergency care provider when related Emergency care services are covered under this Policy; and

2. a Network Pharmacy is not available within a 30-mile radius of Your home or the prescribing Provider.

E. Rate of Payment. For Covered Services that are covered under Part A or Part B of Medicare, We pay 100% of the applicable Medicare deductible and coinsurance amounts. We calculate and pay benefits based upon amounts payable by Medicare, regardless of whether a claim is submitted to or paid by Medicare. For all other Covered Services, We pay 80% of the Allowed Amount.

F. Out-of-Pocket Expense Limit. During a Calendar Year, if Your covered out-of-pocket expenses reach $150 for Prescription Drugs or $850 for Medical Services, We will pay 100% of the Allowed Amount for the applicable category of expense (Prescription Drug or Medical Services) for the remainder of the Calendar Year, subject to applicable limitations or exclusions. Out-of-pocket expenses include Your coinsurance amounts. Any amounts paid for non-Covered Services, amounts in excess of the Allowed Amount and payments for services beyond a benefit maximum or limit do not qualify as an out-of-pocket expense.

Prescription Drug out-of-pocket expenses do not apply to the Medical Services out-of-pocket expense limit. Medical Services out-of-pocket expenses also do not apply to the Prescription Drug out-of-pocket expenses limit.

VI. HEALTH MANAGEMENT

A. Care Management. Care management services help ensure that You receive appropriate and cost-effective medical care. We may require that You participate in Our care management program for Covered Services that are not covered by Part A or Part B of Medicare. In the care management process You can receive a determination in advance about whether a particular service is Medically Necessary. If the service is Medically Necessary and a Covered Service and You are eligible for coverage on the date of service, then We will pay for the service at the appropriate benefit level.

B. Case Management. Case management is a cooperative process among You, Your Health Care Provider and Us to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of Your benefits. The decision to provide benefits for these alternatives is within Our sole discretion. Your participation in a Treatment plan through case management is voluntary. If We reach an agreement for case management, You or Your legal representative, Your Health Care Provider and others participating in the Treatment plan will be required to sign an agreement that sets forth the terms under which benefits will be provided. You should call the number for care management on Your identification card if You would like to learn more about case management.

VII. OTHER INFORMATION

A. Claims.

1. Notice of Claim. You must give Us notice of a claim within 20 days after a loss occurs or starts, or as soon as is reasonably possible. Include Your name and the Policy number shown on the Schedule. Notice should be mailed to the Administrator.

2. Claim Forms. When We receive notice of a claim, We will send You forms for filing proof of loss. If not received within 15 days, You can meet the proof of loss requirement by submitting a written statement of what happened. This statement must be received within the time given for filing proof of loss.

3. Proof of Loss. You must give Us written proof of loss within 90 days after the date of the loss or as soon as is reasonably possible. Proof must, however, be furnished no later than 12 months from the time it is otherwise required, except in the absence of legal capacity.

4. Physical Examinations and Autopsy. At Our expense, We may have You examined by a Health Care Provider when and as often as is reasonable while a claim is pending. We may also, at Our expense, have an autopsy done if it is not forbidden by law.

5. Overpayment. If We pay a benefit under this Policy and it is later shown that a lesser amount should have been paid, We are entitled to a refund of the excess payment and We may deduct any such amount from future amounts payable to You or on Your behalf.

6. Incontestability. After two years from the date of issue of this Policy, no misstatement, except fraudulent misstatements made by You in the application for such Policy, shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of such two-year period.

7. Misstatement of Age and/or Sex. If Your age or sex has been misstated, all amounts payable under this Policy shall be such as if premium paid would have been purchased at the correct age or sex.

8. Assignment of Benefits. All benefits will be paid as soon as We receive acceptable proof of loss, including a Medicare explanation of benefits. Any benefits for Hospital, medical or surgical services that You have assigned will be paid to the Hospital or the provider of the services. If You have not assigned the benefits, We, at Our option, will pay You or the Hospital or the provider of the services.

B. Entire Contract and Changes. This Policy, and any attachments, is the entire contract of insurance. We may change this Policy, and We will provide at least 90 days written notice of any such change. Such change will apply to the form of this Policy (to all Basic Policies) and will not be made with respect to any particular policy.

C. Grace Period. A grace period of 31 days will be granted for the payment of each premium due after the first premium.

D. Release of Information. You agree to authorize release of any information that is necessary for treatment, payment and operations under this Policy.

E. Legal Action. Your right to take any legal action against the Administrator or Us is limited by the civil immunity provision of RCW 48.41.190.

F. Subrogation. If You are injured and have the right to recover damages from the responsible person, benefits under this Policy will still be paid. However, We have the right to recover the money paid for benefits from the responsible person through subrogation. Our subrogation rights are limited to the excess of the amount required to fully compensate You. Full compensation is measured on a case-by-case basis dependent on the circumstances involved and the ability of the responsible person to make You whole again. You or Your representative must cooperate in effecting collection from the person who caused the injury. If a settlement is reached without protecting Our interest, You will be held liable. Reasonable collection costs and legal fees incurred in recovering money that will benefit You and Us will be equitably apportioned between the parties. Failure on Your part to cooperate in effecting reimbursement from a third party who has liability will result in Your being fully responsible for the cost of the subrogated amounts.

G. Medicare Eligibility. If You become ineligible for or You disenroll in either Part A or Part B of Medicare, this Policy will terminate. If You qualify for a different policy offered by Us, You may enroll in such other policy.

VIII. GRIEVANCES AND APPEALS

A. General Grievance and Appeal Rights.

1. Any applicant for individual health coverage from a carrier who believes that the carrier erred in its scoring or administration of the Standard Health Questionnaire ("SHQ") may request review by Us if You have exhausted Your appeal rights directly to the carrier. Our review will be limited to whether the carrier correctly applied the scoring tool for the SHQ and whether the carrier's notice of rejection for coverage was provided within 15 business days of the carrier's receipt of the completed application. Such review will follow the internal two-step procedure below, but will not entail external review by an Independent Review Organization ("IRO"). If We determine that the carrier erred, We will notify the carrier of Our decision and recommend that the carrier take appropriate action.

2. If You are aggrieved by one of Our actions or decisions, You may pursue up to three levels of appeals. The first two levels are internal; first to the Administrator and second to Our grievance committee. The third level of appeal is external and may be made to a designated IRO. IRO review is available only for appeals of decisions relating to the denial, modification, reduction or termination of coverage of or payment for health care services. You may appeal to the IRO only after completion of Our internal review process.

B. Internal Appeal Process.

1. Appeal to the Administrator.

   (a) You must notify the Administrator of Your request for appeal within 90 days of the event giving rise to the appeal. If Your complaint concerns a carrier's application of the SHQ scoring tool, You should include Your completed SHQ and the carrier's scoring, if available.
   (b) Within five business days, the Administrator will respond to You in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested.
   (c) The Administrator will investigate the complaint, consider all information submitted by You, and make its decision within 30 days of receipt of the complete information needed to respond to the appeal.
   (d) The Administrator will notify You of its decision in writing and inform You of any further appeal options.
   (e) The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If the Administrator fails to make its decision within 30 days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and You may appeal to the next level.
   (f) If the complaint concerns the carrier's application of the SHQ scoring tool or the timing of the notice of rejection and the Administrator determines that the carrier erred, the Administrator will also forward its written decision to the carrier and recommend that the carrier take appropriate action.
   (g) If a complaint involves denial of coverage of a service, and You provide written notice to the Administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize Your life, health, or ability to regain maximum function, the Administrator will provide its written decision within 72 hours of receipt of the appeal request.

2. Appeal to Our Grievance Committee.

   (a) You must notify the Administrator of Your request for appeal to Our grievance committee within 90 days of an adverse decision by the Administrator and include a written description of the complaint.
   (b) Within five business days, the Administrator will respond to You in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested.

Within two business days of sending this notice, the Administrator will forward the appeal, with all relevant information from its files, to Our grievance committee.

(c) Our grievance committee will investigate the complaint, consider all information submitted by You, and make its decision within 30 days of its receipt of the complete information needed to respond to the appeal. The grievance committee may engage independent medical and legal experts to assist in the review process.

(d) Our grievance committee will notify You of its decision in writing and inform You of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If Our grievance committee fails to make its decision within 30 days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and You may appeal to the next level.

(e) If the complaint concerns the carrier's application of the SHQ scoring tool or the timing of the notice of rejection and Our grievance committee determines that the carrier erred, the grievance committee will also forward its written decision to the carrier and recommend that the carrier take appropriate action.

