

WASHINGTON STATE HEALTH INSURANCE POOL (WSHIP)

Medical Supplement Plan Policy

(Medicare Plan)

WSHIP Medical Supplement Plan Policy

A plan for Medicare enrollees that supplements your existing Medicare Parts A and B benefits, as well as providing additional benefits for some services not covered by Medicare.

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.

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I. INTRODUCTION

A. Medical Supplement Plan. This Policy's benefits supplement Your existing Medicare Parts A and B benefits, as well as provide additional benefits for some services not covered by Medicare. This Policy provides no Prescription Drug coverage except for secondary coverage of drugs covered by Medicare Part B. 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.

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

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. These requirements include that You are a resident of Washington State; You (or Your covered parent) provide evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a pre-existing conditions limitation on a Medicare supplemental insurance policy; and You do not have access to a reasonable choice of comprehensive Medicare Part C plans (Advantage Plans).

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 claims and administers most services on Our behalf (except for Prescription Drug services which are administered by Our Pharmacy Benefit Manager). If You have any questions about a medical claim or other items such as premiums, coverage or cost-sharing, You should contact the Administrator. If You have any questions about a Prescription Drug claim, You should contact the Pharmacy Benefit Manager.

II. EFFECTIVE DATE, DEPENDENTS, TERMINATION AND POLICY REPLACEMENT OR DISCONTINUATION

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 last day of the month preceding the effective date of Your Policy. Under limited circumstances and after obtaining the written approval of the Administrator, You may have an earlier or later 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 or during Our yearly open enrollment period. 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 26, except that coverage may be continued beyond age 26 while the Dependent Child is:

1. Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and

2. Chiefly dependent upon You for support and maintenance, provided that proof of such incapacity and dependence is furnished to Us within 31 days of the Dependent Child's 26th birthday.

We may require proof of continuing incapacity and dependence from time to time, but not more often than annually after the two-year period following the Dependent Child's 26th 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 30 days of the date of Your death, to continue coverage under one of Our policies.

C. <u>Termination of Coverage</u>. Coverage under this Policy will continue until terminated as set forth below:

1. **Events of Termination.** Coverage under 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 date that the Administrator receives the notice, unless a future date is requested;

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. The last date upon which You are enrolled in both Parts A and B of Medicare;
e. You became eligible for Medicaid after June 30, 2008;
f. You fail to respond within 30 days to Our inquiry about Your eligibility or place of residence; or
g. You commit a material fraudulent act upon or against Us.

2. **Services After Termination.** If You are receiving Covered Services as a registered inpatient in a Hospital, Skilled Nursing Facility (SNF) or other covered facility 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 or confined, until one of the following events occurs:

   a. We determine that it is no longer Medically Necessary for You to be an inpatient at the facility;
   b. You are no longer enrolled in both Medicare Parts A and B;
   c. The benefits available under this Policy for hospitalization or confinement are exhausted, regardless of whether a new Calendar Year begins;
   d. You become covered under another policy that provides benefits for the hospitalization or confinement; or
   e. You become enrolled under an agreement with another carrier that would provide benefits for the hospitalization or confinement if this Policy did not exist.

This provision will not apply if You are covered under another policy that provides benefits for the hospitalization or confinement 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 re-apply for coverage under the Policy if You again become eligible, provided at least 12 months have elapsed since the old Policy terminated or You can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums.

E. Continuity of Coverage: Replacement or Discontinuation. This Policy may be replaced or discontinued by Us as follows:

1. **Replacement.** We may replace this Policy by offering You a replacement policy which includes all of the services covered under this Policy and which does not limit access to the services covered in the replacement policy through

unreasonable cost-sharing requirements or otherwise. We will also offer You the unrestricted right to transfer to a fully comparable plan offered by WSHIP and for which You are otherwise eligible.

2. **Discontinuation.** We may discontinue this Policy after providing You with notice 90 days prior to the date of discontinuation of this Policy. In this event, We will also offer You the option to enroll in any other plan offered by WSHIP and for which You are otherwise eligible. In offering You the option to enroll in other plans, We will act uniformly without regard to health status-related factors of You and other individuals who are or become eligible for the coverage We offer.

