WASHINGTON STATE HEALTH INSURANCE POOL (WSHIP)

SPECIMEN

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 3
- A. Defined Terms 3
- B. Relation to Medicare Coverage 3
- C. Eligibility 3
- D. Please Read—10-Day Right To Examine Policy 3
- E. Administrator of the Policy 3

II. EFFECTIVE DATE, ENROLLMENT AND TERMINATION 3
- A. Policy Effective Date 3
- B. Dependent Children 3
- C. Termination of Coverage 4
- D. Reinstatement 5

III. BENEFITS 5
- A. Conditions For Payment of Benefits 6
- B. Covered Services and Limitations 6

IV. EXCLUSIONS AND LIMITATIONS 11
- A. Pre-Existing Condition 11
- B. Lifetime Maximum Benefits 11
- C. Exclusions 12
- D. Last Payer of Benefits 13

V. PREMIUMS, COST SHARING AND PAYMENTS 14
- A. Premiums 14
- B. Deductible 14
- C. Coinsurance 14
- D. Network Pharmacies 14
- E. Rate of Payment 14
- F. Out-of-Pocket Expense Limit 14

VI. HEALTH MANAGEMENT 14
- A. Care Management 15
- B. Case Management 15

VII. OTHER INFORMATION 15
- A. Claims 15
- B. Entire Contract and Changes 16
- C. Grace Period 16
- D. Release of Information 16

SPECIMEN

E. Legal Action 16
F. Subrogation 16
G. Medicare Eligibility 16

VIII. GRIEVANCES AND APPEALS 17
A. General Grievance and Appeal Rights 17
B. Internal Appeal Process 17
C. External Process 19
D. Enrollment and Services During Appeal Process 19

IX. DEFINITIONS 19

SPECIMEN

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.

SPECIMEN

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.

SPECIMEN

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;

SPECIMEN

(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.

Any premium due will be deducted before payment of claims.

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 items and services covered under Part A or Part B of Medicare and for the services described below. Benefits 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.

SPECIMEN

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 and anesthesia 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.

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

7. Diagnostic Tests. Diagnostic x-rays and laboratory tests.

8. Prostheses. Prostheses other than dental.

9. 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.

10. 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.

SPECIMEN

11. Prescription Drugs. This Policy only covers Prescription Drugs that are covered under Part A or Part B of Medicare.

If an outpatient prescription is an eligible expense under Medicare Part B, You must obtain it from Our Network Pharmacy or through Our mail order pharmacy. 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.

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

13. 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.

14. 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.

SPECIMEN

15. 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).

16. 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.

17. 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.

SPECIMEN

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

19. 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.

20. 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.

21. 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.

22. 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

SPECIMEN

(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.

23. Preventive Health Care. Preventive care services, including routine annual physical exam, well child exam, immunizations and routine cancer screenings, up to the maximum benefit of $200 per Calendar Year.

24. 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.

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

26. 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.

27. Items Prescribed by Physician. Other medical equipment, services or supplies that are ordered by Your Physician, Medically Necessary and consistent with Your diagnosis, treatment and condition.

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.

SPECIMEN

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. This Policy reimburses the coinsurance and copayments for Medicare eligible expenses. If Medicare Parts A or B provides benefits for the service You received, this Policy will reimburse the applicable copayment and deductible. In no event will medical payments under this Policy duplicate any amounts payable under Medicare.

For all other services or supplies, no benefits will be paid or credit given if they are not Covered Services or they exceed the Allowed Amount. No payment will be made or credit given for any services, supplies or drugs relating to:

SPECIMEN

1. Communication or Travel. Communication, transportation or travel except for emergency ambulance services described in Section III.B.14;

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

(a) as provided in Section III.B.9, 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.20;

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 furnished by or on behalf of any government unless payment of the charge is legally required;

10. Investigational or Experimental. Treatment that is Investigational and/or Experimental and the direct or indirect complications of such Treatment;

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;

SPECIMEN

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 and 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.

SPECIMEN

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.

SPECIMEN

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.

SPECIMEN

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.

SPECIMEN

B. Internal Appeal Process.

1. <u>Appeal to the Administrator</u>.

(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.

SPECIMEN

(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.

SPECIMEN

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.

SPECIMEN

"**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.

SPECIMEN

"**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.

SPECIMEN

"**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.

"**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.

SPECIMEN

“**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.

SPECIMEN

"**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.

SPECIMEN