

MEDICAL AND DENTAL INSURANCE PLAN

2011-2012

GRADUATE STUDENT ASSISTANTS



WASHINGTON STATE
 UNIVERSITY

World Class. Face to Face.

This Graduate Student Assistant Medical and Dental Insurance Plan is sponsored by Washington State University (“the Policyholder”). It is designed to help the Covered Person pay a large part of those expenses he or she may incur – Medical and Dental – which are not covered by Health and Wellness Services (HWS). Also see Medical Evacuation, Repatriation & Accidental Death Benefits included in the Schedule of Benefits. Coverage is available worldwide.

CONTENTS

MEDICAL (Underwritten by National Union Fire Insurance Company of Pittsburgh, Pa.)	
Eligibility.....	1
Enrollment Procedures.....	2
Premium Rates.....	3
Coverage Dates.....	3
Health and Wellness Services Information.....	4
Beech Street PPO Network.....	4
Schedule of Benefits.....	5
Exclusions.....	9
Pre-Existing Condition Limitation.....	10
Excess Coverage.....	11
Definitions.....	12
How to File a Medical/Vision Claim.....	15
Proof of Loss.....	16
Information, Branch Campuses.....	16
Travel Guard.....	17
24-Hour Emergency Care Hotline.....	18
DENTAL (Underwritten by Washington Dental Service)	
See Dental Section.....	19
I.D. CARD	Back Cover

ELIGIBILITY

Those eligible to enroll in the Plan are:

1. WSU Graduate Student Assistants who are paying tuition and fees for 10 or more credit hours; who have an Assistantship stipend of at least 50%; and who are eligible for a Qualified Tuition Reduction or a Tuition Fee Waiver.
2. Full-time Graduate Research Fellows/Trainees who are paid a stipend of at least \$800 per month; who are engaged in research similar to that of a Research Assistant; and who are eligible for a Qualified Tuition Reduction or a Tuition Fee Waiver.
3. The spouse of the Covered Student; also the Covered Student’s eligible dependent children who are under age 25 (*See definition of Dependent on page 12*). If continuously enrolled under this Plan, or a Plan previously issued to the University, prior to age 25, a developmentally disabled or physically handicapped dependent child, upon reaching age 25, may continue coverage.
4. A domestic partner of the Covered Student, who qualifies under the eligibility requirements as defined by the University.

5. Coverage for a spouse or child must be requested according to the *Enrollment Procedures on page 2*.

Newly acquired eligible Dependents must be enrolled and premium must be paid for them within 31 days after becoming eligible in order to become insured. Coverage begins the date the dependent qualified as a Dependent, provided premium is paid when due. If a newly acquired Dependent is not enrolled within 31 days after becoming eligible, such Dependent cannot be enrolled until the next Policy Period.

A child born to a Covered Student is automatically covered from the moment of birth until such child is 31 days old. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, the Covered Student must enroll the child within 31 days of such birth and pay the required additional premium in order to have coverage for the newborn child continue beyond such 31 day period.

POLICY PERIOD

The “Policy Period” means the period beginning at 12:01 a.m. August 16, 2011 and ending 12:01 a.m., January 1, 2012, or the period beginning at 12:01 a.m. January 1, 2012 and ending at 12:01 a.m., August 16, 2012.

ENROLLMENT PROCEDURES

Each eligible Graduate Student Assistant and Graduate Research Fellow/Trainee will be automatically enrolled. An insurance I.D. card will be sent to the insured by Maksin Management Corp.

Enrolled eligible Dependents will be assigned the same effective date of coverage as the Student, provided Dependent enrollment is completed, including payment of premium (or arrangement for payroll deduction), prior to the Student’s effective date of insurance. This enrollment procedure must be completed for the Fall Policy Period, **and again** for the Spring/Summer Policy Period. The enrollment is conducted at the Health and Wellness Services Billing Office, Room 120 Washington Building, or visit www.hws.wsu.edu. Payroll deductions may be arranged with the Payroll Office following completion of a Dependent enrollment form.

For those who complete Dependent enrollment on or after the Student’s effective date, but before the enrollment deadline shown below, Dependent insurance becomes effective on the day following completion of enrollment and payment of Premium (or arrangement for payroll deduction).

Dependent Enrollment Deadline:

The seventh (7th) day following the date the Department issues, to the student, his/her letter of appointment as a Graduate Student Assistant or Graduate Research Fellow/Trainee. Thereafter, dependent enrollment is closed, except for those newly acquired (See #5, page 2), until the scheduled enrollment for the next Policy Period.

PREMIUM RATES

	<u>Fall</u>	<u>Spring and Summer</u>
Student.....	Paid by University	
Spouse*.....	\$1,864	\$2,794
Child(ren).....	664	995

*or domestic partner

COVERAGE DATES

Covered Graduate Student Assistants and Graduate Research Fellows/Trainees will be insured during these Policy Periods:

Fall – Coverage begins at 12:01 a.m. August 16, 2011 and ends at 12:01 a.m., January 1, 2012

Spring/Summer – Coverage begins at 12:01 a.m. January 1, 2012 and ends at 12:01 a.m., August 16, 2012

If the Covered Person is Hospital Confined on the effective date of coverage under the Policy, coverage is not effective until the individual is discharged from the Hospital.

TERMINATION OF COVERAGE*

Coverage will terminate for a Covered Person (a) upon expiration of the Policy term, (b) upon the date of entry into an armed service on active duty, (c) for a student whose appointment as a Graduate Student Assistant or a Graduate Research Fellow/Trainee terminates, at the end of the Policy Period during which the appointment terminated, or (d) the end of the month in which status as a Dependent ends. Except as noted above or specifically provided under the Extension of Benefits, Dependent coverage expires concurrently with that of the Covered Student.

*With respect to a Covered Student who receives a W-2 from the Policyholder, the following shall apply: Upon suspension of coverage by the Policyholder as a result of a strike, lockout, or other labor dispute, the Covered Student may continue his or her coverage and that of his or her Dependents by paying premiums directly to the Company for a period not exceeding 6 months; upon termination of the coverage, the Covered Student shall be given the opportunity to purchase an individual policy.