III. BENEFITS

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

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

1. Received while You are insured under this Policy;

2. Ordered by and under the direct supervision of a Physician;

3. Medically Necessary as determined by Us; and

4. 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. **Acupuncture.** Acupuncture services performed by an individual acting within the scope of his or her license that are Medically Necessary to relieve pain, induce surgical anesthesia or treat a covered Illness.

   Benefits for acupuncture are limited to 12 visits per Calendar Year.

2. **Ambulance.** When necessary because of Your medical condition, licensed ambulance services for transportation to the nearest Hospital or SNF qualified to treat Your Illness.

3. **Blood Products and Services.** Blood and blood derivatives.

4. **Breast Reconstruction Following Mastectomy.** Reconstructive surgery of the breast on which the mastectomy has been performed and all stages of reconstructive breast reduction of the non-diseased breast to equal the size of the diseased breast following surgery due to a mastectomy. Treatment of the physical complications of all stages of mastectomy, including lymphedemas, are also Covered Services.

5. **Chemical Dependency.** Services for alcohol, drug, or chemical dependency or abuse are Covered Services when provided by a state-certified chemical dependency program approved under chapter 70.96A Revised Code of Washington (RCW), or by a Physician, psychologist, or community mental health professional, or, at the direction of a Physician, by other qualified licensed health care practitioners.

   Benefits for Treatment of chemical dependency are limited as follows:

   a. The maximum number of days for inpatient care is limited to 30 days each Calendar Year; and
   b. The maximum number of visits for outpatient care is limited to 28 visits each Calendar Year.

   Benefits for Medically Necessary detoxification services are covered under this benefit unless they are rendered in an emergency room setting in which case the detoxification services will be covered under Section III.B, Emergency Room Services. Hospital Inpatient benefits do not accrue toward the chemical dependency treatment benefit maximum above.

6. **Congenital Defects and Birth Abnormalities.** Necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities.

7. **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, and it must be certified by the American Association of Diabetes Educators.

   Benefits for diabetes education programs are paid at 100%.

8. **Diagnostic Services.** Diagnostic laboratory, pathology, imaging and scans such as x-rays and electrocardiograms (EKGs).

9. **Emergency Room Services.** Emergency room facility services, including related services and supplies such as surgical dressings and drugs, furnished by and used in the emergency room. Also covered under this benefit are Medically Necessary emergency room detoxification services.

10. **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 an inability to leave home.)

One home health care visit will consist of:

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

Benefits for home health care are limited to 130 visits per Calendar Year. Home health care provided as an alternative to inpatient Hospital care, as determined by Us, is not subject to this limit.

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

11. **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.

    Benefits for Hospice Care are limited to:

    a. Those services provided under a coordinated, interdisciplinary program provided by a licensed Hospice Care agency; and
    b. Respite care up to a maximum of $7,500 per Calendar Year to relieve anyone who cares for You when You are participating in a Hospice Care program.

    Inpatient hospice services and supplies shall be covered in accordance with Section III.B, Hospital Inpatient.

    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.

12. **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.

13. **Hospital Outpatient.** Hospital Medical Services and supplies furnished on an outpatient basis.

14. **Infusion Therapy.** Outpatient professional services, supplies, drugs and solutions required for infusion therapy (also known as intravenous therapy). This

benefit does not cover over-the-counter drugs, solutions and nutritional supplements.

15. **Mammography.** Routine or diagnostic mammography for a woman that is ordered by a Physician, an advanced registered nurse practitioner (ARNP), or a physician's assistant.

    Benefits for mammography are paid at 100%.

16. **Massage Therapy.** Services of a licensed massage practitioner (LMP) when prescribed by a Physician.

    Benefits for massage therapy are limited to 12 visits per Calendar Year.

17. **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 RN services.