(f) If a complaint involves denial of coverage of a service, and You provide written notice to the Administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize Your life, health, or ability to regain maximum function, Our grievance committee will provide its written decision within 72 hours of its receipt of the appeal request.

C. External Process.

1. If Our grievance committee affirms a decision to deny, modify, reduce or terminate coverage of or payment for health services, You may appeal the decision to an IRO by notifying the Administrator within 30 days of receipt of the grievance committee's written decision.

2. The Administrator will gather all relevant documents and deliver them to the IRO within three business days of receiving Your request for appeal.

3. The IRO, made up of persons not associated with Us, will review Your complaint and make a decision. The IRO will provide its decision in writing to You and Us within 20 days of Your request for appeal. We will pay the charges for the IRO's review and written report.

D. Enrollment and Services During Appeal Process.

1. If You are denied enrollment by a carrier based on Your SHQ results, You may apply for coverage under this Policy while a review is in progress.

2. If Your complaint contests a coverage decision and such decision was based on a finding of no medical necessity, We will continue to provide the service until the appeal is completed. Upon completion of the appeal process, if We continued to provide the service in question and it is determined that the coverage was properly denied, You will be responsible for the cost of the services provided.

IX. DEFINITIONS

"**Administrator**" means that entity identified on page 1 of the Policy as the Administrator or such other entity as identified by Us in writing.

"**Allowed Amount**" means, for services or supplies that are covered by Part A or Part B of Medicare, the amount recognized by Medicare as the allowed amount. For services or supplies that are not covered by Part A or Part B of Medicare, the Allowed Amount is the amount that We determine is payable for the service or supply.

"**Calendar Year**" means, with respect to the first Calendar Year, the period beginning on the policy effective date identified in Section II.A and ending on December 31 of the same year; with respect to all other Calendar Years, the period beginning on January 1 and ending on December 31.

"**Catastrophic Health Plan**" means:

(a) in the case of a contract, agreement or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand dollars; and

(b) in the case of a contract, agreement or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least five thousand five hundred dollars; or

(c) any health benefit plan that provides benefits for hospital inpatient and outpatient services, professional and prescription drugs provided in conjunction with such hospital inpatient and outpatient services, and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

"**Covered Services**" include the services listed in Section III.B. of the Policy.

"**Creditable Coverage**" means coverage under any of the following:

(a) a group health plan;
(b) Part A, B, C or D of Medicare;
(c) Medicaid;
(d) CHAMPUS;
(e) a medical care program of the Indian Health Service or tribal organizations;
(f) a state health benefits risk pool, such as CHIP;
(g) the federal employees health benefits program;
(h) a public health plan such as a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals;
(i) a health benefit plan under the Peace Corps Act; or
(j) a church plan.

"**Custodial Care**" means care that does not require the regular services of a Health Care Provider and is designed primarily to assist You in the activities of daily living. Custodial Care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications that are ordinarily self-administered.

"**Dependent Child**" or "**Dependent Children**" means all minor, unmarried natural or adopted children of Yours who have not reached the age of 19. Dependent Child or Dependent Children also includes such children over the age of 19 who are dependent on You for support and maintenance by reason of developmental disability or physical handicap, provided that proof of such incapacity is submitted to Us within 31 days of the Dependent Child's attainment of age 19.

"**Durable Medical Equipment**" is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an Illness and is used in a home setting. Durable medical equipment includes hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. We, in Our sole discretion, will determine if equipment will be made available on a rental or purchase basis.

Durable Medical Equipment does not include domestic or recreational equipment such as air conditioners, spas and exercise equipment, even if prescribed by a Physician.

"**Emergency**" means the sudden, unexpected onset of a medical condition that in the reasonable judgment of a prudent person is of such a nature that failure to render immediate care by a licensed medical provider would place Your life in danger, or cause serious impairment to Your health.

"**Health Care Provider**" means any Physician, facility or health care professional licensed in Washington State and entitled to reimbursement for health care services.

"**HIPAA Eligible Individual**" means an individual who:

(a) had 18 months or more of Creditable Coverage without a break of 63 full days or more before applying for coverage under this Policy;
(b) had the most recent prior Creditable Coverage under a group health plan, governmental plan, or church plan (or under health insurance coverage offered in connection with such a plan);
(c) is not eligible for a group health plan;
(d) is not eligible for Medicare or Medicaid;
(e) may not have lost the most recent coverage because of fraud or non-payment of premiums; and
(f) if eligible for COBRA or a similar state program, elected and exhausted such coverage.

"**Home Health Agency**" means a public or private agency or organization licensed and operated as a home health agency in accordance with state law.

"**Home Health Care Plan**" means a plan for Your continued care and Treatment by a Home Health Agency. The Home Health Care Plan must be approved in advance in writing by Your attending Physician.

"**Hospice Care**" means a coordinated, interdisciplinary program provided by a licensed hospice agency to meet Your physical, psychological and social needs when You are terminally ill as certified by Your attending Physician.

"**Hospital**" is a facility licensed by the state as a hospital that provides diagnosis, Treatment, and care of persons over a continuous period of twenty-four hours or more.

When Treatment is needed for mental disease or disorder, "Hospital" means a place that meets these requirements:

(a) a facility that provides inpatient psychiatric services for the diagnosis and Treatment of mental Illness on a 24-hour basis;
(b) has rooms for resident inpatients;
(c) is equipped to treat mental diseases or disorders;
(d) has a resident psychiatrist on duty or on call at all times; and
(e) as a regular practice, charges the patient for the expense of confinement.

A Hospital does not include a facility or institution or part of a facility or institution that is licensed or used principally as a clinic, convalescent home, rest home, SNF or home for the aged.

"**Illness**" means a disease, disorder, condition or injury that requires Treatment by a Health Care Provider.

"**Individual Lifetime Maximum**" means the maximum lifetime benefit of $1,000,000 that is payable under this Policy, as further described in Section IV.B.

"**Investigational or Experimental**" means a service, drug or device that meets one or more of the following criteria at the time it is provided, as determined by Us. The service, drug, or device:

(a) cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted;
(b) is subject to a new drug or new device application on file with the FDA;
(c) is provided as part of a Phase I or Phase II clinical trial, as the Experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity or efficacy of the service;
(d) is provided pursuant to a written protocol or other document that lists an evaluation of the safety, toxicity or efficacy of the service, drug or device among its objectives;
(e) is subject to the review or approval of an Institutional Review Board or other body that reviews or approves research concerning the safety, toxicity or efficacy of services, drugs or devices; or
(f) is provided pursuant to informed consent documents that describe the service, drug or device as Investigational or Experimental, or in other terms that indicate that the service, drug or device is being evaluated for its safety, toxicity or efficacy.

If two or more services, drugs or devices are part of the same plan of diagnosis or Treatment, all of the services, drugs or devices are excluded if one of the services is Investigational or Experimental.

"**Medicaid**" means the program established under Title XIX of the federal Social Security Act.

"**Medical Services**" means Covered Services excluding Prescription Drugs.

"**Medical Staff**" means the medical director acting on Our behalf and any independent medical experts engaged by Our medical director.

"**Medically Necessary**" or "**Medical Necessity**" means services or supplies provided by a Health Care Provider to diagnose or treat an Illness that Medicare, Our Medical Staff and/or the Independent Review Organization (under the grievance process set forth in Section VIII) determines is:

(a) appropriate and consistent with Your condition, diagnosis or Illness;
(b) consistent with standards of good medical practice in the United States;
(c) not primarily for Your or Your Health Care Provider's comfort or convenience;
(d) not Investigational or Experimental;
(e) not provided as part of Your scholastic education or vocational training; and
(f) in the case of inpatient care in a Hospital, SNF, Hospice or any other facility, such services or supplies could not be provided safely on an outpatient basis.

"**Medicare**" means the program established under Title XVIII of the federal Social Security Act.

"**Medicare Supplement Policy**" means a health insurance policy or other health benefit plan offered to a Medicare beneficiary that complies with 42 CFR Section 403.205.

"**Myofacial Pain Dysfunction (MPD)**" is a disorder involving muscles surrounding and adjacent to the temporomandibular joint (TMJ) area that is characterized by:

(a) preauricular-temporal, occipital and/or jaw pain;
(b) spasm and/or tenderness of the masticatory muscles; or
(c) limited jaw movement.

"**Network Pharmacy**" is a pharmacy vendor that has contracted with Us to fill prescriptions under this Policy.

"**Our**," "**We**" or "**Us**" means the Washington State Health Insurance Pool.