EXTENSION OF BENEFITS

If a Covered Person is Hospital Confined on the date coverage terminates, the Company will extend that Covered Person's benefits. Benefits will be paid as if coverage had remained in effect. Extension of Benefits will end at the earlier of the date continuous Hospital Confinement ends or the date the Policy Year Maximum Benefit is reached.

PURPOSE OF THIS INSURANCE PLAN

The Medical Insurance Plan benefits described in this brochure are designed to assist you in paying for covered medical expenses described in the Schedule of Benefits. The primary purpose is to help with Eligible Expenses incurred for Inpatient Hospital and surgical care in Pullman (and anywhere in the world) and for Eligible Expenses for services not provided by HWS.

WSU HEALTH AND WELLNESS SERVICES

HWS is located on the Pullman campus and offers high-quality health care at the only accredited clinic in the region. Students can visit the clinic for primary, preventative or mental health care. Board certified physicians with expertise in college health are available, and a pharmacy is located inside the medical clinic. The HWS Pharmacy will bill this insurance plan for you.

For urgent care services, HWS provides a 24-hour telephone nurse service in addition to urgent care during regular business hours, most Saturdays and some holidays. In emergency situations, students should call 911 or go to the emergency room at the hospital.

Please call for an appointment at (509) 335-3575 during regular clinic hours, 9 a.m. to 5 p.m. Monday through Friday; summer clinic hours are 7:30 a.m. to 4:00 p.m.

In addition to the Pullman campus, HWS offers the following locations to access care for health fee paying students:

Rockwood Clinic primary and urgent care locations in the Spokane area as specified on the HWS website. Go to <http://hws.wsu.edu> and click on Regional Campuses. For additional information you may call (509) 335-3575 and select option 3.

Central Washington Family Medicine, 1806 W. Lincoln Ave., Yakima – (509) 452-4520

To better serve you, please identify yourself as a WSU student when scheduling at these clinics.

BEECH STREET PPO NETWORK

Covered Persons may choose to be treated within or outside of the Beech Street PPO Network. This network consists of hospitals, doctors and other health care providers organized into a network for the purpose of delivering quality health care at affordable rates. Therefore, when a Covered Person uses a Beech Street Participating Provider, his or her fee may be reduced. A complete listing of providers is available on the Beech Street website link accessible at: <http://www.maksin.com/wsua.aspx>.

**WSU MEDICAL INSURANCE PLAN
SCHEDULE OF BENEFITS
Graduate Student Assistants**

MAXIMUM AGGREGATE BENEFIT PER POLICY YEAR (ALL CONDITIONS)*

- Students: \$200,000
- Dependents: \$50,000

*Except that the Maximum Aggregate Benefit per Policy Year per Motor Vehicle Accident is limited to \$10,000

DEDUCTIBLE PER POLICY YEAR:

Students*:

- HWS \$ 50 (applies to HWS contractors in Spokane and Yakima)
- Other Providers \$100 (includes the Deductible incurred at HWS)

*Prescriptions are payable only after \$100 of Eligible Expenses are applied to the Deductible no matter where the Eligible Expenses are incurred.

Dependents:

\$100

PAYMENT SCHEDULE (The Covered Percentages below apply to all Eligible Expenses, except as otherwise indicated in the Schedule of Benefits. Applies to all providers, including HWS.)

Students:

- HWS * (Pullman Campus Only) 100% of Allowable Charges
- Any Other Provider 80% of Reasonable and Customary Charges (R & C)

Dependents:

80% of Reasonable and Customary Charges (R & C)

*100% of Allowable Charges at HWS, Pullman Campus only, except as noted in the Schedule of Benefits below.

When Eligible Expenses incurred by a Covered Student or Covered Dependent exceed \$25,000 in a Policy Year, except as otherwise indicated in the Schedule of Benefits, the payment schedule will increase as shown below. Applies to all providers, including HWS.

Students:

- HWS * (Pullman Campus Only) 100% of Allowable Charges
- Any Other Provider 90% of Reasonable and Customary Charges (R & C)

*100% of Allowable Charges at HWS, Pullman Campus only, except as noted in the Schedule of Benefits below.

Dependents:

90% of Reasonable and Customary Charges (R & C)

WEAR SEAT BELTS/HELMETS (STUDENTS ONLY): When a Covered Student is injured in a covered accident while riding a bicycle or a motorcycle or in an automobile or truck and requires medical treatment thereafter, and it can be shown that the Covered Student was wearing a helmet (bicycle/motorcycle) or a seat belt (automobile/truck) then the deductible and coinsurance will be waived on the first \$500 of Eligible Expenses.

INPATIENT		STUDENT	DEPENDENT
<p>Pre-Admission Testing Private Duty Nursing Surgery Assistant Surgeon Doctor's Visits: Does not apply when related to surgery or physiotherapy</p>	Per Payment Schedule	Per Payment Schedule	Per Payment Schedule
<p>Anesthesia</p>	80% of the amount allowed for surgery	80% of the amount allowed for surgery	Per Payment Schedule
<p>Hospital Miscellaneous Expense: includes operating room, laboratory service and x-rays (including professional fees), drugs (excluding take home drugs) casts and related items, surgical supplies, cost of blood and its derivatives including handling and administrative costs.</p>	80% of R & C Charges	80% of R & C Charges	Per Payment Schedule
<p>Hospital Room & Board Expense: semi-private room or intensive care, coronary care or isolation units.</p>	Per Payment Schedule up to \$1,500 per day	Per Payment Schedule up to \$1,500 per day	Per Payment Schedule
OUTPATIENT		STUDENT	DEPENDENT
<p>Allergy Medication (Prescription)</p>	80% Generic / 60% Brand up to a \$300 Policy Year Maximum	80% Generic / 60% Brand up to a \$300 Policy Year Maximum	No Benefits
<p>Anesthesia</p>	80% of the amount allowed for surgery	80% of the amount allowed for surgery	Per Payment Schedule
<p>Cougar Comprehensive Panel, Cougar Chemical Panel and Comprehensive Metabolic (Standard 80053)</p>	Per Payment Schedule up to a \$50 Maximum, limited to one test per Policy Year (whether or not Medically Necessary)	Per Payment Schedule up to a \$50 Maximum, limited to one test per Policy Year (whether or not Medically Necessary)	No Benefits
<p>Doctor's Visits: Does not apply when related to surgery or physiotherapy.</p>	Per Payment Schedule	Per Payment Schedule	Per Payment Schedule
<p>Emergency Room Expense</p>	Per Payment Schedule up to a \$1,500 Maximum, unless Hospital Confined, for each Emergency	Per Payment Schedule up to a \$1,500 Maximum, unless Hospital Confined, for each Emergency	Per Payment Schedule
<p>Hospital Miscellaneous Expense: includes operating room, laboratory service and x-rays (including professional fees), drugs (excluding take home drugs) casts and related items, surgical supplies, cost of blood and its derivatives including handling and administrative costs.</p>	80% of R & C Charges	80% of R & C Charges	Per Payment Schedule
<p>Mammogram</p>	100% of R & C Charges One per Policy Year for Covered Students age 40 and older, not subject to Deductible	100% of R & C Charges One per Policy Year for Covered Students age 40 and older, not subject to Deductible	No Benefits