18. **Medical Supplies and Equipment.**

    a. Medical equipment, services or supplies that require a Physician's order and which are Medically Necessary and consistent with the diagnosis, Treatment and condition.
    b. 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 Us in advance through Our Medical Necessity review process described in Section VI.A, Medical Necessity Review;
        (2) Is prescribed by Your attending Physician; and
        (3) Is used to serve a medical purpose other than for transportation, comfort or convenience;
    c. Initial internal breast prostheses following mastectomy;
    d. Braces, crutches and prostheses (except dental prostheses) needed because of Illness that begins while covered by the Policy;
    e. Up to four post-mastectomy bras and sleeves per Calendar Year. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses;
    f. Colostomy bags and related supplies;
    g. Catheters;
    h. Blood glucose monitors, insulin pumps and accessories to pumps, insulin infusion devices, and syringes and needles for insulin and allergy injections; and
    i. Oxygen.

19. **Medical Therapy.** Chemotherapy, radioisotope, radiation and nuclear medicine therapy.

20. **Mental Health Care.** Covered mental health services include outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Services must be provided by a Hospital, Washington State licensed community mental health agency, Physician, or psychologist. Covered services may also be furnished by a state Hospital that is operated and maintained by the State of Washington for the care of the mentally ill.

21. **Nutritional Therapy.** Outpatient nutritional therapy services.

22. **Oral Surgery.** The following forms of oral surgery:

    a. Oral surgery related to 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.

23. **Outpatient Surgery.** Surgical services and supplies furnished on an outpatient basis.

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24. **Prescription Drugs, Contraceptive Devices, Antigens and Allergy Vaccines.** This Policy only covers Prescription Drugs that are covered under Parts A or B of Medicare.

    Information about Our mail order pharmacy and a list of Network Pharmacies is available on Our website at www.wship.org. You may also request this information by calling Our Pharmacy Benefit Manager at 1-800-859-8810. All Prescription Drugs and pharmacy services must be obtained from a Network Pharmacy or through Our mail order pharmacy except for:

    a. Prescription Drugs dispensed by a Health Care Provider when related to Emergency services; and
    b. Prescription 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.

25. **Preventive Health Care.** Preventive health care services up to the maximum benefit of $500 per Calendar Year. This benefit covers routine physical exams, well-child exams and immunizations. Routine or preventive diagnostic services

are covered under the Diagnostic Services benefit and routine or diagnostic mammography is covered under the Mammography benefit.

26. **Professional Services.** Professional services, including surgical services 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 the Oral Surgery benefit in Section III.B.

27. **Rehabilitation Therapy Services.** 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 prescribed by Your Physician to help restore or improve a function that was lost due to accidental injury or illness.

    Rehabilitation therapy services for children under age seven with neurodevelopmental 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.

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

    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).

    Benefits for an SNF are limited to 100 days of confinement per Calendar Year.

29. **Spinal and Other Manipulative Treatment.** Spinal and other manipulations to treat a covered Illness, injury or condition.

30. **Sterilization.** Sterilization is a Covered Service. Reversal of sterilization is not a Covered Service.

31. **Tobacco Cessation.** When provided through a WSHIP-Designated Network Provider, services related to tobacco cessation are covered, limited to Participation in a WSHIP-designated program.

32. **Temporomandibular Joint (TMJ) Disorders or Myofascial Pain Dysfunction (MPD).** Medical services and supplies for Treatment of TMJ disorders or MPD.

    This benefit is subject to a $1,000 lifetime maximum as set forth in Section IV.B, Lifetime Maximum Benefits.

33. **Transplant Surgery and Related Expense Benefits.** Solid organ transplants and bone marrow/stem cell reinfusion procedures which meet Our criteria for coverage, and related expenses which We have determined, in advance, to be Medically Necessary are Covered Services subject to all applicable limitations and exceptions set forth in Section IV.B, Lifetime Maximum Benefits. Transplant services must be obtained from a Network Provider. Should covered transplant services not be available from any Network Provider, such services performed by a non-Network Provider will be covered as if they had been obtained from a Network Provider if You have obtained prior authorization from Us.

    If You have transplant surgery for which benefits are payable under this Policy, the acquisition costs, including removal and evaluation of the donor organ, bone marrow or stem cells, testing and typing expenses, and donor Physician visits related to the transplant, are Covered Services.

    This benefit is subject to a $350,000 lifetime maximum as set forth in Section IV. B, Lifetime Maximum Benefits.