"**Physician**" means one of the following licensed providers, but only when the provider is rendering a service within the scope of his or her license:

(a) Doctor of Medicine (MD);
(b) Doctor of Osteopathy (DO);
(c) Dentist (DDS);
(d) Optometrist (OD);
(e) Podiatrist (DPM);
(f) Psychologist (Masters or PhD);
(g) Clinical Social Worker (MSW);
(h) Chiropractor (DC);
(i) Registered Nurse (RN);
(j) Advanced Registered Nurse Practitioner (ARNP);
(k) Naturopathic Physician (N.P.); or
(l) any other provider required to be treated as a Physician under the insurance laws of the state of Washington.

This definition does not include someone who is related to You by blood, marriage or adoption or is a member of Your household.

"**Policy**" consists of this plan policy, the Schedule, completed application and all attachments and endorsements included or issued by Us hereafter.

"**Prescription Drug**" means any medical substance, the label of which is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

"**Schedule**" means the Schedule of Benefits attached to this Policy.

"**Skilled Nursing Care**" means any Treatment that is rehabilitative in nature and is required to restore You to Your prior level of health after an accident or Illness. Skilled Nursing Care is a level of care that is higher than Custodial Care and lower than Hospital care.

"**Skilled Nursing Facility**" or "**SNF**" means a facility that primarily provides inpatient Skilled Nursing Care or rehabilitation services and that is licensed by the state as a nursing home. SNF does not include a rest home or place for Custodial Care or maintenance care.

"**Temporomandibular Joint (TMJ)**" dysfunction means a disorder of the temporomandibular joint (the joint which connects the mandible or jawbone to the temporal bone) that is generally characterized by:

(a) pain or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat or shoulders;
(b) popping or clicking of the jaw;
(c) limited jaw movement or locking;
(d) malocclusion, overbite or underbite; or
(e) mastication (chewing) difficulties.

"**Treatment**" means the consultations, tests, procedures and interventions that are:

(a) customarily applied in the care of persons with similar complaints and findings by similarly trained Health Care Providers; and
(b) generally accepted as the effective elements of care.

"**Washington State Resident**" means a person who is domiciled in Washington State for purposes other than obtaining insurance. "Domicile" denotes a person's permanent home and place of habitation.

"**WSHIP**" means Washington State Health Insurance Pool.

"**You**" or "**Your**" means the individual in whose name the Policy is issued and/or any Dependent Children covered under the Policy.

WASHINGTON STATE HEALTH INSURANCE POOL (WSHIP)

Enrollment Packet

Basic Plan

(a Medicare-eligible plan)

Packet includes:

- Eligibility Requirements
- Summary of Benefits
- 2006 Rate Tables
- Application Form
- Appeals & Grievance Policy
- Privacy Policy

HOW TO CONTACT WSHIP

For questions about how to complete your application, please contact our Customer Service Department:

PHONE (8:00 a.m. – 5:00 p.m. Pacific Time)
1.800.877.5187

FAX
WSHIP Billing & Enrollment Department
1.620.792.0535
Claims Department
1.620.792-7053

MAILING ADDRESS
WSHIP
P.O. Box 1090
Great Bend, KS 67530

ON THE WEB
www.wship.org
You can visit us on-line to view additional WSHIP Plan information. The Agent Directory provides a list of insurance agents by city who can assist you in your application.

PLAN ADMINISTERED BY: Benefit Management, Inc. (BMI)

Table of Contents

APPLICATION

WASHINGTON STATE HEALTH INSURANCE POOL
Basic Plan (Medicare Eligible)
Enrollment Information and Summary of Benefits

WHAT IS WSHIP?

The Washington State Health Insurance Pool was created by the Washington State Legislature to provide access to health insurance coverage to all residents of the state who are rejected for individual health insurance.

WSHIP coverage is also available to residents of Washington State counties where commercial Medicare supplemental insurance is not for sale to the general public.

HELP WITH YOUR APPLICATION

We encourage you to use the assistance of a licensed insurance agent to help you complete this application. WSHIP will pay a $50.00 fee to any licensed agent for these services. Enclosed with this packet is a list of agents who have been trained to assist clients with WSHIP applications. The Agent Information form of this application must be signed by the agent and returned with the application. (See Section I, Page P-1)

WHO IS ELIGIBLE FOR COVERAGE?
Medicare eligible applicants only.

Coverage is available to you if you meet these general requirements:

1. You are a Washington State resident. "Resident" means a person who is domiciled in Washington State for purposes other than obtaining insurance. Domicile denotes a person's permanent home and place of habitation. You must attach evidence of residency with this application. (See Section IV, P-4)

2. You must be enrolled in the federal Medicare program Part A and Part B, and you must attach a copy of your Medicare identification card to your application.

3. You must also meet one of the **Eligibility Categories** listed below:

   a) Rejection for Other Health Coverage – You have received within the past 180 days, notification of rejection from an insurance carrier for medical reasons. A copy of the insurance carrier's letter informing you of its decision must be attached to your WSHIP application. Rejection of an application for a Medicare supplemental plan because the carrier does not offer that plan to those under age 65 will be considered a rejection for medical reasons.
   b) Substantially Reduced Coverage – You are a Medicare eligible person who has received substantially reduced coverage on a Medicare supplemental insurance policy from a Washington State licensed carrier due to (1) a requirement of restrictive riders; (2) an up-rated premium; or (3) a pre-existing condition limitation. A copy of the insurance carrier's letter informing you of this must be attached to your WSHIP application.

c) County Without Commercial Individual Coverage – You reside in a Washington State county where Medicare supplement health benefit plans are not marketed to the general public by a member insurance carrier.

DEPENDENT ELIGIBILITY

Coverage for your dependent children is available provided that you are eligible for and are enrolled in WSHIP. Dependent children must be unmarried and under the age of 19. Coverage can be extended for dependent children over age 19 who are disabled. Children can be added to Your Basic Plan policy if they qualify for Medicare Part A and Part B. If they do not meet these qualifications, they can be enrolled in WSHIP's Plan 1 or Plan 3.

WHO IS NOT ELIGIBLE FOR WSHIP'S BASIC PLAN COVERAGE

You are not eligible if:

1. You are not a resident of Washington State.
2. You have terminated coverage in WSHIP within the last 12 months unless you can show continuous other coverage, which has been involuntarily terminated for any reason other than non-payment of premiums.
3. You are an inmate of a public institution.
4. You have been paid $1,000,000 in benefits by WSHIP.
5. You are enrolled in a public program that duplicates benefits provided by WSHIP.

If you are not approved for coverage, read the WSHIP grievance procedures, "Appeals by Applicants and Participants," on Page P-13 of this application.

HOW TO APPLY TO WSHIP

1. Complete the enclosed application form in full.

2. If you have been rejected for coverage on a Medicare supplemental insurance plan by an insurance carrier licensed in the state of Washington because of health status, you must attach a copy of the rejection notice provided by that carrier.

3. If you have received substantially reduced coverage on a Medicare supplemental insurance plan, you must attach a copy of the insurance carrier's letter informing you.

4. Upon approval of your application, we will send you an identification card and an insurance policy, which explains details of your plan benefits and instructions you need to follow in order to get the maximum benefits to which you are entitled.

NON-CREDITABLE COVERAGE

WSHIP's Basic Plan is not a creditable coverage plan. Creditable coverage means the plan's coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage as demonstrated through the use of generally accepted actuarial principles and in accordance with the Centers for Medicare and Medicaid Services (CMS).

If You are enrolled in the Basic Plan and do not (or did not) enroll in the Part D Prescription Drug Plan during the federal Medicare Part D Prescription Plan Initial Open Enrollment period (November 15, 2005 to May 15, 2006), when you do enroll in Part D, You are (or will be) subject to a 1% penalty per month of the Part D premium that would otherwise have applied if You had been covered by a plan with creditable coverage during the Initial Open Enrollment period.

NETWORK PHARMACIES

All drugs, supplies, medicines and pharmacy services must be obtained at a Network Pharmacy or through WSHIP's mail order pharmacy except drugs dispensed by an emergency care provider when related emergency care services are covered under this policy or when a Network Pharmacy is not available within a 30-mile radius of Your home or the prescribing Provider. If either of these situations apply, please contact WSHIP customer service for further information.

SUMMARY OF BENEFITS

<u>NOTICE</u>: Benefits are subject to the full description, provisions, limitations and exclusions defined in the WSHIP Basic Plan Policy, which is the complete Plan contract issued to You at the time of Your enrollment. Plan Policy documents are available for review on the WSHIP web site or upon request to WSHIP. In the event of a discrepancy between this summary and the WSHIP Plan Policy, the WSHIP Plan Policy will govern.

