WASHINGTON STATE HEALTH INSURANCE POOL POLICY

ADMINISTRATOR
Benefit Management, Inc. (BMI)
P.O. Box 1090
Great Bend, KS 67530
www.wship.org
For Claims Information Call Toll Free 1.800.877.5187

WSHIP Plan 1 Policy

This Policy is issued to You by the Washington State Health Insurance Pool in consideration of the payment in premium and the statements in the application attached to this Policy. This Policy takes effect on the Policy Date shown on the Schedule.

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Notice: Encouragement to use Network Providers
WSHIP has contracted with medical care providers and facilities in order to bring You the highest quality medical care. Your Plan Administrator will provide You with a list of these Participating Network Providers and facilities. You are strongly encouraged to obtain all Covered Services from a Participating Network Provider. If You obtain Covered Services from a Participating Network Provider, You are not required to make payment at the time the service is received (except for Pharmacy), and the provider may not charge You more than the amount allowed by WSHIP.

On the other hand, if You obtain Covered Services from a non-Network Provider, You may be required to pay at the time the service is received, and the provider may bill You for charges that exceed the amount allowed by WSHIP.

Covered Services received from Participating Network Providers or non-Network Providers are payable at an 80% benefit rate.

Notice: Requirement to use Pharmacy Network Providers.
Pharmacy (Drugs)
All drugs, supplies, medicines and pharmacy services must be obtained at a Network Pharmacy except for the following: *Also see Parts J and N-J.*

- Drugs dispensed by an Emergency care provider when related Emergency care services are covered under this contract.
- A Network Pharmacy is not available within a 30-mile radius of the enrollee's home or prescribing Provider.
- Antigen and allergy vaccine when dispensed as set forth in Part N.

PART A PLEASE READ - 10-DAY RIGHT TO EXAMINATION

If You are not satisfied after reading Your Policy, return it within 10 days after You have received it. Your premium will be returned and this Policy will be considered as never in force.

PART B ADMINISTRATOR OF THE POLICY

You may notify the Administrator of the Washington State Health Insurance Pool for any reason, such as return of this Policy for refund, verification of coverage or submission of medical claims.

PART C RENEWAL OF COVERAGE

Subject to the termination provision, Your Policy will be renewed upon receipt of premium within the 31-day grace period until You are eligible for Medicare.

PART D TERMINATION OF COVERAGE

Your Policy will terminate on the earliest of:
(a) The date premium is due and has not been paid.
(b) The date You are no longer a Washington State Resident.
(c) The date the maximum benefit has been paid by the Pool.
(d) The date Washington state statutes require cancellation of this Policy.
(e) The date You become eligible for Medicare.
(f) 30 days after the date We make inquiry concerning Your place of residence or eligibility if You do not reply.
(g) The date that You become eligible for benefits under CHAMPUS.

This Policy is Renewable as Stated in Part C. We will return any unused premium to You.

NOTE: When this Policy ceases, no payments for expenses incurred after the termination date will be made regardless of the course of Treatment You may be pursuing. However, if You are confined in the Hospital at the time this Policy ceases, coverage will continue for that condition until the date of discharge from

the Hospital or exhaustion of benefits, whichever occurs first. Any premium due will be deducted upon payment of the claims.

PART E PREMIUM CHANGES

Premium changes are based on Your attained age and type of plan selected or a combination of these factors. Rates will be revised under this Policy in the same manner the other Policies are with the same provisions and benefits, issued to persons of the same classification. We will notify You 30 days in advance.

PART F DEFINITIONS

"**Administrator**" means that entity shown on the Policy Schedule as the Administrator.

"**Calendar Year**" begins on January 1 and ends on December 31. The first Calendar Year begins on the Policy Date and ends on December 31 of the same year.

"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.

"Co-insurance" means that percentage of a covered charge that is payable by You.

"**Confinement**" means You are a resident of a Hospital or Skilled Nursing Facility (SNF) as a regularly admitted bed patient. It must be for a period of at least 12 consecutive hours and a Physician must recommend and supervise the Confinement.

"**Custodial Care**" means services or supplies used when there is not a reasonable expectation of a measurable progressive improvement in the patient's condition during the course of or immediately following use of such services. Custodial care includes services or supplies which:

(a) Are furnished mainly to train or assist in personal hygiene or the activities of daily living, rather than to provide therapeutic Treatment.
(b) Can safely and adequately be provided by persons without professional licensure.
(c) Are requested by or for the convenience of the patient or the patient's family.
(d) Enable family members to work outside the home.

Activities of daily living include such things as:
(1) bathing or dressing;
(2) assistance with mobility; or
(3) feeding or taking oral medicines.

Such care is custodial regardless of:
(1) who recommends, provides or directs care;
(2) where the care is provided; or
(3) whether or not the patient can be or is being trained for self-care.

"**Dependent Child**" means all minor, unmarried natural, foster or adopted children of the person in whose name this Policy is issued who have not reached the age of 19. Dependent children also includes such children over the age of 19 who are chiefly dependent on the person in whose name this Policy is issued for support and maintenance by reason of developmental disability or physical handicap, provided that proof of such incapacity is submitted to the Pool within 31 days of the child's attainment of age 19. See Part H for further clarification of this definition.