    Cornea transplantation, skin grafts, and the transplant of blood or blood derivatives (except for bone marrow or stem cells) are not considered "transplant" services and are covered on the same basis as other Medical Services.

34. **Limited Coverage for Investigational and Experimental Services.** Investigational and Experimental services are covered only under certain limited circumstances. Your participation in a clinical trial which is researching an emerging technology that has been deemed Investigational by WSHIP may be eligible for coverage when all of the following criteria are met:

    a. The technology must be a Treatment for a condition that is life-threatening and that has a poor prognosis with the most effective available Treatment. A condition is considered to be life-threatening if it has a substantial probability of causing premature death within the immediate foreseeable future.

    b. The technology must be therapeutic, used to directly improve health outcomes, and not for diagnosis or supportive care.

    c. Your request must be to participate in a phase II or phase III clinical trial.

    d. The clinical trial must be conducted under a written research protocol with Institutional Review Board approval.

    e. The clinical trial must be approved by a national body, such as the National Institutes of Health, the National Cancer Center Institute, or the FDA.

    f. The technology must have approval from the appropriate government regulatory bodies, if applicable:
        1. Devices must be FDA-approved via one of the following processes:
            a. PMA (Premarket Approval)
            b. 510(k)

c. HDE (Humanitarian Device Exemption)

2. Drugs must have one of the following:
   a. Final FDA approval for marketing for at least one indication via the NDA (New Drug Application) process
   b. IND (Investigational New Drug) approval

g. You must be enrolled in the clinical trial at the time of Treatment for which You are requesting coverage.

h. Routine costs of a clinical trial eligible for coverage, either in the experimental or control arm, include:
   1. Items or services that are typically provided absent a clinical trial (e.g., conventional care);
   2. Items or services required solely for the provision of the Investigational item or service being studied, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
   3. Items or services needed for reasonable and necessary care arising from the provision of an Investigational item or service—in particular, for the diagnosis or Treatment of complications.

i. Investigational costs not eligible for coverage include:
   1. The Investigational item or service *itself*, unless otherwise covered outside of the clinical trial;
   2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); and
   3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Services provided in a trial that are approved for coverage will have benefits provided as specified in the appropriate benefit category that would ordinarily be assigned. Services provided in a clinical trial that are fully funded by another source may not be covered by Your WSHIP Policy.

A Medical Necessity review to confirm coverage of Experimental or Investigational Treatment prior to beginning Treatment is highly advisable.

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 prenatal care services or benefits for outpatient prescription drugs. 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 following requirements: 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 as defined by this Policy at the time of commencement of Your coverage under this Policy.

B. Lifetime Maximum Benefits.

1. **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 $350,000 for all Covered Services related to organ, bone marrow, or stem cell transplant services. The $350,000 transplant lifetime maximum limitation will apply from one day prior to the date of the transplant or the date of hospital admission if the entire admission is transplant related, if You receive a transplant during the course of a longer hospital stay, through 100 days after the transplant. The transplant lifetime maximum shall apply to donor-related expenses incurred at any time. Covered Services which You receive outside this 100-day period including necessary post-surgery drugs will not be counted in the transplant lifetime maximum.

2. **Temporomandibular Joint (TMJ) Disorders and Myofascial Pain Dysfunction (MPD) 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 $1,000 for TMJ and/or MPD services.

C. Exclusions. If Medicare Parts A or B provides benefits for the service You received, this Policy will reimburse the applicable Medicare deductibles, coinsurance and copays with the exception of the deductible amount for Medicare Part B, for which You will be responsible. In no event will payments under this Policy duplicate any amounts payable under Medicare.

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

1. **Cosmetic and Reconstructive.** Cosmetic or reconstructive services or plastic surgery except:

   a. As provided in Section III.B, 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 Illness that occurs during the coverage period.

2. **Counseling.** Marital, family, sexual, vocational, outreach counseling, counseling for life transition problems or job training.

3. **Custodial Care.** Custodial Care as defined in Section IX, Definitions.

4. **Dental.** Dental exams and Treatment of any kind except as provided in Section III.B, Oral Surgery.

5. **Education and Training.** Special education or training except diabetes education as described in Section III.B, Diabetes Education.

6. **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.