BASIC PLAN BENEFITS AND LIMITATIONS	EXPENSES YOU ARE RESPONSIBLE FOR
MEDICARE PREMIUM PAYMENT You must enroll in Medicare Part A and Part B and pay the Part B premium.	You pay Medicare Part B premium
ANNUAL DEDUCTIBLE The portion of health care expenses the member must pay out-of-pocket before any insurance coverage applies or reimbursement by WSHIP for expense begins.	You pay none; Medicare annual deductible is paid by WSHIP
COINSURANCE A defined percentage of the Allowed Amount for Covered Services that You are required to pay. Coinsurance applies only to services that are not covered under Medicare Part A or B.	You pay no coinsurance for services covered by Medicare Parts A or B You pay 20% for services not covered by Medicare

BASIC PLAN BENEFITS AND LIMITATIONS	EXPENSES YOU ARE RESPONSIBLE FOR
OUT-OF-POCKET EXPENSE LIMITATION The out-of-pocket expense limit is the amount of money you must pay per calendar year before the Plan pays 100% of allowed amounts for the remainder of that calendar year. Out-of-pocket expense includes your coinsurance amounts. Any amounts paid for non-covered services, amounts in excess of the allowed amount, and payments for services beyond a benefit maximum or limit do not qualify as an out-of-pocket expense.	You pay $850 Medical out-of-pocket, after which WSHIP pays 100% of allowed amount
PRESCRIPTION DRUG OUT-OF-POCKET EXPENSE LIMITATION Prescription drug out-of-pocket expenses do not apply to the medical out-of-pocket expense limit. Medical out-of-pocket expenses also do not apply to the prescription drug out-of-pocket expenses limit.	You pay $150 prescription drug out-of-pocket, after which WSHIP pays 100% of allowed amount
COMPLEMENTARY & ALTERNATIVE MEDICINE (CAM) Services for acupuncture and massage therapy must be received from a provider performing within the scope of his/her license and be medically necessary. Some services must be prescribed by a physician. Plan coinsurance applies. Maximum 12 visits per year for each of acupuncture and massage therapy. Chiropractic and naturopathic physician services are covered as professional services.	You pay 20%
DIABETES EDUCATION WSHIP pays 80% of the expense incurred by the insured person who enrolls, participates in, and completes a Diabetes Patient Education Program. $250 lifetime maximum.	You pay 20%
HOME HEALTH CARE Covered up to 130 visits per calendar year for medically necessary services provided in the home by a licensed home health agency. Services must be ordered and directed by a physician as part of a home heath care plan. Covered services are: part time nursing care; physical, occupational, respiratory, or speech therapy provided by a licensed therapist; intermittent home health aide services under supervision of a registered nurse; medical supplies and equipment suitable for home use which would be covered if the patient were confined to a hospital.	You pay 20%

BASIC PLAN BENEFITS AND LIMITATIONS	EXPENSES YOU ARE RESPONSIBLE FOR
HOSPICE CARE Benefits are payable for the services and supplies of a licensed hospice. Respite care is covered for a maximum of five continuous days for every three-month period of hospice care.	You pay 20%
HOSPITAL SERVICES – INPATIENT Semi-private room and any other hospital services and supplies up to 180 days annual maximum. **HOSPITAL SERVICES – OUTPATIENT** Services are provided.	You pay 20% You pay 20%
MATERNITY Maternity delivery and postnatal care are subject to the pre-existing condition limitation. The pre-existing limitation does not apply to pre-natal care. Plan coinsurance applies.	You pay 20%
MEDICAL SUPPLIES AND EQUIPMENT Purchase (or rental up to the purchase price) of Durable Medical Equipment is a covered benefit; plan limitations apply.	You pay 20%
MENTAL CONDITIONS AND CHEMICAL DEPENDENCY Services for the treatment of mental and nervous conditions and state-approved chemical dependency programs for alcohol, drug, or chemical dependency or abuse are covered services. Services must be provided by a physician, psychologist, community mental health professional, or under the direction of a physician by other qualified licensed health care practitioners. Combined maximum of 30 inpatient days annually and 20 outpatient visits annually.	You pay 20%
OUTPATIENT SURGERY Medical services and supplies are covered.	You pay 20%
PREVENTIVE CARE Benefits for preventive care are covered. $200 annual maximum.	You pay 20%

BASIC PLAN BENEFITS AND LIMITATIONS	EXPENSES YOU ARE RESPONSIBLE FOR
PROFESSIONAL SERVICES Services, including surgery, for treatment of injuries, illnesses or conditions are covered.	You pay 20%
REHABILITATION THERAPIES Physical, occupational, respiratory or speech therapy are covered services.	You pay 20%
SKILLED NURSING FACILITY (SNF) The room rate shall be the most common semi-private room rate of the facility in which you are confined. 100 days annual maximum.	You pay 20%
TRANSPLANT SURGERY Medically necessary services are covered. $250,000 lifetime maximum.	You pay 20%
PRESCRIPTION DRUG COVERAGE	**EXPENSES YOU ARE RESPONSIBLE FOR**
COVERED PRESCRIPTION DRUGS All prescription drugs that are covered under Parts A or B of Medicare.	You pay nothing; WSHIP pays 100% of the applicable deductible and coinsurance amount
PRESCRIPTION DRUGS NOT COVERED Drugs covered by Part D and all other drugs are not covered.	You pay 100% of drugs not covered by Medicare Parts A or B
NETWORK PHARMACY All prescription drugs and pharmacy services must be obtained at a Network Pharmacy or through WSHIP's mail order pharmacy, except for the following: (a) drugs dispensed by a Health Care Provider when related to Emergency services; and (b) drugs dispensed by a non-Network Pharmacy when a Network Pharmacy is not available within a 30-mile radius of Your home or prescribing Provider. (*If either of these situations apply, please contact WSHIP customer service for further information.)*	Except as indicated, You pay 100% of drugs not provided by a Network Pharmacy or WSHIP's mail order pharmacy

PRE-EXISTING CONDITION LIMITATION

A pre-existing condition is an illness, injury or condition for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the policy effective date.

The pre-existing condition limitation will not apply to pre-natal care. Maternity delivery and postnatal care are subject to the pre-existing condition limitation.

Benefits will not be paid for a pre-existing injury, illness or condition for the first six months following your policy effective date except as follows:

Waiver or Credit of the Pre-existing Condition Wait Time
The pre-existing condition wait time will be waived or credited to the extent that you have been covered under a previous medical plan. The previous coverage must have been terminated no more than 63 days from the date You applied for WSHIP coverage, or if You applied as a result of rejection by a carrier, 63 days before You applied to the carrier. The previous coverage must not be a catastrophic coverage only plan (meaning a plan that has $1,500 or more deductible or $3,000 or more out-of-pocket cost or provides benefits for hospital inpatient/outpatient services and excludes or substantially limits outpatient physician services and those services usually provided in an office setting). If WSHIP receives your application before the end of the month following the month you applied to an insurance carrier, the 63 days will be counted from the date the insurance carrier received a completed application.

HEALTH MANAGEMENT

CARE MANAGEMENT
Use of care management services for covered services not covered by Medicare ensure that You receive appropriate and cost-effective medical care, and may reduce instances of non-covered services. When You use the Care Management services, You receive a determination in advance about whether or not a particular service is medically necessary.

CASE MANAGEMENT
Participation in Case Management is voluntary. Case Management is used to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of Your benefits.

EXCLUSIONS TO COVERED SERVICES

For a complete list of exclusions, see the Plan Policy. No benefits shall be paid or credit given for services or supplies that are not Covered Services or that exceed the Allowed Amount. Nor will any payment be made or credit given for any services, supplies or drugs relating to:

Communication or Travel – Communication, transportation or travel except for emergency ambulance services as described in the Plan policy.

Cosmetic and Reconstructive – Reconstructive or cosmetic purposes or plastic surgery except as provided in the Plan policy.

Counseling – Marital, family, sexual, vocational or outreach counseling or job training.

Custodial Care – Services or supplies that are designed primarily to assist You in the activities of daily living.

Dental – Dental treatment of any kind except as specified under oral surgery "eligible expenses" in the Plan policy.

Education and Training – Special education and training except as described for the Diabetes Education benefit.

Fertility – Fertility or infertility diagnosis or enhancement and any related direct or indirect complications.

Foot Care – Routine foot care or treatment of fallen arches or flat feet.

Governmental Facilities – Treatment provided by a state or federal hospital or facility that is not a Network Provider unless payment of the charge is legally required.

Investigational or Experimental – Treatment that is investigational and/or experimental.

Medically Necessary – Treatment that the Administrator determines is not Medically Necessary.