"**Durable Medical Equipment**" is medical equipment designed mainly for use in a Hospital for therapeutic purposes such as:

(a) Mechanical respirators.
(b) Hospital beds.
(c) Wheelchairs.
(d) Similar medical equipment designed mainly for use in a Hospital for therapeutic purposes.

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

"**Eligible Expense**" means expense incurred for the Medically Necessary Covered Services and supplies described in Section N. The services and supplies must be ordered or prescribed by a Physician as needed for diagnosis or Treatment. An Eligible Expense is considered incurred on the date it is received.

"**Emergency**" means there is a sudden, acute and unexpected medical condition which, if not immediately diagnosed and treated, could lead to additional disability or death.

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

"**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 continued care and Treatment of an Insured Person:

(a) Who is under the care of a Physician.
(b) Who, because of their medical condition, would need Hospital or Skilled Nursing Care facility Confinement without the Home Health Care.

The Home Health Care Plan must be approved in advance in writing by the patient's attending Physician.

"**Hospice Care**" means a coordinated, interdisciplinary program provided by a licensed hospice agency to meet the physical, psychological and social needs:

(a) Of persons certified by their Physician to be terminally ill.
(b) By providing palliative (pain controlling) and supportive medical, nursing and other health services.
(c) Through home or inpatient care during the sickness.

"**Hospital**" is a facility licensed as an acute care Hospital that provides diagnosis, Treatment and care of persons who need acute inpatient Hospital care under the supervision of medical or osteopathic doctors. It must also be either:

(a) Registered as a general Hospital by the American Hospital Association with accreditation from the Joint Commission on Accreditation of Health Care Organizations.
(b) Licensed by the state as a Hospital.

When Treatment is needed for mental disease or disorder, "Hospital" can also mean 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.
(e) As a regular practice, charges the patient for the expense of Confinement.

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

"**Illness**" means a disease, disorder or condition which requires Treatment by a Physician. It must result in loss independently of Illness and other causes.

"**Investigational or Experimental Services**"

A. A service is Experimental for an enrollee's condition if any of the following statements apply to it as of the time the service is or will be provided to the enrollee. The service:
    (1) 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.
    (2) Is subject to a new drug or new device application on file with the FDA.
    (3) 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.
    (4) Is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy among its objectives.
    (5) Is subject to the review or approval of an Institutional Review Board ("IRB") or other body that reviews or approves research concerning the safety, toxicity or efficacy of services.
    (6) Is provided pursuant to informed consent documents that describe the service as Experimental or Investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.

    As to the service:
    (7) The prevailing opinion among experts as expressed in the published authoritative medical and scientific literature is that:
        (a) Use of the service should be substantially confined to research settings, or
        (b) Further research is necessary to determine the safety, toxicity, or efficacy of the service.

B. In making determinations whether a service is Investigational or Experimental, the following sources of information will be relied upon exclusively:
    (1) The enrollee's medical records.
    (2) The written protocol(s) or other document(s) pursuant to which the service has been or will be provided.
    (3) Any consent document(s) the enrollee or enrollee's representative has executed or will be asked to execute to receive the service.

(4) The files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body.
(5) The published authoritative medical or scientific literature regarding the service, as applied to the enrollee's Illness or injury.
(6) Regulations, records, applications and any other documents or actions issued by, filed with, or taken by the FDA, the Office of Technology Assessment or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

D. The WSHIP Administrator will consult with its Medical Director who will then use the criteria described above to decide if a particular service is Experimental or Investigational. The Medical Director may consult with independent experts as he or she deems necessary.

"**Insured Person**" means a person named as insured under this Policy, the covered person receiving medical services. Also referred to as "You" or "Your."

"**Medicaid**" means the federal-state assistance program established under Title XIX of the federal Social Security Act. Also, referred to as "Medical Assistance" under Title XIX.

"**Medical Staff or our Medical Staff**", means the Medical Director for the Plan Administrator and designated staff of the Administrator acting under his / her direction; independent medical experts engaged by the Administrator or the WSHIP Board of Directors or the Board Grievance Committee.

"**Medically Necessary Care**" means services or supplies provided by a Hospital, Physician or other covered provider of health care services to diagnose or treat an Illness or injury, which our Medical Staff determines is:
(a) Appropriate and consistent with the patient's condition, diagnosis, Illness or injury.
(b) Consistent with standards of good medical practice in the United States.
(c) Not primarily for the personal comfort or convenience of the patient, the family, doctor or other provider.
(d) Not "Investigative or Experimental Services".
(e) Not allowed for the scholastic education or vocational training of the patient.
(f) In the case of inpatient care, such services or supplies could not be provided safely on an outpatient basis.

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

"**Myofacial Pain Dysfunction (MPD)**" is a disorder involving muscles surrounding and adjacent to the Temporomandibular Joint (TMJ) area which is characterized by:

(a) Preauricular-temporal, occipital and / or jaw pain.
(b) Spasm and / or tenderness of the masticatory muscles.
(c) Limited jaw movement.

"**Network Pharmacy**" is a pharmacy vendor which has contracted with the Washington State Health Insurance Pool to fill prescriptions for persons enrolled in this Washington State Health Insurance Pool Medical Coverage Contract.

"Network Provider" or **"Participating Network Provider"** is a licensed provider of medical services for whose services Washington State Health Insurance Pool has contracted to deliver covered medical services to persons enrolled in this Washington State Health Insurance Pool medical contract.