OUTPATIENT (CONTINUED)	STUDENT	DEPENDENT
Prescription Drugs: Each Prescription and each refill is limited to the supply needed for 30 days (90 days for Prescriptions ordered through HWS and birth control; 90 day supplies are not permitted after May of each Policy Year.) Prescriptions include charges for diabetes equipment and supplies.	80% Generic / 60% Brand	80% Generic / 50% Brand
Radiation and Chemotherapy	Per Payment Schedule	Per Payment Schedule
Special Nursing	Per Payment Schedule up to a \$400 Policy Year Maximum	Per Payment Schedule up to a \$400 Policy Year Maximum
Surgery	Per Payment Schedule	Per Payment Schedule
Wellness Benefits: includes routine Doctor's office visits, physical examinations and laboratory tests not otherwise covered in the Schedule of Benefits.	Per Payment Schedule up to a \$150 Policy Year maximum. Not subject to Deductible.	See Well-Care for Children.
Well-Care for Children: includes outpatient charges for routine physical examinations and scheduled immunizations, incurred from birth through age 7, when ordered by the attending Doctor.	See Wellness Benefit	90% of R & C Charges up to a \$300 Policy Year Maximum per covered child. Not subject to Deductible.
X-ray and Lab Expense (including Cat Scans and MRIs)	Per Payment Schedule up to a \$4,000 Policy Year Maximum	Per Payment Schedule
OTHER	STUDENT	DEPENDENT
Accidental Death & Dismemberment	\$10,000 Maximum Benefit See Policy for details.	No Benefits
Alcoholism and Chemical Dependency Treatment (Inpatient and Outpatient combined)	Paid as any other Sickness up to a \$7,500 Maximum in any consecutive 12 month period. No Lifetime limit applies.	Paid as any other Sickness up to a \$7,500 Maximum in any consecutive 12 month period. No Lifetime limit applies.
Ambulance	75% of R & C Charges up to a \$10,000 Policy Year Maximum	75% of R & C Charges up to a \$8,000 Policy Year Maximum
Colorectal Cancer Screening	Paid as any other Sickness	Paid as any other Sickness
Dental Care for injury to sound natural teeth (Inpatient and Outpatient combined)	85% of R & C Charges up to a \$300 Maximum per Injury per Policy Year	85% of R & C Charges up to a \$300 Maximum per Injury per Policy Year
Durable Medical Equipment / Braces and Appliances: orthotics are limited to one set per Policy Year	Per Payment Schedule	Per Payment Schedule
Elective Abortion	Paid as any other Sickness	Paid as any other Sickness
Maternity Care: Inpatient benefits will not be less than: (a) 48 hours after a non-cesarean delivery; or (b) 96 hours after a cesarean section, for the mother and the newborn infant(s), unless an earlier discharge occurs.	Paid as any other Sickness	Paid as any other Sickness

OTHER (CONTINUED)	STUDENT	DEPENDENT
Medical Evacuation: Benefits are payable if the Covered Student, by reason of Injury or Sickness and following at least 5 consecutive days of Hospital Confinement, requires medical evacuation to his or her home country. The evacuation must be certified as Medically Necessary by the attending Doctor and approved by the Company.	\$250,000 Maximum (Medical Evacuation and Repatriation combined)	No Benefits
Mental or Nervous Disorders (Inpatient and Outpatient)	Paid as any other Sickness	Paid as any other Sickness
Physiotherapy, diathermy, heat treatment in any form, manipulation or massage and office visits in connection therewith (Inpatient and Outpatient combined)	80% of R & C Charges up to a \$2,000 Policy Year Maximum	80% of R & C Charges up to a \$1,500 Policy Year Maximum
Rabies series pre-exposure inoculations for Veterinary Students Only	Up to \$50 each (lifetime maximum of 3). This lifetime maximum of \$150 includes rabies titer test. Not subject to Deductible.	No Benefit
Repatriation: Benefits are payable if the Covered Student dies as the result of Injury or Sickness. All expenses are subject to prior approval by the Company.	\$250,000 Maximum (Medical Evacuation and Repatriation combined)	No Benefits
Vision Care: <ul style="list-style-type: none"> • Eye examinations (to determine the need for a new or changed prescription for corrective lenses) by an ophthalmologist (M.D.) or optometrist (O.D.) • Lenses and frames; including contact lenses. 	Limited to one in any 24 consecutive months. Up to a \$65 Maximum. Not subject to Deductible. Combined maximum, each 24 consecutive months, up to \$200	No Benefits
LIMITED BENEFITS FOR SPECIFIC SERVICES AT WSU HEALTH & WELLNESS SERVICES (HWS) Deductible is waived. The HWS Fee must be paid before services can be provided. Although not Medically Necessary for treatment of a Sickness, payment will be made for the following services when ordered by HWS, including HWS contractors at Spokane and Yakima, and will be paid as follows:	STUDENT	DEPENDENT (Dependent care is not provided at HWS)
Hepatitis B series pre-exposure inoculations for those Covered Students whose studies expose them to the disease, e.g. working with blood, blood products or in pathology.	Up to \$31 each (lifetime maximum of 3)	No Benefit
Influenza Vaccination	One per Policy Year	No Benefit
Pap Smear: One each Policy Year	Up to \$27	No Benefit
STI Test: Maximum 2 tests per Policy Year.	Up to \$25 each test	No Benefit