7. **Foot Care.** Routine foot care or Treatment for fallen arches or flat feet.

8. **Governmental Medical Facilities.** Treatment provided by a state or federal Hospital or facility that is not a Network Provider unless payment of the charge is legally required.

9. **Military and War-Related Conditions; and Illegal Acts.** Treatment for an Illness caused by or related to military service or war-related acts, or Illness caused by Your commission of an illegal act.

10. **Not Medically Necessary.** Treatment that We determine is not Medically Necessary as defined in Section IX, Definitions.

11. **Obesity and Weight Control.** Treatment of obesity or weight management and any direct or indirect complications from such Treatment. This exclusion applies to all medical Treatment, surgical procedures, medication, or programs for weight reduction, even if You also have an Illness that might be helped by weight loss.

12. **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.

13. **Sexual Dysfunction.** Diagnosis or Treatment of sexual dysfunction regardless of origin or cause, and any direct or indirect complications of such Treatment.

14. **Transportation or Travel.** Transportation or travel except for ambulance services described in Section III.B, Ambulance.

15. **Vision and Hearing.** Routine vision and hearing exams, vision analysis, contact lenses, eyeglasses, hearing aids, 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.

16. **Work-Related Conditions.** Treatment or diagnosis for Illness caused by or related to employment, regardless of whether a claim has been made for workers' compensation, except if You are exempt from state or federal workers' compensation laws.

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 for health care through any other insurance, 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 (including Personal Injury Protection coverage and Uninsured/Underinsured Motorist coverage), and any Hospital or medical benefit paid or payable under or provided pursuant to any state or federal law or program.

V. PREMIUMS, RATE CHANGES, AND COST SHARING

A. Premiums. Your premiums must be paid on or before the due date or during a 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.

B. Rates and Rate Changes. We may change premium rates for WSHIP policies. We will notify You at least 30 days before any general premium change. WSHIP rates are based on rates in the Medicare Supplement market in Washington State. Your individual rate may also change due to changes in Your age. WSHIP rates vary by age.

C. Deductible. Benefits under this Policy are not subject to a deductible. But note, this Policy will not cover Your Medicare Part B deductible amount, for which You will be responsible.

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

Services Covered By Medicare Parts A or B: For services that are covered under Parts A or B of Medicare, We pay 100% of the applicable Medicare deductible and coinsurance amounts, with the exception of the deductible amount under Medicare

Part B. We calculate and pay benefits based upon amounts payable by Medicare, regardless of whether a claim is submitted to or paid by Medicare.

Services Not Covered By Medicare Parts A or B: For all other Covered Services, We pay 80% of the Allowed Amount. Your coinsurance is 20%.

E. Out-of-Pocket Expense Limit. If, during a Calendar Year, Your out-of-pocket expenses reach $850 for covered Medical Services or $150 for covered Prescription Drugs, We will pay 100% of the Allowed Amount for the remainder of the Calendar Year. Out-of-pocket expenses include 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.

Pharmacy expenses do not apply to the medical out-of-pocket expense limit, and medical expenses do not apply to the pharmacy out-of-pocket expense limit.

VI. CARE MANAGEMENT

Care management services help ensure that You receive appropriate and cost-effective medical care.

For services covered by Medicare, We pay benefits in accordance with all coverage determinations made by Medicare.

For services not covered by Medicare but covered under this Policy, Our Care management services include the following:

A. Medical Necessity Review. You can receive a determination in advance about whether a particular service is Medically Necessary by calling Our Medical Necessity review telephone number on Your WSHIP identification card. 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. We will not pay for any services that are determined by Us to be not Medically Necessary.

We encourage You to ask Your provider to call Us and request a Medical Necessity review before all admissions to a Hospital, SNF or other covered facility to verify that it meets the required criteria for claims payment. In the case of an Emergency admission, Your provider should request a Medical Necessity review on the first business day following admission. We encourage You to also obtain a Medical Necessity review prior to receiving any of the outpatient Covered Services that are listed on Your identification card.

Medical Necessity reviews let You know ahead of time if the service is Medically Necessary. They also help Us to identify situations that might benefit from case management.

A Medical Necessity review and pre-approval is required for Durable Medical Equipment, and transplant surgery and related expenses.