"**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) Another 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 normally a member of Your household.

"**Skilled Nursing Care**" means any Treatment that is rehabilitative in nature, is required to restore an individual to his or her prior level of health after an accident or Illness and hospitalization and is related to the condition which was the cause of the Confinement. Skilled Nursing Care is any level of care greater than that considered Custodial Care.

“**Skilled Nursing Facility**,” “**SNF**” or “**Nursing Home**” means a lawfully operated institution that primarily provides inpatient Skilled Nursing Care or rehabilitation services. Skilled Nursing Facilities must:

(a) Provide daily room and board.
(b) Provide daily, 24-hour Skilled Nursing Care.
    (1) through one or more professional nurses;
    (2) for persons convalescing from Illness or injury;
(c) Be supervised by a Physician or has available the services of a Physician by an established agreement.
(d) Maintain adequate medical records.

SNF does not include a:

(a) Rest home.
(b) Place for Custodial or Maintenance Care.

“**Temporomandibular Joint (TMJ)**” dysfunction is a disorder of the Temporomandibular Joint (the joint which connects the mandible or jawbone to the temporal bone) which 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.
(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 practitioners.
(b) Generally accepted as the effective elements of care.

“**Usual, Customary and Reasonable Charge (UCR)**” means the lowest of the following:

(a) The provider’s actual charge to the patient after any discounts or other reductions.
(b) The charge that is most frequently made by the provider to all other patients for comparable services or supplies.
(c) The charge that is most frequently made by providers with similar professional qualifications for comparable services or supplies within the same geographic area.
(d) The charge for services or supplies generally considered by medical professionals to provide substantially the same benefits at significantly lower cost.

“**Utilization Review Panel**” or “**Panel**” means the Plan Administration Care Review Unit.

"**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. The domicile of any person shall be determined considering the following factors:

(a) Registration and payment of Washington taxes and fees on motor vehicles.
(b) Employment in Washington State.
(c) Registration to vote for state officials in Washington.
(d) Permanent home address in Washington.
(e) Expressed intent to reside in Washington State for reasons other than obtaining insurance.

"**You**" or "**Your**" means the person named as Insured on the Plan Policy.

PART G PRE-EXISTING CONDITION LIMITATION.

The benefits of this Policy will not be payable for any pre-existing injury or Illness for the first six months following Your Policy effective date. A pre-existing condition is an Illness, injury or condition for which medical advice was given, or 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 of the effective date of WSHIP coverage.

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.

Waiver or Credit of the Pre-existing Condition Wait:

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 not be a catastrophic coverage only plan. The previous coverage must have been terminated no more than 63 days from the date You applied for WSHIP coverage. 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 and health questionnaire form if required.

The Pre-existing condition wait time will be entirely waived for individuals defined as an "Eligible Individual" according to the Health Insurance Portability and Accountability Act. To be classified as an "Eligible Individual", You:

(1) Must have had 18 months or more of creditable coverage without a break of 63 full days prior to applying for this Plan;
(2) Must have 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);
(3) May not be eligible for a group health plan;
(4) May not be eligible for Medicare or Medicaid;
(5) May not have lost the most recent coverage because of fraud or non-payment of premiums;

(6) If offered COBRA or a similar state program, must elect and exhaust such coverage.

For purposes of this provision, “Creditable Coverage” means coverage under any of the following:

(1) a group health plan;
(2) Part A or B of Medicare;
(3) Medicaid;
(4) CHAMPUS;
(5) a medical care program of the Indian Health Service or tribal organizations;
(6) a state health benefits risk Pool, such as CHIP;
(7) the federal employees health benefits program;
(8) a public health plan; (a plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals)
(9) a health benefit plan under the Peace Corps Act; or
(10) a church plan.

PART H DEPENDENT CHILDREN

Newborn, foster or adopted children of the person in whose name this Policy is issued will be covered automatically for 60 days from the moment of birth, placement in Your home or adoption. Coverage will include the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities.

Coverage is subject to the payment of premium from birth or adoption. Benefits for each dependent will be subject to all of the provisions of this contract, including the plan annual deductible, coinsurance and out-of-pocket stop loss limits.

To continue coverage beyond 60 days, application must be made to us for each child as an enrollee under his or her own Pool Policy. At the time of application, such children must meet the eligibility requirements for Pool coverage, be unmarried and primarily dependent upon the person in whose name this Policy is issued for support and maintenance.

The Dependent Child’s coverage will terminate upon attainment of age 19. Except that coverage may be continued beyond age 19 while the dependent is and continues to be both:

(a) Incapable of self-sustaining employment by reason of developmental disability, or physical handicap.
(b) Is chiefly dependent upon the person in whose name this Policy is issued for support and maintenance, provided that proof of such incapacity and dependence is furnished to the Pool within thirty one (31) days of the dependent’s 19th birthday.

The Pool may require proof of continuing incapacity and dependence from time to time, but not more often then annually after the two-year period following the dependent's attainment of age 19.

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.

For the 60-day period Your newborn, foster or adopted child is automatically covered under Your Policy, the terms "You" or "Your" shall include the newborn, foster or adopted child.