EXCLUSIONS

The Policy does NOT cover nor provide benefits for Loss or Expenses incurred:

1. as a result of dental treatment except for treatment resulting from Injury to sound, natural teeth as provided elsewhere in the Policy.
2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or services covered by the Student Health Service fee.
3. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses or prescription for such except as specified under Vision Care Expense.
4. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
5. for Injury or Sickness resulting from war or act of war, declared or undeclared.
6. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from Injury, provided such Injury necessitated medical care within the 24 hours after the Injury occurred. It also shall not include breast reconstructive surgery after a mastectomy.
10. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
11. for any services rendered by a Covered Person's Immediate Family Member.
12. for a treatment, service or supply which is not Medically Necessary.
13. as a result of intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
14. for reconstruction or realignment of the jaw (except as the result of Injury), treatment for malocclusion or other abnormalities of the jaw, including services for temporomandibular joint dysfunction and associated myofacial pain, or related appliances.
15. for treatment of mental or nervous disorders except as specifically provided in the Policy.
16. for the treatment of alcoholism or substance abuse except as specifically provided in the Policy.
17. for treatment of acute intoxication, inebriation or drunkenness as a result of ingestion of alcohol or abuse of drugs.

18. for orthotics that are used for purposes other than treatment of an Injury.
19. for surgery and/or treatment of: allergy and allergy testing (except for emergency treatment of acute distress or asthma brought on by allergy or allergy prescriptions for Covered Students); biofeedback-type services; breast implants or breast reduction; circumcision; corns, calluses and bunions (except capsular or bone surgery); deviated nasal septum, including submucuous resection and/or other surgical correction thereof unless due to Injury occurring while coverage is in force; learning disabilities; obesity; sexual reassignment surgery; sleep disorders, including testing thereof; preventive medicines serums or vaccines, except where required for the treatment of Injury; and weight reduction.
20. for routine physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in the Policy.
21. for sterilization or sterilization reversal, including surgical procedures and devices; or for birth control, except prescription contraceptives.
22. for treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer and in vitro fertilization, or any other form of assisted conception.
23. for organ transplants or services or supplies relating to organ transplants.
24. for Injury resulting from: the practicing for, participating in intercollegiate sports sponsored by the Intercollegiate Athletic Department of the Policyholder
25. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
26. by a Covered Person who is not a United States Citizen for services performed within the Covered Person's home country if the Covered Person's home country provides national health insurance.
27. for Elective Treatment or elective surgery, unless otherwise provided under the Policy.
28. as a result of committing or attempting to commit a felony or participation in a felony.

PRE-EXISTING CONDITION LIMITATION

There is no coverage for Pre-existing Conditions during the first 3 months following a Covered Person's effective date of coverage under the Policy.

This limitation will not apply if, during the period immediately preceding the Covered Person's effective date of coverage under the Policy, the Covered Person was covered under prior Creditable Coverage for 3 consecutive months. Prior Creditable Coverage of less than 3 months will be credited toward satisfying the Pre-existing Condition Limitation. **The Covered Person must provide proof of Creditable Coverage.**

A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person's effective date under this Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable

Coverage of more than 63 days, the Company will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

- (a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- (b) The federal Medicare Program pursuant to Title XVIII of the Social Security Act;
- (c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
- (d) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;
- (e) a medical care program of the Indian Health Service or of a tribal organization;
- (f) a state health benefits risk pool;
- (g) a health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;
- (h) a public health plan as defined by federal regulations; or
- (i) a health benefit plan under section 5(e) of the Peace Corps Act.

EXCESS COVERAGE

Benefits payable for the Eligible Expenses under this provision will be limited to that part of the Eligible Expense, if any, which is in excess of the total benefits payable for the same Injury or Sickness, on a provision of service basis or on an expense incurred basis under any other valid and collectible group insurance. If the other valid and collectible group insurance provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose policy or service contract has been in effect for the longer period of time at the date of such Injury or Sickness.

For purposes of the Policy a Covered Person's entitlement to other valid and collectible group insurance will be determined as if the Policy did not exist and will not depend on whether timely application for benefits from other valid and collectible group insurance is made by or on behalf of the Covered Person.

Benefits under the Policy will be reduced to the extent that benefits for Expenses are covered by any other valid and collectible group insurance whether or not a claim is made for such benefits.

DEFINITIONS

“Accident” means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

“Allowable Charges” means the charges incurred for covered medical treatment, services and supplies provided and billed by Pullman HWS and approved by the Company.

“Cougar Chemical Panel” means: 80053: Comprehensive Metabolic Panel; 84550: Uric Acid; 84443: TSH; 82465: Cholesterol; 84478: Triglyceride.

“Cougar Comprehensive Panel” means: 80053: Comprehensive Metabolic Panel; 84550: Uric Acid; 84443: TSH; 82465: Cholesterol; 85025: CBC W/Auto Diff; 84478: Triglyceride.

“Covered Person” means a Covered Student while coverage under the Policy is in effect and those Dependents with respect to whom a Covered Student is insured.

“Covered Student” means a student of the Policyholder who is insured under the Policy.

“Deductible/Deductible Amount” means the dollar amount of Eligible Expenses a Covered Person must pay during each Policy Year before benefits become payable.

“Dependent” means: (a) the Covered Student’s Spouse residing with the Covered Student; and (b) the Covered Student’s unmarried child under age 25.

The term “child” includes:

- (a) a Covered Student’s legally adopted child;
- (b) a child for whom the Covered Student has assumed legal obligation for total or partial support of a child in anticipation of adoption of the child; and
- (c) a Covered Student’s step-child if such child resides with the Covered Student and depends on the Covered Student for full support.

“Dependent” also means:

(a) the Covered Student’s domestic partner provided they are living together and a written declaration of domestic partnership acceptable to the Company has been completed and/or any applicable requirements of the state, city and/or country in which they reside regarding domestic partnership have been met.