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 and to help You to make more efficient use of Your benefits. Your participation in a Treatment plan through case management is voluntary. You should call the same telephone number that is printed on Your identification card for Medical Necessity reviews if You would like to learn more about case management. We may also contact You.

C. Other Care Management Programs. We may offer other care management programs to You from time to time, such as disease management programs for specific diseases or conditions. Disease management programs are designed to help You better understand Your disease and how to avoid problems or complications.

VII. OTHER INFORMATION

A. Claims for Benefits.

1. **Timely Filing.** Most providers will submit claims to Us directly. Otherwise, You must submit a claim to WSHIP for payment of the benefit. You should submit all claims within 30 days after the service is completed. We must receive all claims within 365 days of discharge for Hospital or other facility expenses, or within 365 days of the date services or supplies were provided. You may obtain a claim form from the Administrator or Pharmacy Benefits Manager.

2. **Assignment of Benefits.** Where You have assigned Your right to receive payment for any benefits for Hospital, medical or surgical services to the provider of those services, payment 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 other provider of the services.

3. **Misstatement of Age.** If Your age has been misstated in application materials, the premium payable under this Policy shall be adjusted for the correct age and You will be responsible for payment of the adjusted premium from the effective date of coverage. We will refund any overpayment of premium by You.

4. **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. In the absence of fraud or intentional misconduct, We will not request refunds for overpayments made more than 365 days from the date the overpayment was made by Us.

B. Eligibility Verification. You are required to complete and return an eligibility verification and residency form yearly or upon request. Your Policy is subject to

termination in accordance with Section II.C, Termination of Coverage, in the event You fail to return the requested information.

C. Entire Contract. This Policy, and any attachments, is the entire contract of insurance.

D. False or Misleading Statements. If benefits are paid in error due to intentionally false or misleading statements made by You or on Your behalf, including intentionally false or misleading statements in application materials, We may, at Our option, deny Your claims, terminate Your coverage or rescind Your coverage under this Policy as of the effective date. (See also Section II.C, Events of Termination.) We may also refund premiums previously paid and recover claims and administrative costs from You or other persons responsible for the intentionally false information.

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

F. Notices. Any notice We are required to send to You will be considered to be delivered if it is mailed to You at the most recent address provided by You to Us. We will use the date of postmark in determining the date of Our notification. If You are required to submit notice to Us, it will be considered delivered on the postmark date or, if not postmarked, the date We receive it.

G. Notice of Information Use and Disclosure. In the course of administering Your benefits and as permitted by law, We may collect, use, or disclose certain information about You. This personal information may include health information or personal data such as Your address, telephone number or Social Security Number. We may receive this information from, or release it to, Health Care Providers, insurance companies, or other sources. We are required by law to maintain the privacy and security of Your personal health and financial information and to provide You with a notice of Our legal duties and privacy practices. That notice is provided separately.

We may use or disclose Your information for reasons including the following:

1. For payment: To determine eligibility, to process claims for benefits, to coordinate benefits with other health plans and insurers, and to collect premiums.

2. For healthcare operations: To operate Our program, including determining the cost of benefits, to provide care and case management services; to support grievance or quality review boards, for audit or accreditation programs or other necessary business purposes; and to fulfill Our obligations under this Policy.

3. To You or to Your representative.

Your information may also be collected, used or released as required or otherwise permitted by law.

To safeguard Your privacy, We take care to ensure that Your information remains confidential. If a disclosure of Your information is not related to a routine business function or required by law, We remove anything that could be used to easily identify

You or We obtain Your prior written authorization. You also have the right to request inspection and/or amendment of records retained by Us that contain Your personal information.

This is a summary of Our privacy policy**.** Further information and a copy of Our privacy policy is available from the Administrator and on Our website.

H. Notification of Address Change. You are required to notify Us of a change in Your physical residence or mailing address within 30 days of such change.