"**Foster Child**" means a child:

(a) You are raising as Your own.
(b) Who lives in Your home.
(c) Who is chiefly dependent on You for support.
(d) For whom You have taken full parental responsibility and control.

A foster child is NOT:

(a) A child temporarily living in Your home.
(b) A child placed with You in Your home by a social service agency that retains control of the child.
(c) A child whose natural parent is in a position to exercise or share parental responsibility or control.

Evidence supporting the status of the child as Your foster child will be required as a condition of enrollment.

PART I COVERAGE PROVIDED

Covered expenses are those Expenses listed in Section N that:

(a) Are incurred while You are insured under this Policy.
(b) Are due to Illness or injury.
(c) Are ordered by and under the direct care of a Physician.
(d) Are Medically Necessary as determined by the Plan Administrator.
(e) Are not excluded from coverage or beyond the Limitations or Benefit Maximums of this Policy.
(f) Exceed the Deductibles shown in the Schedule.
(g) Do not exceed the Usual, Customary and Reasonable Charge (UCR).

PART J RATE OF PAYMENT

Subject to the cost containment requirement of Part O, the rate of payment for covered expenses incurred each Calendar Year will be as follows for Usual, Customary and Reasonable Charges for covered expenses in excess of the Deductible:

- 80% of services other than pharmacy.

- 80% of services which meet the definition of “Emergency” as set forth in this contract;
- Pharmacy copayments per prescription of a 30-day supply or less. (90-day supply or less for prescriptions obtained through the WSHIP mail order pharmacy). Annual deductible does not apply to covered pharmacy (see Part N-J for Benefit Description).

Prescription Drug Charges for $500, $1,000, and $1,500 Deductible Plan

Copay per Prescription up to 30 Day Supply (Up to a 90 day supply for mail order)

	Brand	**Generic**
a. ($500 Deductible Plan)	$15	$ 7
b. ($1,000 Deductible Plan)	$20	$10
c. ($1,500 Deductible Plan)	$25	$12

Generic pharmacy is defined in Part N, Section I. When an equivalent Generic substitute is available but the enrollee requests a Brand name drug, the Brand copayment will apply. The enrollee will also be responsible for the difference in cost between the Brand drug and the Generic equivalent unless the prescribing Physician verifies a medical need for use of the Brand drug instead of a Generic equivalent.

PART K DEDUCTIBLE

The “**Deductible**” means the initial amount of covered expense You must incur each Calendar Year before benefits can be provided. Benefits are not payable for expense that is used to satisfy the Deductible.

The Deductible required depends upon the WSHIP Plan selected.

a. $ 500
b. $1,000
c. $1,500

Covered pharmacy expense is not subject to the Plan’s annual Deductible. Covered pharmacy expense does not accrue toward the satisfaction of the annual Deductible.

Covered expenses are applied toward the individual Deductible in the year in which they are incurred. Covered expenses incurred in the last three months of the year which were applied to meet the Deductible are also applied in an equal amount toward the individual Deductible required for the next year.

Your Deductible may not be decreased, however, You may elect to increase Your Deductible. The adjusted amount You choose must be a Deductible option We offer on the date the change becomes effective. The change will become

effective on January 1 following the date Your request is received. You will be advised of any changes in premium.

PART L OUT-OF-POCKET EXPENSE LIMIT

If, during a Calendar Year, Your share of Covered Expenses, including the Deductible, reaches the amount shown in the Schedule for an individual, We will pay at the rate of 100% of Usual, Customary and Reasonable Eligible Expenses for the remainder of the Calendar Year. This 100% rate does not apply to covered expenses with separate limitations or exclusions or services requiring preauthorization under Part O for which no preauthorization was made. The Pharmacy Benefit has a separate Out-of-Pocket expense limit. Pharmacy Out-of-Pocket expense does not apply to the Non Pharmacy Out of Pocket expense limit. Non Pharmacy Out-of-Pocket expense does not apply to the Pharmacy Out-of-Pocket expense.

	Individual Out of Pocket Limit	
	Medical	**Pharmacy Services**
a. $ 500 Deductible Plan	$1,000	$ 500
b. $1,000 Deductible Plan	$1,650	$ 850
c. $1,500 Deductible Plan	$2,000	$1,000

This Plan pays 100% of covered expenses for the remainder of the Calendar Year once Your family's Out-of-Pocket expenses reach the following limits:

	Family Out of Pocket Limit	
	Medical	**Pharmacy Services**
a. $ 500 Deductible Plan	$2,000	$1,000
b. $1,000 Deductible Plan	$3,300	$1,700
c. $1,500 Deductible Plan	$4,000	$2,000

PART M INDIVIDUAL LIFETIME MAXIMUM

Payments made by Us under this Policy and any other Policy issued to You by Us will not exceed the total individual lifetime Maximum Benefit of $1,000,000, except benefits in Your lifetime will be limited to $250,000 for all covered expenses related to organ transplant services including pre-surgery testing. The $250,000 lifetime organ transplant limitation will not apply to necessary post surgery drugs or medical services, but payments made by Us for such post surgery covered expenses will be applied against the $1,000,000 Lifetime Maximum Benefit. Benefits for diabetes education are limited to a lifetime maximum of $250. Payments made by Us which are subject to the organ transplant benefit limitation or the diabetes education benefit limitation shall be applied against the $1,000,000 Lifetime Maximum Benefit, and shall not be in addition to the Lifetime Maximum Benefit.