“Doctor” as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term “Doctor” does not include a Covered Person’s Immediate Family Member.

“Eligible Expense” as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while this Policy is in force as to the Covered Person except with respect to any expenses

payable under the Extension of Benefits Provision.

“Emergency Medical Condition” means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent lay-person with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to such person’s bodily functions; or (c) serious dysfunction of any bodily organ or part of such person.

Emergency Services means the following: (a) a medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition; (b) such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

“Experimental/Investigational” means a drug, device or medical care or treatment that meets the following:

- (a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- (b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
- (c) the drug, device, medical care or treatment or the patient’s informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval;
- (d) reliable evidence shows that the drug, device, medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

“Hospital” means a facility which meets all of these tests:

- (a) it provides in-patient services for the care and treatment of injured and sick people; and
- (b) it provides room and board services and nursing services 24 hours a day; and
- (c) it has established facilities for diagnosis and major surgery; and
- (d) it is supervised by a Doctor; and
- (e) it is run as a Hospital under the laws of the jurisdiction which it is located; and
- (f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for Mental or Nervous Disorders, except as specifically provided. The term “Hospital” includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; (c) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

“Hospital Confinement/Hospital Confined” means a stay of 18 or more hours in a row as a resident bed-patient in a Hospital.

“Immediate Family Member(s)” means a person who is related to the Covered Person in any of the following ways: Spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

“Injury” means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person’s effective date of coverage; and (c) occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

“Medical Necessity/Medically Necessary” means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Covered Person or provider; or
- (b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or
- (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.
- (d) it is Experimental/Investigational or for research purposes; or

- (e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
- (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
- (g) involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- (h) it can be safely provided to the patient on a more cost-effective basis such as out-patient, by a different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

"Policy Year" means the period beginning 12:01 a.m. August 16, 2011 and ending 12:01 a.m., August 16, 2012.

"Pre-Existing Condition" means a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended within the 3 months prior to the Covered Person's effective date of coverage under the Policy or a pregnancy existing on the Covered Person's effective date of Coverage under the Policy.

"Reasonable and Customary" means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

Reasonable and Customary charges also means the 75th percentile of the MDR, Inc. payment system in effect on the Effective Date.

"Sickness" means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and Complications of Pregnancy.

All Sicknesses due to the same or a related cause are considered one Sickness.

HOW TO FILE A MEDICAL/VISION CLAIM

Obtain a Graduate Student Assistant Medical Insurance claim form from Health and Wellness Services, Washington Bldg., phone (509) 335-3575. Or access the following website:

<http://www.maksin.com/wsua.aspx>

FOR INITIAL CLAIM, EACH CONDITION

1. Complete claim form.
2. Attach the Doctor's bill.
3. Send Claim form and all itemized bills to:

Maksin Management Corp
P.O. Box 2677
Camden, NJ 08101-2677
1-888-679-5676

TO SUBMIT SUBSEQUENT EXPENSES, SAME CONDITION

Once you have filed the initial claim:

1. Complete claim form.
2. Obtain itemized Doctor's bill(s).
3. Mark the claim form "Continuing Claim."
4. Send claim form and additional itemized bills to the above address.

PROOF OF LOSS

Written proof of loss must be furnished to the Company within 90 days after the date of such loss or as soon as reasonably possible thereafter, but in no event shall the time limit exceed one year after the time otherwise allowed.

CLAIMS APPEAL PROCESS

- If the Insured has a concern about a claim denial, the Insured may appeal the denial by submitting a written appeal request to Maksin Management Corp;
- Assistance will be available to the Insured with respect to the appeal process. For assistance, the Insured may contact: Maksin Management Corp at 1-888-679-5676;
- A written acknowledgment of each appeal will be sent to the Insured;
- The Company will make a decision regarding the appeal within 30 days of the date the appeal is received or sooner if the insured's health, life or ability to regain maximum function are in jeopardy, in which case a decision will be made within 72 hours of the date the appeal is received.
- The Company will cooperate fully with representatives designated in writing by the Insured;
- The Company will investigate all information submitted;
- Written notification of our decision will be provided to the Insured, and, with the Insured's permission, to the providers. The notice will explain the decision and provide the supporting documentation and clinical bases for our decision, and inform the insured of his or her right to request an independent review of the decision.

INFORMATION, BRANCH CAMPUSES

Obtain claim forms and advice at these locations:

WSU Spokane:	130 Student Affairs Office 600 N. Riverpoint Blvd. Spokane, WA 99210 (509) 358-7978	WSU Tri-Cities:	West Building 269K 2710 University Dr. Richland, WA 99354 (509) 372-7228
--------------	--	-----------------	---

WSU Vancouver: Student Services Bldg.
14204 NE. Salmon Creek Ave.
Vancouver, WA 98686
(360) 546-9559

TRAVEL GUARD

PROCEDURES ON HOW TO ACCESS TRAVEL GUARD 24-HOUR ASSISTANCE CALL CENTER

How to Contact Travel Guard:

- Inside the U.S. and Canada, dial 1-877-249-5362 toll-free.
- Outside the U.S. and Canada:
 - Request an international operator.
 - Ask the international operator to connect to an AT&T operator.
 - Request the AT&T operator to place a collect call to the USA at 1-715-295-9625.
- Our fax number is 01-262-364-2203.

When to Contact Travel Guard:

- Call Travel Guard when you require medical assistance or have a medical emergency.
- Call Travel Guard for all non-medical situations (lost luggage, lost documents, legal help, etc.).
- Call Travel Guard whenever there is a question.

Travel Guard is available 24-hours-a-day/7-days-a-week/365-days-a-year.

Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help you should the need arise while you are traveling or away from home. The Travel Guard Medical Staff consists of full-time, onsite Registered Nurses and Emergency Doctors who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a doctor has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide to Travel Guard when you call:

- Advise Travel Guard who you are insured by.
- Provide your Policy number, CHH0042932 /CAS9499390.
- Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

DESCRIPTION OF SERVICES

Information/General: These services include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available currency exchange rates, local Bank/Government holidays, and, by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage & relay and translation services.