Military Service and War Related – Illness caused by or related to military or war related acts.

Obesity and Weight Control – Treatment of obesity or weight management and any direct or indirect complications from such treatment.

Services for Which You Do Not Have to Pay – Treatment for which no charge is made, no charge would have been made if this Policy were not in effect or for which you are not legally required to pay.

Sex or Gender Reassignment – Sex transformation or gender reassignment or the direct or indirect complications of such treatment, supplies or drugs.

Sexual Dysfunction – Treatment or diagnosis of sexual dysfunction and any direct or indirect complications of such treatment.

Vision and Hearing – Eye exams, vision analysis, contact lenses, eyeglasses or hearing aids, or surgery or other procedure or training intended to improve or correct vision or hearing, except (a) when due to an accidental injury to the eyes or ears; or (b) for the initial contact lenses or eyeglasses after a covered cataract surgery without intra-ocular lens implant.

Work or Employment Related – Treatment for Illness caused by or related to employment regardless of whether a claim has been made for workers compensation.

WASHINGTON STATE HEALTH INSURANCE POOL

Rates Effective January 1, 2006

Basic Plan
(Medicare eligible plan)

Information and premium rates contained herein are subject to change with a 30-day advance notification.

INSERT RATE TABLE HERE

APPLICATION CHECKLIST

Contact WSHIP Customer Service Dept., 1.800.877.5187; or via email at www.wship.org if you have questions filling out your application form.

- Is your application completely filled out and signed in black ink? **See Section VII, Page P-7**
- If you have a post office box, is a street address also included? **See Section II, Page P-2.**
- Have you included proof of Washington residency? **See Section IV, Page P-4.**
- Did you check an eligibility category and include a copy of the documentation for the category you checked? **See Section IV, Page P-4.**
- Have you included a copy of your Medicare card? See **Section IV, Page P-4**.
- Have you included a copy of the rejection or substantially reduced coverage notice, which must be on insurance carrier letterhead, signed by an underwriter, addressed to the applicant and be due to the applicant's health. **See Section IV, Page P-4.**
- Did you identify any other health care coverage in effect? **See Section V, Page P-5.**
- If the Pre-existing Waiver Benefit applied to you and your coverage was an individual plan, did you include a Certificate of Creditable Coverage from your previous insurance carrier? If prior coverage was on an individual plan, did you include a Summary of Benefits? Or, have you included substitute documentation to show proof of previous coverage? **See Section VI, Page P-6.**
- Did you sign the Disclosure Certification? **See Section VII, Page P-7.**
- Did you identify a premium payment cycle (Monthly Bank Draft, Quarterly, Semi-Annual, or Annual)? **See Section VIII, Page P-7.**
- Have you included the premium payment due according to the payment cycle chosen? **See Section VIII, Page P-7.**
- Have you selected your Effective Date of Coverage**? See Section IX, Page P-8.**
- If you wish to designate a Personal Representative, have you filled out and signed the form? **See Section X, Page P-9.**
- If you chose the Monthly Bank Draft premium payment cycle, did you include one month's premium? Did you complete, sign and enclose the Authorization Agreement for Automatic Withdrawal? Did you attach a voided check? **See Authorization Form, Page P-12.**

All necessary information must be included and appropriate documentation attached in order for application to be processed. An incomplete application will delay the approval process.

PLEASE

CAREFULLY REMOVE

THE FOLLOWING PERFORATED

SECTION OF THIS BROCHURE

WHICH CONTAINS THE APPLICATION

(pages are marked application P1-P12)

If applicable, also include the
Bank Authorization Form,
(This page is also perforated.)

IF APPLICATION IS BEING MADE THROUGH AN AGENT, RETURN THE SIGNED AGENT INFORMATION FORM (SECTION I).

APPLICATION for COVERAGE

Washington State Health Insurance Pool

Basic Plan

(Medicare-eligible Plan)

MAIL APPLICATION TO:

BMI (Benefit Management, Inc.)
P.O. Box 1090, Great Bend, KS 67530
1.800.877.5187 or www.wship.org

Please type or print in black ink. All questions must be filled out with complete detail (attach a separate piece of paper if necessary). Incomplete applications may delay the effective date of your policy. If you have questions while completing the application, call WSHIP Customer Service at **1.800.877.5187.**

INFORMATION AND PREMIUM RATES CONTAINED HEREIN ARE SUBJECT TO CHANGE WITH A 30-DAY NOTIFICATION.

SECTION I: AGENT INFORMATION

IF APPLICATION IS BEING MADE THROUGH AN AGENT, HE/SHE MUST PROVIDE THE INFORMATION BELOW. RETURN THIS FORM WITH YOUR APPLICATION.

Agent Information	
Agent Name:	Firm or Agency:
Agent Address:	
Agent Phone: ( )	Agent email address:

I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application and the Standard Health Questionnaire (if applicable) has been completed truthfully by the applicant(s).

Agent Signature Date

Agent's Washington State License No:

- ☐ Copy of License Attached
- ☐ Copy of current license on file with WSHIP

Agent's Tax I.D. Number: Contact Person: ( )

☐ Pay commission to agent OR ☐ Pay commission to firm

A copy of the agent's current Washington state license and a W-9 form must be submitted with this application, or be on file with WSHIP, for an agent to receive commission payment from WSHIP.

FOR OFFICE USE ONLY
Effective Date:___/___/_____

SECTION II: APPLICANT INFORMATION

Last Name_____ First Name _____ MI _____

Social Security Number_____

Street Address (**required**)_____

City _____ State_____ ZipCode_____

County of Residence _____

Billing Address and Name of Organization / Agency Responsible for Payment, if different from above:

Organization Name_____

Billing Address _____

City_____State_____Zip_____

Contact person _____Phone_____

☐ Male ☐ Female Birth Date _____/_____/_____ Age_____

Home Telephone_____ Work Telephone_____

Email address _____

Custodial Parent / Guardian if Applicant is a minor or not legally competent:

_____

Receiving DSHS Medical Assistance? _____ ☐ Yes ☐ No

SECTION III: DEPENDENT INFORMATION

If you are eligible for WSHIP and enroll, you can elect to cover your dependent children. They do not have to be rejected by an insurance carrier. List dependents to be covered. Dependent children must be unmarried and under age 19 or disabled. Additional premiums are required for each dependent AND dependent must be on Medicare Part A and Part B to be eligible for the Basic Plan. A dependent child who does not meet these eligibility requirements may be enrolled in Plan 1 or 3. Do not use this form for non-Medicare children. Please contact WSHIP Enrollment Department for forms to enroll non-Medicare dependent children.

Dependent A

Last Name_____ First Name _____ MI _____

Social Security Number_____ Birth Date_____/_____/_____

Disabled and over age 19? ☐ **Yes** ☐ **No**

If yes, receiving Social Security disability? ☐ **Yes** ☐ **No** Entitlement date_____/_____/____

Receiving DSHS medical assistance? ☐ **Yes** ☐ **No** Relationship to applicant_____

Dependent B

Last Name_____ First Name _____ MI _____

Social Security Number_____ Birth Date_____/_____/_____

Disabled and over age 19? ☐ **Yes** ☐ **No**

If yes, receiving Social Security disability? ☐ **Yes** ☐ **No** Entitlement date _____/_____/____

Receiving DSHS medical assistance? ☐ **Yes** ☐ **No** Relationship to applicant_____

Add an additional sheet if you have more dependents.

☐ **Yes** ☐ **No** Is Applicant or any Dependent listed currently insured through WSHIP?

If **YES**, name of person(s): _____

Relationship: _____

Policy Number: _____

SECTION IV: ELIGIBILITY INFORMATION

I CERTIFY that I am eligible for coverage because I meet the following requirements:

(1) I am a resident of the state of Washington – "resident" means a person who is domiciled in Washington State for purposes other than obtaining insurance. Domicile denotes a person's permanent home and place of habitation. **You must attach evidence of residency with this application. The evidence must match the home address listed in Section II, page P-2.** Evidence of residency includes, but is not limited to, a copy of:

a) A bill in your name from any public utility at your dwelling in the state of Washington; or
b) Receipts for rent, mortgage or lease payments for your dwelling in Washington state; or
c) A Washington state drivers license or state identification card; or
d) Proof of registration and payment in Washington of taxes and fees on motor vehicles; or
e) Proof of employment in Washington state; or
f) A voter registration card; or
g) A federal tax return as a resident of Washington state.

(2) I verify that I am enrolled in both Part A and Part B of the federal Medicare program. Please include a copy of your Medicare card with this application. If the dependents listed in this application are enrolled in Medicare Parts A and B, please provide a copy of the Medicare card for each dependent. Dependents must be enrolled in Medicare Parts A and B to be eligible for the Basic Plan. If they are not eligible for these plans, you may enroll them in Plan 1 or Plan 3.