If You have received benefits from any other Washington State Health Insurance Pool Policy for which You were covered as an Insured, those benefits will be applied toward the benefit limits of this Policy.

PART N ELIGIBLE EXPENSES

Subject to all provisions in this contract, the following expenses are eligible:

A. Hospital Inpatient (Please refer to Hospital Confinement Review Requirements to determine limitations that apply to this benefit.)

(a) (1) room and board at the semiprivate room rate, or the facility's most common private room rate if a private room is Medically Necessary.
(2) room and board for intensive care; and
(3) other Hospital services and supplies which are furnished to You as an inpatient.

(b) Only the expenses incurred during the first 180 days of inpatient Confinement will be considered as Eligible Expenses in a Calendar Year.

(c) Expenses incurred for a Hospital admission on a Friday, Saturday or Sunday are not covered, unless they are incurred one day prior to surgery or for an Emergency.

B. Hospital Outpatient

Hospital medical services and supplies furnished on an outpatient basis.

C. C. Outpatient Surgery

Medical services and supplies furnished on an outpatient basis.

D. Oral Surgery

Oral surgery is limited to the following:

(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 (excluding Treatment for Temporomandibular Joints).
(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 this coverage.
(h) Excision of impacted wisdom teeth.

E. Professional Medical Services

(a) Professional services, including surgical services, anesthesia, diagnostic x-ray and laboratory services, for the diagnosis or Treatment of injuries.

(b) Illnesses rendered by a Health Care Provider or at the direction of a Health Care Provider.

Professional Services do not include the following:
(1) Dental, except as specifically provided under the Oral Surgery provision;
(2) Pharmacy case management services other then those provided directly to the patient by the attending Physician and included in the professional fee made by the attending Physician.

(c) When Medically Necessary, the maximum covered expense for an assistant surgeon is covered, limited to 20% of the Usual, Customary and Reasonable Charge for the surgery.

F. Medical Therapy

Chemotherapy, radioisotope, radiation and nuclear medicine therapy.

G. Breast Reconstruction Following Mastectomy

(a) Reconstructive surgery on the breast on which the mastectomy has been performed.
(b) All stages of reconstructive breast reduction on the nondiseased breast to equal size of the diseased breast following surgery due to a mastectomy.
(c) Physical complications of all stages of mastectomy, including lymphademas.

H. Medical Supplies and Equipment

(a) Rental or purchase, 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, provided:
(1) it is approved by the Administrator in advance;
(2) it is prescribed by the attending Physician;
(3) It reduces or eliminates the time required for Hospital or Skilled Nursing Care or facility Confinement; and
(4) It 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:
(1) injury that occurs while insured; or
(2) Illness that begins while insured.
(d) Colostomy bags and related supplies.
(e) Catheters.
(f) Syringes and needles for insulin and allergy injections.
(g) Oxygen.

I. Pharmacy (Drugs)

(a) Legend (Prescription) Drugs and medicines for outpatient use.

(b) Drugs and medicines requiring a prescription filled by a licensed pharmacist to treat a covered condition or contraceptives when prescribed and approved by a prescribing Provider. Antigen and allergy vaccines dispensed by a Physician or a certified laboratory are Eligible Expenses.
(c) Over the counter drugs, food supplements, vitamins and herbs are not covered.

All drugs, supplies, medicines and pharmacy services must be obtained at a Network Pharmacy or through the WSHIP mail order pharmacy except for the following:
(a) Drugs dispensed by an Emergency care provider when related Emergency care services are covered under this contract.
(b) A Network Pharmacy is not available within a 30-mile radius of the enrollee's home or Network Provider.
(c) Antigen and allergy vaccine when dispensed as set forth in this section.

The Plan Administrator will provide You with information about the WSHIP mail order pharmacy and a list of network pharmacies.

Copayment amounts for each prescription of 30 days supply or less (90 day supply or less for mail order pharmacy) are set forth in Part J.

When an equivalent Generic substitute is available but the enrollee requests a Brand name drug, the Brand copayment will apply. The enrollee will also be responsible for the difference in cost between the Brand drug and the Generic equivalent unless the prescribing Physician verifies a medical need for use of the Brand drug instead of a Generic equivalent.

A generic drug is one:
(a) That meets all Federal Drug Administration standards.
(b) That does not have a registered trademark.
(c) Whose name can be used by more than one drug company.

Covered pharmacy does not include charges for pharmacy management services.

Pharmacy / disease management by the attending Physician is covered as part of his / her professional fee.

Pharmacy Out-of-Pocket limit is set forth in Part L.

J. Sterilization

Sterilization is covered. Charges for reversal of sterilization are not Eligible Expenses.

K. Maternity

Maternity services are covered subject to the provisions of this contract.

For covered maternity and newborn care, the attending provider in consultation with the member makes the following decisions:
(a) Length of inpatient stay;
(b) Inpatient post-delivery care;
(c) Follow-up care to include type and location which may include Home Health Care agencies and registered nurses.

L. Emergency Ambulance.
When necessary because of the patient's medical condition, licensed ambulance service for transportation to the nearest Health Care facility qualified to treat the injury or Illness.