- Visa & Immunization
- Weather & Exchange Rates
- Environmental & Political Warnings

Technical: These services provide assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Guard can arrange cash transfers and vehicle return in the event of Sickness or accident, provide legal

referrals, and help with arrangements for members who encounter enroute emergencies that force them to interrupt their trips.

- Legal Referral
- Embassy/Consulate Information
- Lost/Stolen Luggage and Personal Effects Assistance
- Lost Document Assistance/Cash Transfer Assistance
- En-route Travel Assistance
- Claims-related Assistance
- Telephone Interpretation

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard's Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler's behalf. These services include Doctor/dental/Hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains, and insurance/claims coordination.

Medical Assistance:

- Medical Referral
- Out-patient Assistance
- In-patient Assistance

AMERICAN HEALTH HOLDING, INC.

24-HOUR STUDENT EMERGENCY CARE HOTLINE

(American Health Holding, Inc. is not affiliated with the National Union Fire Insurance Company of Pittsburgh, Pa.)

**For confidential health care advice and information,
24 hours a day, 365 days a year, call toll-free 866-315-8756.**

Comprehensive Resources and Advice from Registered Nurses

- Direct access to an extensive Health Information Library, covering issues ranging from women's health to pediatrics. Detailed directories with topic codes and instructions for access to health related topics.
- Choose to talk directly with a nurse. Discuss a current illness or health issue, or receive counseling on chronic conditions. Nurses can also educate callers about treatments, lifestyle choices and self-care strategies.
- Integrated phone services to specially trained personnel, trained to provide referral services for a number of health related concerns including mental health and/or substance abuse.

DENTAL FOR STUDENTS ONLY

These Dental Benefits are underwritten by Washington Dental Service (WDS), Seattle, Washington. Please see dental claims and customer service information at the end of this section.

Most dentists in Washington and Idaho are Delta Dental Participating Dentists. For best benefits please verify that yours is a Delta Dental Participating Dentist before receiving care. Listings of participating dentists are available from the WSU Health and Wellness Services Office or WDS upon request.

ELIGIBILITY, COVERAGE DATES AND TERMINATION

Those eligible to enroll in this Plan are WSU Graduate Student Assistants who are paying tuition and fees for 10 or more credit hours; who have an Assistantship stipend of at least 50%; who are eligible for a Qualified Tuition Reduction or a Tuition Fee Waiver and full-time Graduate Research Fellows/Trainees who are paid a stipend of at least \$800.00 per month; who are engaged in research similar to that of a Research Assistant and who are eligible for a Qualified Tuition Reduction or a Tuition Fee Waiver.

Each Eligible Graduate Student Assistant or Graduate Research Fellow/Trainee will be advised of automatic enrollment by the Health and Wellness Services Office.

Eligible Graduate Student Assistants and Graduate Research Fellows/Trainees will be insured during these policy periods:

Fall – Coverage begins August 16, 2011 and ends at 12:01 am., January 1, 2012

Spring/Summer – Coverage begins January 1, 2012 and ends at 12:01 a.m., August 16, 2012

Coverage will terminate for a Covered Student (a) upon expiration of the policy term; (b) upon the date of entry into an armed service on active duty; and (c) for a Student whose appointment as a Graduate Student Assistant or Graduate Research Fellow/Trainee terminates, at the end of the policy period during which the appointment terminated.

CLAIMS PROCEDURE

You may select any licensed dentist. Tell your dentist you are covered by the WSU/GSA Dental Plan through WDS Group No. 00681 and give your member identification number.

Delta Dental/Washington Dental Service Participating Dentists

If you select a dentist who is a WDS participating dentist, that dentist has agreed to provide treatment for eligible persons covered by WDS plans. You won't have to hassle with sending in claim forms. Participating dentists complete claim forms and submit them directly to WDS. They receive payment directly from WDS. You will be responsible only for stated coinsurance, deductibles, any amount over the plan maximum and for any elective care you choose to receive outside the covered dental benefits. You will not be charged more than the participating dentist's approved fee or the fee that the WDS dentist has filed with us.

Nonparticipating Dentists in Washington State

If you select a dentist who is not a WDS participating dentist, you are responsible for having your dentist complete and sign a claim form. We accept any American Dental Association-approved claim form that your dentist may provide. You can also download

claim forms from our website at www.DeltaDentalWA.com. It is up to you to ensure that the claim is sent to WDS. Payment for services performed by a nonparticipating dentist will be based on actual charges or WDS's maximum allowable fees, whichever is less. You will be responsible for any balance remaining. Please be aware that WDS has no control over nonparticipating dentists' charges or billing procedures.

Out-of-State Dentists

If you receive treatment from a dentist outside Washington state, you may be responsible for having the dentist complete and sign a claim form. It may be up to you to ensure that the claim is sent to WDS. Payment will be based upon actual charges or the allowable fee, whichever is less.

You will receive a Notice of Payment showing the amount paid on your claim and the amount that is your responsibility.

You may obtain claim forms from WSU Health & Wellness Services Office, Washington Building, (509) 335-3575 or WDS. WDS shall not be obligated to pay for treatment performed if claim forms are not submitted for payment in a timely manner after the date of such treatment. Written notice of claim for benefits must be received by WDS within six months after the date of treatment or as soon as medically possible. No claims will be accepted later than one year from the date of treatment unless the Eligible Person is legally incapacitated throughout the year.

COORDINATION OF BENEFITS

If an eligible person is entitled to benefits under two or more group dental plans, the amount payable under this plan will be coordinated with any other plan. The amount paid by WDS, together with amounts from other group programs, will not exceed the total of the highest allowable dental expenses incurred.

The benefits of the plan that does not have a coordination of benefits (COB) provision will be primary. The benefits of the plan that covers the eligible student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first.

If the above order does not establish the primary plan, then the plan that has covered that person for the longest period of time is the primary plan.

If you are covered by more than one health plan, you or your provider should file all your claims with each plan at the same time.

If payments that should have been made under this plan are made by another plan, WDS has the right, at its discretion, to remit to the other plan the amount it determines appropriate. To the extent of such payments, WDS is fully discharged from liability under this plan.