(3) I also meet one of the ELIGIBILITY CATEGORIES listed below. Please check the eligibility category you are applying under:

☐ **REJECTION FOR OTHER HEALTH COVERAGE** I have received notification from a carrier that I was rejected for medical reasons. Rejection of an application for a Medicare supplemental plan because the carrier does not offer that plan to those under age 65 will be considered a rejection for medical reasons. **A copy of the insurance carrier's rejection notice is attached to my WSHIP application.** WSHIP will accept a denial notice for up to 180 days from the date you received the denial letter. Applicants may be required to reapply to a health carrier if the denial was received more than 180 days from the WSHIP application date. The WSHIP application date is the fax received date or postmarked date, whichever occurs first.

☐ **COUNTY WITHOUT COMMERCIAL INDIVIDUAL COVERAGE** I reside in one of the state of Washington counties where commercial individual medical insurance is not marketed to the general public by a member insurance carrier.

Name of county: _____

☐ **SUBSTANTIALLY REDUCED COVERAGE** I am a Medicare eligible person who has received substantially reduced coverage on a Medicare supplemental insurance policy from a Washington State licensed carrier due to (1) a requirement of restrictive riders; (2) an up-rated premium; or (3) a preexisting conditions limitation on a Medicare supplemental insurance policy. A copy of the insurance carrier's notice is attached to my WSHIP application.

Please Note:
Involuntary termination of other coverage and / or currently disabled with no coverage other than Medicare, by themselves, do not necessarily make you eligible for WSHIP.

NO PERSON IS ELIGIBLE FOR WSHIP COVERAGE IF ONE OF THE FOLLOWING APPLIES TO THEM:

a) They have terminated coverage in WSHIP within the last 12 months, unless they can show that they had continuous other coverage from the date WSHIP coverage terminated, which has been involuntarily terminated for any reason other than non-payment of premiums or fraud;
b) WSHIP has paid out one million dollars in benefits on their behalf;
c) They are an inmate of a public institution;
d) Their benefits are duplicated under public programs; or
e) They do not reside in Washington state (except qualified resident dependent children temporarily living outside of Washington state).

SECTION V: OTHER COVERAGE

WSHIP will pay secondary to any other coverage unless pre-empted by federal law.
Do you or any person named on this application have any other medical or hospital insurance including public programs such as Medicaid? ☐ **Yes** ☐ **No**
If **YES,** complete the following for each person(s):

_____
Last Name First Name MI

_____
Insurance Company Name Insurance Company Phone No.

_____
Policy Number Description of Coverage

Is it a Group Plan? ☐ **Yes** ☐ **No** Is it your intent to replace it with this coverage? ☐ **Yes** ☐ **No**

SECTION VI: PRE-EXISTING CONDITIONS PROVISION

WSHIP plans have a six-month waiting period for pre-existing conditions. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for shortening the pre-existing condition waiting period, please complete the following information and **attach your Certificate of Coverage from your current or prior carrier**. If you do not have a Certificate of Coverage, you may provide other documentation of prior coverage beginning and ending dates (such as a letter from the employer, group administrator, prior insurance carrier, or your insurance agent).

Name of carrier (insurance company): _____

Telephone Number of carrier: _____

Name of subscriber (contract holder):_____

ID Number of subscriber: _____

Names of all enrollees on prior coverage:_____

Date coverage began:_____Date coverage ended:_____

Deductible amount: $ _____

Out-of-pocket maximum amount per family, per year: $_____

Type of coverage: ☐ Individual ☐ Group ☐ Group COBRA

☐ Healthy Options ☐ Other Medicaid ☐ Medicare ☐ Basic Health Plan

Type of benefits (check all that apply): ☐ Medical ☐ Hospital Only ☐ Accident Only

☐ Prescription Drug ☐ Dental ☐ Vision

Do you intend to continue this other coverage if you are accepted by WSHIP?

☐ YES ☐ NO (If no, remember to contact your insurance company to cancel.)

Reduction or Waiver of Pre-Existing Waiting Period

The pre-existing condition waiting period will be reduced or waived in the following circumstances:

(a) Applicants will receive a pre-existing condition wait credit for time spent in their immediate previous group or non-catastrophic individual plan, if application is made to WSHIP or a health plan carrier within 63 days of termination of that previous plan. (A catastrophic plan means a plan that has $1,500 or more deductible or $3,000 or more out-of-pocket cost or provides benefits for hospital inpatient/outpatient services and excludes or substantially limits outpatient physician services and those services usually provided in an office setting).

(b) WSHIP will waive the pre-existing condition wait for any person who is eligible for such waiver under the standards of the Federal Health Insurance Portability Act (18 months "creditable coverage" and application to WSHIP or a member health plan carrier was made within 63 days of termination).

SECTION VII: DISCLOSURE CERTIFICATION

THIS FORM MUST BE SIGNED BY ALL ADULT APPLICANTS.

By signing this form, I, as an adult applicant, certify the following:

a) All of the answers provided for all persons listed as applicants are true and complete.
b) I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under WSHIP coverage and may face other penalties for prosecution and collection.
c) WSHIP coverage will not be effective until this application has been signed, submitted in full by the applicants and approved by WSHIP. Deposit of premium payment does not guarantee coverage. The payment will be refunded for applicants who are not eligible for WSHIP coverage.
d) I have read the privacy notice at the end of this brochure.
e) If I have designated someone as my personal representative, I have included that signed form with this application.
f) I understand that any changes to Medicare eligibility must be reported to WSHIP within 30 days.

SIGNATURE OF APPLICANT (OR CUSTODIAL PARENT IF APPLICANT IS UNDER AGE 18 OR NOT LEGALLY COMPETENT:

_____

Signature **Date**

_____

Print Name

SECTION VIII: PREMIUM PAYMENT SELECTION

PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:

☐ **MONTHLY BANK DRAFT** – 1 month premium due with application.
(Complete attached Authorization Form and include a VOIDED check.)

☐ **QUARTERLY** – 3 months premium due with application.

☐ **SEMI-ANNUAL** – 6 months premium due with application.

☐ **ANNUAL** – 12 months premium due with application.

Please note: The billing frequency will be adjusted to the calendar year – quarters, biannual and annual.

MAKE CHECK PAYABLE TO WSHIP

Use the BASIC RATE TABLE to determine your premium payment.

SECTION IX: EFFECTIVE DATE OF COVERAGE

Please note:

1. The **"Application Received by WSHIP" date** is determined as the date WSHIP receives a faxed copy of your application, or the postmark date of the application that You mailed to WSHIP, whichever occurs first.
2. The original application must be postmarked and mailed to WSHIP no later than five (5) days following the date You faxed the application to WSHIP.
3. If the application is approved, Your insurance coverage and premiums will begin on the first (1st) of the month based on Your choice.

Select Your effective date of coverage; checkmark only one choice:

☐ **AS SOON AS WSHIP CAN PROCESS MY APPLICATION.**

I understand that if my application is faxed or postmarked on or before the 20th of the month, then WSHIP coverage will be effective the 1st of the next month. However, if my application is faxed or postmarked after the 20th of the month, my coverage will not start until the 1st of the SECOND month. (Example: Application received by WSHIP July 21, 2006, will be effective September 1, 2006)

☐ **A FUTURE DATE**: This must be on the 1st of the month and can be no more than 60 days ahead of when your application was faxed or postmarked. (For example, with a postmark date of May 2, 2006, your coverage can be effective no later than July 1, 2006.)

Tell WSHIP what your Future Date of Coverage should be:

(month) _____ (year) _____

☐ **AN EARLIER DATE:** To select an earlier (*retroactive*) effective date, these two things must be true:

a) You applied for individual coverage with a Washington state health insurance carrier no later than the 20th of the month for an effective date of the 1st of the following month, and You were rejected; and,
b) You are mailing or faxing this WSHIP application within 15 days of receiving that carriers' Notice of Rejection.

If both of the above are TRUE, you may select an effective date that your coverage with the individual carrier would have been effective:

Enter the date of the application to the other carrier _____

Enter Requested Effective Date here: (month)_____(year)_____

SECTION X: PERSONAL REPRESENTATIVE FORM

Include this form with your application if you wish to designate someone as your Personal Representative(s) for discussion and disclosure of Personal Health Information and Personal Financial Information with WSHIP or BMI, the plan administrator. This designation will not affect benefits, claims processing and payment, or eligibility status.