I. Third-Party Recoveries.

1. **Subrogation.** If You are injured and have the right to recover damages from a responsible third party (someone other than You or Us), benefits under this Policy will still be paid. However, We have the right (called "subrogation"), to the fullest extent permitted by law, to recover directly from the third party to the extent of benefits We have paid on Your behalf for Illness or injury after You have been fully compensated for Your loss. We may at Our election either (1) assert Our right to recover benefits directly from the third party in Our name, or (2) sue any such third party in Your name, and have a security interest in and lien upon any recovery to the extent of the amount of benefits paid by Us and for Our expenses in obtaining a recovery, in both circumstances, after You have been fully compensated for Your loss. You or Your representative must cooperate in Our effort to collect from the third party who is responsible for Your injury. Failure on Your part to cooperate with Us in this effort may result in Your being fully responsible for the cost of the subrogated amounts. By providing benefits under this Policy, We are not acting as a volunteer and are not waiving any rights to subrogation.

2. **Reimbursement.** If You or Your representative obtain a recovery from a third party who is responsible for compensating You for Your injuries or Illness, to the fullest extent permitted by law, after You have been fully compensated for Your loss, We are entitled to the proceeds of any settlement or judgment that results, up to the amount of benefits paid by Us for the Illness or injuries caused to You. In recovering benefits provided, We may at Our election either hire Our own attorney or be represented by Your attorney. If We choose to be represented by Your attorney, We will pay, on a contingent basis, a reasonable portion of the attorney fees which are necessary for asserting Our right of recovery in the case, not to exceed 20% of the amount We seek to recover. We will not be required to pay for any legal costs incurred by You on Your behalf, and You will not be required to pay for any legal costs incurred by Us on Our behalf. You must protect Our interests in any negotiation regarding settlement of Your claim against a third party. Before accepting any settlement on Your claim against a third party, You must notify Us in writing of any terms or conditions offered in settlement, and You must notify the third party of Our interest in the settlement pursuant to this contractual provision. If You retain an attorney or other agent to represent You in the matter, You must require Your attorney or agent to reimburse Us directly from the settlement or recovery after You have been fully compensated for Your loss. By providing benefits under this Policy, We are not acting as a volunteer and are not waiving any rights to reimbursement.

VIII. GRIEVANCES AND APPEALS

A. Complaints and Appeals.

1. **Complaints.** If You have a complaint about Our services or about a benefit or coverage decision or any other WSHIP decision regarding Your Policy, please contact Our Customer Service department. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve Our service.

2. **Appeals.** If You are not satisfied with Our response to a complaint or Your complaint is a request that We reconsider Our decision to deny, modify, reduce, or end payment, coverage or authorization of coverage, You will need to submit Your complaint as a formal appeal. You or Your authorized representative will need to request an appeal within 90 days of the event giving rise to the appeal. Following receipt of Your appeal, We will let You know if We need more information to respond to Your complaint. We will review Your complaint and respond as soon as possible, but not more than 30 calendar days after receiving the information requested to review Your complaint.

   Your appeal rights and the appeal process are described below. If You have questions about the appeal process, please contact Our Customer Service department for assistance.

B. General Grievance and Appeal Rights.

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 Independent Review Organization (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.

C. Internal Appeal Process.

1. **Appeal to the Administrator.**

   a. You must notify the Administrator of Your request for appeal within 90 days of the event giving rise to the appeal.
   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 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 appeal process timelines could seriously jeopardize Your life, health, or ability to regain maximum function, the Administrator will provide its written decision within 72 hours of receipt of the appeal request.

2. **Appeal to Our Grievance Committee.**

a. You must notify the Administrator of Your request for appeal to Our grievance committee within 90 days of an adverse decision by the Administrator and include a written description of the complaint.

b. Within five business days, the Administrator will respond to You in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint, and the resolution requested. Within two business days of sending this notice, the Administrator will forward the appeal, with all relevant information from its files, to Our grievance committee.

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

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

e. 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 appeal 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.

D. <u>External Appeal Process</u>.

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.

E. Services During Appeal Process.

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 the entity identified in the cover letter sent with Your Policy as the Administrator or such other entity as identified by Us to You in writing.

"**Allowed Amount**" means, for services or supplies received from a Network Provider, the amount agreed upon by Us and the Network Provider for the Covered Service. For services or supplies received from a non-Network Provider, the Allowed Amount will be no greater than the maximum amount We otherwise would have allowed had the Covered Service been furnished by a Network Provider. We reserve the right to determine the Allowed Amount for any service or supply.