In the event WDS makes payments in excess of the maximum amount, WDS shall have the right to recover the excess payments from the patient, the subscriber, the provider or the other plan.

If you are covered by more than one dental benefit plan, and you do not know which your primary plan is, you or your provider should contact any one of the dental plans to verify which plan is primary. The dental plan you contact is responsible for working

with the other plan to determine which is primary and will let you know within 30 calendar days.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

Note: All dental plans have timely claim filing requirements. If you or your provider fails to submit your claim to a secondary dental plan within the plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary dental plan, you or your provider will need to submit your claim to the secondary dental plan within its claim filing time limit to prevent a denial of the claim.

SUMMARY OF DENTAL BENEFITS

POLICY YEAR DEDUCTIBLE PER PERSON – \$50	Waived on Class I
Reimbursement Levels	
Class I	90%
Class II	75%
Policy Year Maximum per Person	\$1,000

The payment level for covered dental expenses arising as a direct result of an accidental bodily injury is 100%, up to the unused policy year maximum (deductible is waived).

COVERED TREATMENT CLASS I

DIAGNOSTIC

Covered Treatment

- Diagnostic evaluation for routine or emergency purposes.
- X-rays.

Limitations

- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is paid as a periodic oral evaluation.
- Routine evaluation is covered twice in a Policy Year. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a Policy Year.
- A complete series or a panorex X-ray is covered once in a 3-year period from the date of service.
 - Any number or combination of X-rays billed for same date of service that equals or exceeds the allowed fee for a complete series will be paid as a complete series.
- Supplementary bitewing X-rays are covered once in a Policy Year.
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I covered dental benefits.

Exclusions

- Consultations or elective second opinions.
- Study models.

PREVENTIVE

Covered Treatment

- Prophylaxis (cleaning).
- Periodontal maintenance.
- Space maintainers.
- Preventive resin restoration.

Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a Policy Year.
 - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- Space maintainers are covered once in a patient's lifetime for the same missing tooth or teeth.
- Preventive resin restorations
 - Payment for preventive resin restorations will be for permanent molars with no restorations on the occlusal (biting) surface.
 - The application of preventive resin restoration is not a paid covered benefit for two years after a fissure sealant or preventive resin restoration on the same tooth.

Exclusions

- Plaque control program (oral hygiene instruction, dietary, instruction and home fluoride kits).
- Fissure sealants.
- Topical application of fluoride.

CLASS II

You should consult the provider regarding any charges that may be your responsibility before treatment begins.

SEDATION

Covered Treatment

- General anesthesia when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.
- Intravenous sedation when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary, for a physically or developmentally disabled person, when in conjunction with Class I and II covered dental benefits.
- Intravenous sedation is covered in conjunction with certain covered endodontic,

periodontic and oral surgery procedures, as determined by WDS.

- Either general anesthesia or intravenous sedation (but not both) is covered when performed on the same day.
- General anesthesia or intravenous sedation for routine post-operative procedures is not a paid covered benefit.

PALLIATIVE TREATMENT

Covered Treatment

- Palliative treatment for pain.

RESTORATIVE

Covered Treatment

- Restorations (fillings).
- Stainless steel crowns.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a 2-year period from the date of service for the following reasons: Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay); Fracture resulting in significant loss of tooth structure (missing cusp); Fracture resulting in significant damage to an existing restoration.
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspids), it will be considered an elective procedure and an amalgam allowance will be made. The difference in cost is your responsibility.
- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made, with any difference in cost being the responsibility of the eligible person.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.
- Stainless steel crowns are covered once in a 2-year period from the seat date.

Exclusions

- Overhang removal, copings, re-contouring or polishing of restoration.

ORAL SURGERY

Covered Treatment

- Removal of teeth.
- Preparation of the mouth for insertion of dentures.
- Treatment of pathological conditions and traumatic injuries of the mouth.

Exclusions

- Bone replacement graft for ridge preservation.
- Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth.
- Tooth transplants.
- Materials placed in extraction sockets for the purpose of generating osseous filling.

PERIODONTICS

Covered Treatment

- Surgical and nonsurgical procedures for treatment of the tissues supporting the

teeth.

- Services covered include periodontal scaling/root planing, periodontal surgery and limited adjustments to occlusion (8 teeth or less).

Limitations

- Periodontal scaling/root planing is covered once in a Policy Year.
- Limited occlusal adjustments are covered once in a Policy Year.

Exclusions

- Occlusal guard (nightguard).
- Major (complete) occlusal adjustment.

ENDODONTICS

Covered Treatment

- Procedures for pulpal and root canal treatment.
- Services covered include pulp exposure treatment, pulpotomy and apicoectomy.

Limitations

- Root canal treatment on the same tooth is covered only once in a 2-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a different dental office.

Exclusions

- Bleaching of teeth.

ACCIDENTAL INJURY

Washington Dental Service will pay 100% of the filed fee or the maximum allowable fee of Class I and Class II covered dental benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused program maximum. The accidental bodily injury must have occurred while the patient was eligible. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

ADDITIONAL PROCEDURES

In some cases, there may be two or more treatment options that meet the standard of care for dental needs covered by the program. In such instances, the program will pay the proper percentage of the lowest fee. The balance of treatment cost remains the eligible person's responsibility.

GENERAL LIMITATIONS (Dental)

- Dentistry for cosmetic reasons is not a paid covered benefit.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth are not a paid covered benefit.

GENERAL EXCLUSIONS (Dental)

This Plan does NOT cover the following:

- Services for injuries or conditions which are compensable under Worker's Compensation or Employer's Liability laws, services which are provided to the covered Student by any federal, state or provincial government agency or provided without cost to the covered Student by any municipality county, or other political subdivision other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
- Bleaching of teeth.
- Application of desensitizing agents.
- Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, WDS, in conjunction with the American Dental Association, will consider if (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition and (4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.

Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental may be appealed to WDS. By law we must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20 day period may be extended only with written consent of the covered Student.

Whenever WDS makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, WDS shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, WDS shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-620(2).