M. Skilled Nursing Facility (Please refer to Health Management, Section O, for restrictions which may apply to this benefit)
(a) Subject to all provisions of this section, the following are Eligible Expenses while confined to a Skilled Nursing Facility:
(1) room and board at the facility's lowest semiprivate room rate;
(2) services and supplies which are furnished for medical care therein.
(b) Skilled Nursing Facility benefits under this section are limited to 100 days of Confinement each Calendar Year.
(c) Any Skilled Nursing Facility Confinement is covered only if it is in lieu of Medically Necessary Hospital Confinement when under the supervision of a medical doctor or doctor of osteopathy (MD or DO).

N. Home Health Care (Please refer to Health Management, Section O, for restrictions which may apply to this benefit)
Home health care services are the services and supplies listed below which are ordered and directed by a Physician and are furnished: (a) in a private home, (b) by a Home Health Agency; and (c) in accord with a Home Health Care Plan. Home Health Care services are covered only if the patient is unable to leave home due to health problems or Illness (unwillingness to travel or arrange for transportation does not constitute inability to leave home).
(a) Nursing care provided on a part-time (less than an eight-hour shift) or intermittent basis by:
(1) a registered nurse (RN); or
(2) a licensed practical nurse (LPN).
(b) Physical, occupational or speech therapy provided by a licensed therapist.
(c) Part-time or intermittent home health aide services provided:
(1) by a home health aide; and
(2) under the supervision of a registered nurse (RN).

Home health aide services include (but are not limited to) helping You with:
(a) Bathing and care of mouth, skin and hair.
(b) Bowel and bladder care.

(c) Getting in and out of bed and walking.
(d) Exercises prescribed and taught by appropriate professionals.
(e) Medication ordered by a Physician.
(f) Household services essential to the Home Health Care (if the services would be performed if the Insured Person were in a Hospital or Skilled Nursing Facility).
(g) Reporting changes in Your condition to the supervising nurse.

Under Subsections (1) through (3) above, Home Health Care Benefits are limited to 100 visits for each Calendar Year subject to the Rate of Payment and Deductible provisions in Part J and L. One Home Health Care visit will consist of:
(a) One visit for the services listed under Subsections (1) and (2). or
(b) Up to four consecutive hours for the home health aide services shown under Subsection (3).

Excluded from coverage are 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 which are not listed as covered in this contract.

O. Hospice Care

Subject to the following, Hospice Care Services are Eligible Expenses: Persons who elect to receive Hospice Care do so in lieu of curative Treatment for their terminal Illness for the period of time that they are participating in a Hospice Care program.
(a) Hospice Care provided under a coordinated, interdisciplinary program provided by a licensed Hospice agency.
(b) Eligible Respite Care limited to a maximum of five (5) continuous days for every three month period of Hospice Care.

Hospice Care Exclusions: All services not specifically listed in this section including:
(a) Bereavement therapy or counseling.
(b) Financial or legal counseling services.
(c) Housekeeping or meal services.
(d) Custodial or maintenance care.
(e) Any services provided by members of the immediate family.
(f) All exclusions listed in Part P of this contract.

P. Routine Mammography

Expenses incurred by a female Insured Person for a routine mammography will be paid in the same manner as any other covered x-ray or laboratory service upon the recommendation of:
(a) A Physician.

(b) An advanced registered nurse practitioner.
(c) A Physician's assistant.

Q. Therapy Benefits

The services of a:
(a) Registered physical therapist.
(b) Certified speech pathologist or speech therapist for the purpose of restoring lost speech function.
(c) Licensed occupational therapist.

Services must be provided within a Treatment plan for conditions for which significant improvement as a result of the therapy is expected within a short Treatment program.

Maintenance care is not covered except for children under age seven with neurodevelopmental disabilities when medically documented that without such care the condition would deteriorate. Therapy for learning and education disabilities or difficulty is not covered.

R. Diabetes Education Benefit

(a) Expense incurred when You enroll, participate and complete a Diabetes Patient Education Program will not be subject to the Deductible, and will be paid at 90% of UCR and subject to the following limitations:
  (1) a maximum amount of $250 for covered expenses in Your lifetime.
  (2) You must be the one enrolled in the Diabetes Patient Education Program.
  (3) charges in excess of lifetime maximum listed in Subsection (1) above cannot be used toward satisfying the Deductible or Out-of-Pocket Expense Amount.
(b) A Diabetes Patient Education Program consists of instruction which:
  (1) is provided by a Physician, registered nurse, licensed pharmacist, dietitian or other licensed health professional;
  (2) is designed to teach diabetic patients and their families to:
    a. understand the diabetic disease process;
    b. manage daily diabetic therapy; and
    c. avoid frequent complications and Hospital Confinements; and
  (3) meets any standards by which the state or local diabetes agency recognizes as an acceptable program. The instructor of such program must be certified by the American Association of Diabetes Educators.
(c) A program which is mainly for the purpose of weight reduction is not included.

S. Transplant Surgery and Related Expense Benefits

(a) (1) If You receive an organ transplant precertified by the Utilization Review Panel, benefits will be payable up to a maximum of $250,000 in Your lifetime as set forth in Part M.

(2) If the transplant surgery is not precertified by the Panel, or is determined to be Investigative or Experimental, no benefits will be payable for such procedure or other Covered Services or supplies related to the transplant or mode necessary because of the transplant.