Type of Information

WSHIP and BMI may discuss or release Personal Health Information (PHI) and Personal Financial Information (PFI) to my Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through the Washington State Health Insurance Pool (WSHIP), and BMI, the health plan administrator.

Authorized Use and/or Disclosure

I authorize WSHIP and BMI to release PHI and PFI to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider, or other person subject to federal privacy laws, my PHI and PFI may no longer be protected by those privacy laws and may be subject to re-disclosure by my Personal Representative. WSHIP and BMI are not responsible should my Personal Representative further disclose my protected PHI and PFI information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating no limitation on disclosure of PHI of PFI.

Disclosure Limitations: _____

Expiration and Revocation

The authorization to release information to my Personal Representative(s) will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan administrator. Revocation will not affect any action that WSHIP or BMI has taken, or any information that has already been released based upon prior authorizations.

Designation of Personal Representative(s)

Name of Authorized Person	Relationship to Member	*Privacy Password
Name of Authorized Person	Relationship to Member	*Privacy Password

**Privacy Password – such as mother's maiden name, your elementary school, birth city, etc.*

Signature and Authorization

I, the undersigned, do hereby swear that I am the above-mentioned member or an authorized legal representative of the above-mentioned member. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

Member/Applicant name:_____

_____

Signature of Member/Legal Representative Date

_____

Printed Name of Legal Representative Description of Legal Representative's Relationship to Member

MAIL COMPLETED APPLICATION TO:

WSHIP
ATTN: Enrollment
P.O. Box 1090
Great Bend, KS 67530

ALL PAGES (P1-P9) OF THE APPLICATON MUST BE RETURNED

IF APPLICATION IS BEING MADE THROUGH AN AGENT, RETURN THE SIGNED AGENT INFORMATION FORM (SECTION I, P-1).

All necessary information must be included and appropriate documentation attached when requested in order for the application to be processed. An incomplete application will delay the approval process.

WASHINGTON STATE HEALTH INSURANCE POOL

BANK SERVICE PLAN AUTHORIZATION FORM

TO: The financial institution named on the reverse side.

So that you may comply with your depositor's request, the Pool (Washington State Health Insurance Pool) agrees:

a) To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, order or direction to debit an account purporting to be executed by this Pool and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

b) In the event that any such check, draft, order or direction shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in forfeiture of that insurance.

c) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your action taken pursuant to the foregoing request or in any manner arising by reason of your participating in the foregoing plan of premium collection.

WASHINGTON STATE Health Insurance Pool

Washington State Health Insurance Pool • PO Box 1090 • Great Bend, KS 67530

REQUEST FOR BANK SERVICE PLAN

TO: Washington State Health Insurance Pool

Please use your Bank Service Plan to make my premium payments by withdrawing funds by automatic debit entry from the account of:

Name as shown on Account | Insured / Applicant

_____
Insured / Applicant Identification Number (if you are a NEW applicant, leave blank)

Name of Financial Institution | Branch

City | State | ZIP

Transit/ABA No. _____ Account No. _____

Please indicate below the type of account to be debited.

Checking ☐ Savings ☐

As a convenience to me, I authorize you to pay and charge to my account automatic debit entries made upon my account by, and payable to, the order of Washington State Health Insurance Pool. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. **This authorization is to remain in effect until you receive 15 days' written notice from me to revoke it.**

X _____ **X** _____
Authorized signature as shown on account | Date

WSHIP will withdraw from your account the first Friday of each month except when it falls on the 1st, 2nd, or 3rd. In that case, we will withdraw on the second Friday of the month. If you have any questions, call WSHIP's Customer Service Dept. at 1.800.877.5186.

ATTACH A VOIDED CHECK HERE:

Please return the Bank Service Plan to:
WASHINGTON STATE HEALTH INSURANCE POOL
P.O. BOX 1090, GREAT BEND, KS 67530

Washington State Health Insurance Pool
Appeals by Applicants and Participants

I. General

(a) Any applicant for individual health coverage from a carrier who believes that the carrier erred in its scoring or administration of the Standard Health Questionnaire ("SHQ") may request review by WSHIP if the applicant has exhausted his or her appeal rights directly to the carrier. WSHIP's review will be limited to whether the carrier correctly applied the scoring tool for the SHQ and whether the carrier's notice of rejection for coverage was provided within 15 business days of the carrier's receipt of the completed application. Such review will follow the internal two-step procedure below, but will not entail external review by an Independent Review Organization ("IRO"). If WSHIP determines that the carrier erred, WSHIP will notify the carrier of its review and recommendation.

(b) Any WSHIP applicant or participant who is aggrieved by an action or decision of WSHIP may pursue up to three levels of appeals. The first two levels are internal, first to WSHIP's administrator and second to the WSHIP's grievance committee. The third level of appeal is external and may be made to a designated IRO. IRO review is available only for appeals of decisions relating to the denial, modification, reduction or termination of coverage of or payment for health care services. A person may appeal to the IRO only after completion of WSHIP's internal review process.

II. Internal Process

(a) Appeal to WSHIP's Administrator

(i) The person, or his or her authorized representative, must notify WSHIP's administrator of his or her request for appeal within 90 days of the event giving rise to the appeal. If the complaint concerns a carrier's application of the SHQ scoring tool, the person should include his or her completed SHQ and the carrier's scoring, if available.

(ii) Within five business days, the WSHIP administrator will respond to the person in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested.

(iii) WSHIP's administrator will investigate the complaint, considering all information submitted by the person, and make its decision within 30 days of receipt of the complete information needed to respond to the appeal.

(iv) WSHIP's administrator will notify the person of its decision in writing and inform the person of any further appeal options. The written notice will explain the decision and

any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If WSHIP's administrator fails to make its decision within 30 days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and the person may appeal to the next level.

(v) If the complaint concerns the carrier's application of the SHQ scoring tool or the timing of the notice of rejection and WSHIP's administrator determines that the carrier erred, WSHIP's administrator will also forward its written decision to the carrier and recommend that the carrier take appropriate action.

(vi) If a complaint involves denial of coverage of a service, and the person provides written notice to WSHIP's administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize the person's life, health or ability to regain maximum function, WSHIP's administrator will provide its written decision within 72 hours of receipt of the appeal request.

(b) Appeal to WSHIP's Grievance Committee

(i) The person, or his or her authorized representative, must notify WSHIP's administrator of his or her request for appeal to WSHIP's grievance committee within 90 days of an adverse decision by WSHIP's administrator and include a written description of the complaint.

(ii) Within five business days, WSHIP's administrator will respond to the person in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested. Within two business days of sending this notice, WSHIP's administrator will forward the appeal, with all relevant information from its files, to the WSHIP's grievance committee.

(iii) WSHIP's grievance committee will investigate the complaint, considering all information submitted by the person, and make its decision within 30 days of its receipt of the complete information needed to respond to the appeal. The grievance committee may engage independent medical and legal experts to assist in the review process.

(iv) WSHIP's grievance committee will notify the person of its decision in writing and inform the person of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If WSHIP's grievance committee fails to make its decision within 30 days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and the person may appeal to the next level.

(v) If the complaint concerns the carrier's application of the SHQ scoring tool or the timing of the notice of rejection and WSHIP's grievance committee determines that the carrier erred, the grievance committee will also forward its written decision to the carrier and recommend that the carrier take appropriate action.

(vi) If a complaint involves denial of coverage of a service, and the person provides written notice to WSHIP's administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize the person's life,

health, or ability to regain maximum function, WSHIP's grievance committee will provide its written decision within 72 hours of its receipt of the appeal request.

III. External Process

(a) If the WSHIP's grievance committee affirms a decision to deny, modify, reduce, or terminate coverage of or payment for health services, the person may appeal the decision to an IRO by notifying the WSHIP's administrator within 30 days of receipt of the grievance committee's written decision.

(b) The WSHIP's administrator will gather all relevant documents and deliver them to the IRO within three business days of receiving the person's request for appeal.

(c) The IRO, made up of persons not associated with WSHIP, will review the complaint and make a decision. The IRO will provide its decision in writing to the person and WSHIP within 20 days of the person's request for appeal. WSHIP will pay the charges for the IRO's review and written report.

IV. Enrollment and Services During Appeal Process

(a) A person denied enrollment by a carrier based on his or her SHQ results may apply for coverage under WSHIP while a review is in progress.

(b) If the complaint is from a WSHIP enrollee contesting a coverage decision and such decision was based on a finding of no medical necessity, WSHIP will continue to provide the service until the appeal is completed. Upon completion of the appeal process, if WSHIP continued to provide the service in question and it is determined that the coverage was properly denied, WSHIP may charge the enrollee for the cost of the services provided.