- Analgesics such as nitrous oxide, conscious sedation, or euphoric drugs or injections.
- Prescription drugs.
- In the event a covered Student fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
- Dental services started prior to the date the Student became covered for services under this program.
- Broken appointments, patient management problems, and completing claim forms.
- Habit breaking appliances, including nightguards, except as specifically provided herein.

- Orthodontic services or supplies and services for temporomandibular joint dysfunction.
- TMJ services or supplies.
- This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, under-insured motorist, personal injury protection (PIP), commercial liability, homeowners policy or other similar type of coverage.
- In the event a student ceases to be covered, WDS shall not pay for services beyond the termination date, except for the completion of single procedures prepared prior to termination but completed within 3 weeks of termination.
- Expense incurred which is recoverable under any other insurance policy or service contract, and expense incurred as a result of acts of some other person and payable by that person.
- All other services not specifically included in this program as covered dental benefits.

WDS shall determine whether services are covered dental benefits in accordance with standard dental practice and the general Limitations and Exclusions shown in this benefits booklet. Should there be a disagreement regarding the interpretation of such benefits, the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this benefits booklet and may seek judicial review of any denial of coverage of benefits.

CLAIM REVIEW AND APPEAL

Predetermination of Benefits

A predetermination is a request made by your dentist to WDS to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services. Please be aware that the predetermination is not a guarantee of payment but strictly an estimate for services. Payment for services is determined when the claim is submitted. (Please refer to the Initial Benefits Determination section regarding claims requirements.)

A standard predetermination is processed within 15 days from the date of receipt if all appropriate information is completed. If it is incomplete, WDS may request additional information, request an extension of 15 days and pend the predetermination until all of the information is received. Once all of the information is received a determination will be made within 15 days of receipt. If no information is received at the end of 45 days, the predetermination will be denied.

Urgent Predetermination Requests

Should a predetermination request be of an urgent nature, where a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, WDS will review the request within 72 hours from receipt of the request and all supporting documentation. When practical, WDS may provide notice of determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to WDS for payment, modification, or denial of services. In accordance with regulatory requirements, WDS processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, you will be furnished with a written explanation of benefits (EOB) that will include the following information:

- The specific reason for the denial or modification
- Reference to the specific plan provision on which the determination was based
- Your appeal rights should you wish to dispute the original determination

APPEALS OF DENIED CLAIMS

Informal Review

If your claim for dental benefits has been denied, either in whole or in part, you have a right to request an informal review of the decision. Either you, or your Authorized Representative, must submit your request for a review within 180 days from the date your claim was denied (please see your Explanation of Benefits form). A request for a review may be made orally or in writing, and must include the following information:

- Your name and ID number
- The group name and number
- The claim number (from your Explanation of Benefits form)
- The name of the dentist

Please submit your request for a review to:

Washington Dental Service
Attn: Appeals Coordinator
P.O. Box 75983
Seattle, WA 98175-0983

For oral appeals, please refer to the phone numbers listed on the inside back cover of your benefit booklet.

You may include any written comments, documents or other information that you believe supports your claim.

WDS will review your claim and make a determination within 30 days of receiving your request and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision.

Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

Appeals Committee

If you are dissatisfied with the outcome of the informal review, you may request that your claim be reviewed formally by the WDS Appeals Committee. This Committee

includes only persons who were not involved in either the original claim decision or the informal review.

Your request for a review by the Appeals Committee must be made within 90 days of the post-marked date of the letter notifying you of the informal review decision. Your request should include the information noted above plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeal Committee will review your claim and make a determination within 30 days of receiving your request or within 20 days for Experimental/Investigational procedure appeals and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigation in nature, WDS will consult with a dental professional advisor.

The decision of the Appeals Committee is final. If you disagree with this the outcome of your appeal and you have exhausted the appeals process provided by your group plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter.

Authorized Representative

You may authorize another person to represent you and to whom WDS can communicate regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form not be returned or any document confirming the right of the individual to act on your behalf (i.e., power of attorney), the appeal will be closed.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

WDS is committed to protecting the privacy of your dental health information. The Health Insurance Portability and Accountability Act (HIPAA) requires WDS to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting www.deltadentalwa.com. You may also request a printed copy by calling the WDS privacy hotline at (206) 985-5963.

MYSMILE[®] PERSONAL BENEFITS CENTER

The MySmile[®] personal benefits center, available on WDS's Web site at www.DeltaDentalWA.com, is customized to your individual needs and provides you with answers to questions about your dental coverage. A simple, task-oriented, self-service interface, MySmile lets you search for a dentist in your plan network, review your recent dental activity, check details of your plan coverage, view and print your ID card, check the status of current claims and more.

DENTAL CLAIMS QUESTIONS

For answers about benefits or your claim, please call or write:

Washington Dental Service
P.O. Box 75983, Seattle, WA 98175-0983
Telephone (206) 522-2300
Toll Free 1-800-554-1907
WDS Group No. 00681
Website: www.DeltaDentalWa.com

ADDITIONAL INFORMATION

The Master Policy is on file at the University. Questions may be directed to the Health and Wellness Services Office, Washington Bldg., Washington State University, Pullman, Washington 99164-2302, phone (509) 335-3575.

Student Medical Insurance Coverage is not required for access to Health and Wellness Services.

STUDENT MEDICAL PLAN

UNDERWRITTEN BY:

**National Union Fire Insurance Company of Pittsburgh, Pa.,
with its principal place of business in New York, NY
("the Company")**

This is only a brief description of the coverage available under Policy series S30494NUFIC. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between the contents of this document and the Policy, or if any point is not covered in this document, the terms and conditions of the Policy will govern in all cases.

Administrator Policy No. CHH0042932
Underwriter Reference No. CAS9499390

NON-RENEWABLE ONE YEAR TERM INSURANCE

The Policy is non-renewable one year term insurance. Similar coverage may be purchased for the following academic year. It is the Covered Student's responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new Policy Year.

STUDENT DENTAL BENEFITS

GROUP NO. 00681 UNDERWRITTEN BY:

**WASHINGTON DENTAL SERVICE
P.O. BOX 75983
SEATTLE, WASHINGTON 98175-0983**