(b) (1) If You have transplant surgery for which surgical or medical benefits are payable under this Policy and covered expense incurred by the donor for charges made by a Physician for surgery or Physician visits will be included as expense incurred.

(c) This benefit will be provided to the same extent they are available under (a) (1) above, except:

(1) benefits for the donor are payable only after Your covered expenses have been paid; and

(2) We will not pay benefits for the donor that are paid by other insurance.

T. Mental and Nervous Conditions and Chemical Dependency

Mental Health Services and Your Rights

WSHIP and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee Your right to informed consent to Treatment, to assure the privacy of Your medical information, to enable You to know which services are covered under this Plan and to know the limitations on Your coverage. If You would like a more detailed description than is provided here of covered benefits for mental health services under this Plan, or if You have a question or concern about any aspect of Your mental health benefits, please contact Us at 1-800-877-5187.

If You would like to know more about Your rights under the law, or if You think anything You received from this Plan may not conform to the terms of Your contract or Your rights under the law, You may contact the Office of Insurance Commissioner at 800-562-6900. If You have a concern about the qualifications or professional conduct of Your mental health service provider, please call the state health department at 1-800-525-0127.

Eligible Expenses for Treatment for Mental and Nervous Conditions or Chemical Dependency are set forth below:

(a) The maximum number of days for inpatient care is limited to 30 days each Calendar Year.

(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, psychologist, clinical social worker (MSW) or community mental health agency.

(c) Charges for visits in excess of (a) and (b) above are not Eligible Expenses.

Services of a state approved chemical dependency program under Chapter 70.96A RCW for alcohol, drug, or chemical dependency or abuse are covered as set forth in this section.

PART O HEALTH MANAGEMENT

Only expenses for Medically Necessary care are covered. A Utilization Review Panel will perform preadmission review of Hospital and Skilled Nursing Facility admissions and Home Health Care. The purpose of these services is to determine whether the facility admission, surgery or Home Health Care is Medically Necessary. In an effort to reduce the total cost of medical care, the following provisions will apply. It is Your responsibility to ensure that the Physician fulfills these requirements.

In addition, the Plan reserves the right to utilize Care Management procedures including, but not limited to, voluntary individual case management, voluntary disease management and concurrent review of inpatient facility admissions. These features are designed to ensure that You receive the highest quality of medical care while managing medical costs.

The rate of payment, lifetime maximum, Out-of-Pocket Expense Amount and Deductible will apply unless stated otherwise.

1. Hospital Confinement Review Requirements

Hospital Confinement review is required when You are or may be confined in a Hospital. Any days of non-Emergency Hospital Confinement that are not certified by the Utilization Review Panel will not be covered.

(a) Non Emergency Admission - Before admission, the attending Physician must notify the Utilization Review Panel by telephone at least seven days prior to scheduled Hospital admission with admission information which consists of: diagnosis or reason for Confinement, proposed Treatment or surgical procedure and expected days of Confinement. Within one day after the Panel receives the required information, written notice of any one period of Confinement that is precertified will be sent to You, the Physician and the Hospital.

(b) If no notice is received by the Panel before Hospital admission, for any days of Confinement that fail to be precertified, the following limitations apply:

(1) benefits are limited to no more than 70% of the expense incurred for Covered Services;

(2) expenses incurred will not be used to satisfy the maximum Out-of-Pocket Expense Amount;

(3) if the maximum Out-of-Pocket Expense Amount has already been satisfied, benefits for expenses incurred will only be paid at a rate of 70% of the expense incurred for Covered Services.

(c) Emergency Admission - In the case of an Emergency Hospital admission or admission for child birth, the attending Physician must notify the Panel by telephone with the admission information:
(1) by the first business day following admission;
(2) in the case of documented unusual circumstances, as soon as reasonably possible thereafter.

The Panel will, within 24 hours from when the information is received:
(1) phone the attending Physician and confirm any days of Hospital Confinement which are precertified; and
(2) send written confirmation of the days certified as Eligible Expenses to You, the attending Physician and the Hospital.

(d) Continued Confinement - Prior to the end of the approved period of Confinement, the Panel will contact the attending Physician to determine whether further Hospital Confinement is required. Written confirmation of any additional days of Confinement which are certified as Eligible Expenses will be sent on the same day to You, the attending Physician and the Hospital.

2. Second Surgical Opinion Benefit

Second surgical opinions are covered as any other service under this Plan, and may be obtained without prior approval.

PART P EXCLUSIONS

No benefits will be paid or credit given for expenses which are not Eligible Expenses. Nor will any payment be made for or credit given for an expense if the Confinement, service or supply is:

(a) For Illness or injury due to war or act of war, declared or undeclared, occurring while the person is insured by this Policy.
(b) Due to Illness or injury arising in the course of employment.
(c) Furnished by or on behalf of any government, unless payment of the charge is legally required.
(d) One for which charge would not have been made in the absence of insurance, for which the Insured Person is not legally liable.
(e) Furnished in connection with any special education or training, except as described in the Diabetes Education Benefit section in the Cost Containment Provisions.
(f) For cosmetic purposes, except for Treatment of:
(1) reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
(2) congenital defects or birth abnormalities for functional repair or restoration of any body part when necessary to achieve normal body functioning; and

(3) reconstructive breast surgery if the surgery resulted from a mastectomy which was caused by disease, Illness or injury;

(g) Furnished for fitting or cost of eyeglasses, contact lenses or hearing aids except:
(1) when due to an accidental injury to the natural eye or ear; or
(2) for the initial contact lens or pair of eyeglasses after cataract surgery without intra-ocular lens implant;

(h) For eye exams, vision analysis, non-surgical therapy or training relating to muscular imbalance of the eye, orthoptics (except when performed to prevent surgery), radial keratatomy or surgical correction of refractive error.