"**Calendar Year**" means, with respect to the first Calendar Year, the period beginning on the Policy effective date 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) For grandfathered health benefit plans (under the Affordable Care Act) issued before January 1, 2014, and renewed thereafter, Catastrophic Health Plan means:

(i) 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 seven hundred fifty 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 five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; and

(ii) 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 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 six thousand dollars, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a Catastrophic Health Plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the U.S. Department of Labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of the Affordable Care Act, as amended. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, Catastrophic Health Plan means:

(i) A health benefit plan that meets the definition of "catastrophic plan" set forth in section 1302(e) of the Affordable Care Act, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) above.

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

"**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 26. Dependent Child or Dependent Children also includes such children over the age of 26 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 26.

"**Designated Network Provider.**" See "Network Provider" below.

"**Durable Medical Equipment**" is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an Illness and is used in a home setting. Durable Medical Equipment includes Hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. We, in Our sole discretion, will determine if equipment will be made available on a rental or purchase basis. Durable Medical Equipment does not include domestic or recreational equipment such as air conditioners, spas and exercise equipment, even if prescribed by a Physician.

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

"**Health Care Provider**" means any Physician, facility or health care professional duly licensed 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 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**" means 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 facility that meets these requirements:

- Provides inpatient psychiatric services for the diagnosis and Treatment of mental Illness on a 24-hour basis;
- Has rooms for resident inpatients;
- Is equipped to treat mental diseases or disorders;
- Has a resident psychiatrist on duty or on call at all times; and
- As a regular practice, charges the patient for the expense of confinement.

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

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

"**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:

- Cannot be legally marketed in the United States without the approval of the FDA and such approval has not been granted;
- Is subject to a New Drug or New Device Application on file with the FDA;
- 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;
- 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;
- 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

- 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 Our Medical Staff and/or the IRO (under the grievance process set forth in Section VIII) determines is:

- Appropriate and consistent with Your condition, diagnosis or Illness;
- Consistent with standards of good medical practice in the United States;
- Not primarily for Your or Your Health Care Provider's comfort or convenience;
- Not Investigational or Experimental;
- Not provided as part of Your scholastic education or vocational training; and
- In the case of inpatient care in a Hospital, SNF, Hospice or any other facility, such services or supplies could not be provided safely via a less costly level of service.

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

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

- Preauricular-temporal, occipital and/or jaw pain;
- Spasm and/or tenderness of the masticatory muscles; or
- Limited jaw movement.

"**Network Pharmacy**" is a pharmacy vendor for whose services We have contracted to fill prescriptions under this Policy.

"**Network Provider**" is a Health Care Provider for whose services We have contracted to deliver Covered Services under this Policy. For certain Covered Services, certain Health Care Providers ("Designated Network Providers") have specially contracted to provide better pricing for WSHIP enrollees.

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

"**Pharmacy Benefit Manager**" means the entity identified in the cover letter sent with Your Policy as the Pharmacy Benefit Manager, or such other entity as identified by Us to You in writing.

"**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:

- Doctor of Medicine (MD);
- Doctor of Osteopathy (DO);
- Dentist (DDS);
- Optometrist (OD);
- Podiatrist (DPM);
- Psychologist (Masters or PhD);
- Clinical Social Worker (MSW);
- Chiropractor (DC);
- Registered Nurse (RN);
- Advanced Registered Nurse Practitioner (ARNP);
- Naturopathic Doctor (ND); or
- any other provider required to be treated as a Physician under the insurance laws of the State of Washington.

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

"**Prescription Drug**" means any medical substance that (1) has been approved by the FDA, and (2) is required to bear the following legend on its label: "Caution: Federal law prohibits dispensing without a prescription."

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

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

"**Skilled Nursing Facility (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:

- Pain or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat or shoulders;
- Popping or clicking of the jaw;
- Limited jaw movement or locking;
- Malocclusion, overbite or underbite; or
- Mastication (chewing) difficulties.

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

- Customarily applied in the care of persons with similar complaints and findings by similarly trained Health Care Providers; and
- 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.