WSHIP PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully. The privacy of your personal health and financial information is very important to us.

I. OUR COMMITMENT TO PRIVACY

Washington State Health Insurance Pool (WSHIP) is required by law to maintain the privacy of your personal health and financial information (PHI) and to provide you with notice of its legal duties and privacy practices with respect to your PHI.
In the course of administering your health benefits, WSHIP collects personal health and financial information from you and your health care providers. These records are used and maintained by WSHIP, but the PHI contained in the records belongs to you.

II. HOW DO WE PROTECT YOUR INFORMATION?

We maintain the highest possible physical and electronic security safeguards to protect your

personal health and financial information (PHI) against unauthorized access. We have policies and procedures in place to make certain we only share the minimum amount of PHI necessary and only with those parties who have a legitimate business need for the information. We have a privacy director dedicated to developing procedures to protect your PHI, to educating our staff, and to testing and enforcing our privacy protection mechanisms.

We will not disclose PHI except as permitted by law.

III. TO WHOM IS YOUR PHI DISCLOSED & WHY?

To effectively administer your health benefits, WSHIP must share some of your personal health and financial information (PHI). The law permits WSHIP to use or disclose your PHI for the following reasons:

- **For treatment:** WSHIP may disclose your medical information when requested by a doctor, hospital or other provider requiring the information to appropriately treat you.
- **For payment:** WSHIP may use or disclose your PHI to pay or deny your claims for provider services that may or may not be covered by your WSHIP benefits. This may include exchanging eligibility, benefits or prior authorization information with your health care providers or pharmacy benefits carrier or providing information to your other insurance carrier (if applicable).
- **For healthcare operations:** WSHIP may use or disclose your PHI as required to operate the WSHIP program. For example, PHI may be used in determining the cost of your premiums, to collect your premiums, to support grievance or quality review boards, for audit or accreditation programs or for necessary business purposes.
- **For the creation of data:** WSHIP may use your PHI for the creation of a historical database that is de-identified (not traceable back to you).
- **To you or to your designee upon your authorization:** WSHIP will release your PHI to you or someone who has the legal right to act for you (your personal representative). You retain the right to give us permission, via a written authorization, to use your PHI or release it to whomever you choose for any purpose. If you give us such an authorization, you have the right to cancel it at any time.

WSHIP considers the activities described above key for the proper administration of your health plan. There are also other limited circumstances in which WSHIP must release your PHI. These include:

- **As required by law.** WSHIP may use or disclose your PHI when required to do so by law. For example, we will disclose your PHI to the Secretary of the U.S. Department of Health and Human Services (HHS), should HHS choose to ensure we are in compliance with federal law. Additionally, we may disclose your PHI for the purpose of law enforcement or as otherwise required by state laws.
- **For public health purposes:** WSHIP may use or disclose your PHI to avert a serious threat to your health and safety or the health and safety of others such as reporting disease outbreaks to the department of health.
- **For emergency situations and disaster relief purposes:** If you are unavailable to agree to disclosure due to an emergency situation or one of disaster relief, WSHIP may use or disclose your PHI as reasonably indicated for your best interest.
- **For public safety:** WSHIP may disclose your medical information to appropriate authorities if we reasonably believe you to be a victim of abuse, neglect, domestic violence or other crimes.

- **For judicial and administrative proceedings:** WSHIP may disclose your PHI in the course of any administrative or judicial proceeding. Examples of this include: in response to a court order, subpoena or summons.
- **For health oversight activities:** WSHIP may disclose your PHI to a health oversight agency for activities authorized by law, including investigation of activities involving fraud and abuse, audits, inspections or licensure.
- **For research:** WSHIP may use or disclosure your PHI for limited research purposes as approved by the WSHIP Privacy Board.
- **For military and national security:** WSHIP may disclose PHI of enrollees who are armed forces personnel for activities deemed necessary by military command authorities. Furthermore, we may disclose to authorized federal officials, that PHI required for national security activities authorized by the national Security Act (50 U.S. C. 401, *et seq.*).
- **For change of ownership:** WSHIP may use or disclose your PHI to facilitate the change over or acquisition of your health plan to another insurer or administrator.

IV. WHAT ARE MY INDIVIDUAL RIGHTS?

By law, WSHIP must have your written permission (an "authorization") to use or give out your PHI for any reason that is not described in this Privacy Notice. If you give us an authorization, you have the right to revoke (or cancel) it at any time. Revoking or changing an authorization must be done in writing and shall not affect any uses or disclosures of PHI already performed while the authorization was in effect.

In addition to the right to authorize any specific use or disclosure, you also have the following individual rights (listed below).

- **You have the right to request a copy of our current notice of privacy practices.** Under the law, we are required to provide you with a written copy of this Privacy Notice. You may request a copy of our current Privacy Notice at anytime. You may obtain this Privacy Notice via our web site at www.wship.org or you may request this notice in written form by contacting our customer service department.
- **You have the right to request a restriction.** If you object to the use or disclosure of your PHI as described in this Privacy Notice, you may submit a written request that WSHIP place restrictions and limit the use or disclosure of your PHI. WSHIP may not be able to agree to all requested restrictions, but we will review your request and notify you in writing.
- **You have the right to request a copy of or access to your records.** WSHIP must provide you, or your personal representative, with access to your PHI maintained by WSHIP. You also have the right to request we provide copies to you or your personal representative. You must make this request in writing. WSHIP will respond to your request within 30 days unless you have agreed upon an alternative time period. If you have requested copies, a fee for materials, staff time and postage will be charged. Should you prefer, WSHIP can prepare a summary report of your PHI for a fee. To request copies of records, or information regarding any applicable fees, please contact us by using the information at the end of this notice.
- **You have the right to request and obtain an accounting of disclosures.** You have the right to request a list of those third parties who received a disclosure of your PHI from WSHIP. WSHIP will provide you this information within 30 days of receiving your written request. This list will not include any disclosures that were made to you or your personal representative, disclosures made for treatment, payment or health care

operations activities as described in this notice, disclosures made for law enforcement purposes or disclosures made prior to the mandatory effective date of this requirement: April 14, 2003. This service may be subject to a fee. To request an accounting of disclosures, or information regarding any applicable fees, please contact us by using the information at the end of this notice.

- **You have the right to request an amendment.** You have the right to request that WSHIP amend your medical records that you feel are incorrect or incomplete. You must submit your request in writing to the address listed at the end of this notice. This request must include the reason for the requested amendment. WSHIP may accept or deny your request for amendment and will provide you with a written explanation. If WSHIP denies your request, you may respond with a written statement of disagreement and request the statement be appended to the medical record.
- **You have the right to request confidential communications.** If you would like to request that WSHIP communicate with you in confidence, in a different manner or at an alternative location, (for example: you may request that we send materials to a P.O. Box instead of your home address), please submit your request, including the reason for the request, in writing to the address listed at the end of this notice. WSHIP will accommodate all reasonable requests if we are able.
- **You have the right to submit a complaint.** WSHIP takes extraordinary measures to protect your PHI. In the event that an accidental or inappropriate disclosure occurs, you have the right to expect WSHIP to mitigate or correct any loss or damage. If you feel that WSHIP has violated your privacy rights set out in this notice, you or your personal representative, may complain directly to WSHIP by using the information at the end of this notice, or to the Secretary of the U.S. Department of Health & Human Services (HHS). A customer service representative will provide you with the address to HHS upon request and assist you in filing your complaint.

  Filing a complaint with WSHIP or HHS will not affect your benefits or services provided by WSHIP. We shall not retaliate in any way if you choose to file a complaint.

For more information regarding filing a complaint, exercising any of the above-described rights or any questions relating to our Privacy Notice, please contact our privacy director or a customer service representative using the information at the end of this notice.

V. CHANGES TO THIS NOTICE OR THE PRIVACY PRACTICES OF WSHIP

All rights and privacy practices described in this Privacy Notice will take effect on January 1, 2003 and remain in effect until replaced by an updated Privacy Notice. WSHIP is required by law to follow the privacy practices described in this notice for as long as it is in effect.

WSHIP reserves the right to change the way we use or disclose your personal health and financial information (PHI). If WSHIP makes any changes to the privacy practices described in this notice, WSHIP will provide an updated notice via www.wship.org. Upon its effective date, the new notice provisions will be effective for any uses or disclosures by WSHIP.

VI. CONTACT INFORMATION

Address: WSHIP Administrator, Attn: Privacy Director, P.O. Box 1090, Great Bend, KS 67530

Customer Service: If you have any questions regarding this Privacy Notice, please call the toll-free customer service number at 1.800.877.5187.