(i) For dental Treatment of any kind, except as specified under oral surgery under Eligible Expenses.

(j) For preventive care, such as:
(1) immunization;
(2) physical examination and related diagnostic x-ray or laboratory studies;
(3) well-baby care;

(k) In excess of the Usual, Customary and Reasonable Charge, as determined by the Administrator.

(l) For Treatment of Temporomandibular Joint (TMJ) dysfunction or Myofacial Pain Dysfunction (MPD).

(m) Treatment for weight control, such as:
(1) any Treatment intended to result in weight loss;
(2) Treatment for obesity including surgery and complications;

(n) For the following foot care procedures:
(1) trimming of nails, corns and calluses;
(2) routine hygienic care;
(3) services and supplies for fallen arches or flat feet;

(o) “Investigational or Experimental” services as defined in Part F.

(p) For reproductive and sexual disorders and defects, whether or not the consequence of Illness, disease or injury, including, but not limited to:
(1) impotency;
(2) frigidity;
(3) infertility;
(4) reversal of sterilization;
(5) artificial insemination;
(6) in vitro fertilization;
(7) embryo transfer;
(8) hormone therapy to enhance ovulation or fertility;
(9) sex change operations; and
(10) genetic testing or counseling.

(q) For marital, family or sexual counseling, vocational counseling, outreach, and job training.

(r) For Custodial Care.

(s) For communications, transportation or travel time, except for ambulance service.

PART Q BENEFITS AFTER MEDICARE ELIGIBILITY

When You are eligible for Medicare, You will be issued a new Policy that will supersede this Policy.

PART R LAST PAYOR OF BENEFITS

This Plan 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 benefits paid or payable under or provided pursuant to any state or federal law or program.

PART S 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 the Insured Person. Full compensation is measured on a case-by-case basis dependent on the circumstances involved and the ability of the responsible person to make the Insured Person 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 which 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.

PART T – GRIEVANCE AND APPEAL PROCEDURES

1. General Grievance and Appeal Rights

    (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.

2. Internal Appeal 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'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.

(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.

3. 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.

4. 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.

PART U GENERAL PROVISIONS

EFFECTIVE DATE

Your insurance will become effective on the first of the month following approval of Your application. Coverage starts at 12:01 a.m. Pacific Time provided that a completed application and required premium payment is received by the 20th of the month prior to the effective date of coverage.

Under limited circumstances, a WSHIP applicant may choose to have the effective date of coverage retroactive to an earlier date. In order for this opportunity to apply, the applicant must first apply for coverage and be rejected by a health insurance carrier licensed in Washington State. If the applicant then applies to WSHIP no later than the end of the full calendar month following the date of original application to the health carrier, the WSHIP applicant may choose the first of the month of WSHIP application as the effective date for coverage. All applicants listed in a single WSHIP application must have the same effective date.

Coverage ends at 12:01 a.m. Pacific Time on the first renewal date. Each time You renew Your Policy, coverage will begin when the old Policy ends.

CLAIMS

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

Claim Forms: When notice is received, forms for filing proof of loss will be sent. 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.

Proof of Loss: Written proof of loss must be given 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.

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

Overpayment: If a benefit is paid 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.

Incontestability: After two years from the date of issue of this Policy, no misstatement, except fraudulent misstatements made by the applicant 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.

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.

Legal Action: Your rights to take any legal action against the Administrator or the Washington State Health Insurance Pool are limited by the civil immunity provision of RCW 48.41.190.

Release of Information: You agree to authorize release of any information that is necessary for the payment of claims under this Policy.

Entire Contract and Changes: This Policy, and any attachments, is the entire contract of insurance. Only the Board of Directors of the Washington State

Health Insurance Pool can approve a change. Such changes must be shown in Your Policy.

Grace Period: Premium must be paid on or before the date it is due or during the 3l-day grace period that follows. The Policy stays in force during the grace period subject to the right of the Washington State Health Insurance Pool to terminate in accordance with the Termination of Coverage provision.

Reinstatement: We do not provide for the reinstatement of this Policy if it lapses due to nonpayment of premium. If You mail or deliver a premium to Us after the grace period, We will return it to You as soon as We determine the premium is late. No agent is authorized by Us to accept a late premium.

You may reapply for coverage under the Washington State Health Insurance Pool if You again become eligible, provided 12 months have elapsed since You terminated this Policy.

Assignment of Benefits:
All benefits will be paid as soon as We receive acceptable proof of loss.

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. Benefits unpaid at Your death will be paid to Your beneficiary.

If any benefits are payable to Your estate, to a minor or to any person not legally able to give a valid release, We may pay up to $1,000 to any relative of Yours who We find entitled to the payment. Payment made in good faith shall fully discharge Us to the extent of the payment.