## DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET

<table>
<thead>
<tr>
<th></th>
<th>Preferred Provider</th>
<th>HSA Qualified Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Individual)</td>
<td></td>
<td>$3,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Combined Medical and Prescription Drug deductible)</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>20% Network</td>
<td>20% Network</td>
</tr>
<tr>
<td></td>
<td>40% Non-Network</td>
<td>40% Non-Network</td>
</tr>
<tr>
<td><strong>Annual</strong></td>
<td><strong>Out-of-Pocket</strong></td>
<td></td>
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<tr>
<td><strong>Expense Limits</strong></td>
<td></td>
<td></td>
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<tr>
<td>(Individual)</td>
<td></td>
<td></td>
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<tr>
<td><em>The maximum amount you pay yearly including deductible and coinsurance</em></td>
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</tbody>
</table>

| **$500 Plan:**          | $1,000 Network     | $5,250 Network                   |
|                        | $2,000 Non-Network | $10,500 Non-Network              |
|                        | $ 500 Prescription Drug | (Combined Medical and Prescription Drug out-of-pocket limit) |

| **$1,000 Plan:**        | $1,650 Network     | $ 5,000                          |
|                        | $3,300 Non-Network | $10,000                          |
|                        | $ 850 Prescription Drug |                                  |

| **$2,500 Plan:**        | $5,000 Network     |                                  |
|                        | $7,500 Non-Network |                                  |
|                        | $5,000 Prescription Drug |                                  |

| **$5,000 Plan:**        | $10,000 Network    |                                  |
|                        | $15,000 Non-Network |                                  |
|                        | $ 5,000 Prescription Drug |                                  |

## PRESCRIPTION DRUGS

| **$500 Plan:**          | $2 copay           | 20%                              |
|                        | (After annual combined Medical & Prescription Drug deductible is met) |
| **Generic:**           |                    |                                  |
| **Preferred Brand:**   | 10% up to $50      |                                  |
| **Non-Preferred:**     | 15% up to $100     |                                  |

| **$1,000 Plan:**        | $5 copay           |                                  |
|                        | (After annual combined Medical & Prescription Drug deductible is met) |
| **Generic:**           |                    |                                  |
| **Preferred Brand:**   | 15% up to $50      |                                  |
| **Non-Preferred:**     | 20% up to $100     |                                  |

| **$2,500 and $5,000 Plans:** | $500 Prescription Drug |                                  |
|                             | (After annual combined Medical & Prescription Drug deductible is met) |
| **Drug Deductible:**       | $500               |                                  |
| **Generic:**               | 20%                |                                  |
| **Preferred Brand:**       | 30%                |                                  |
| **Non-Preferred:**         | 50%                |                                  |

**NOTE:** All coinsurance amounts are based on allowable charges. Balance billing may apply if provider is not in network.
### MEDICAL BENEFITS

#### PREVENTIVE CARE
- Preventive care exams and immunizations (deductible waived)
  - Preferred Provider: 0% / 40%
  - HSA Qualified Preferred Provider: 0% / 40%

#### PROFESSIONAL SERVICES
- Office, inpatient, and outpatient professional services
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%

#### DIAGNOSTIC SERVICES
- Diagnostic x-ray & laboratory services
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Mammography (deductible waived)
  - Preferred Provider: 0% / 40%
  - HSA Qualified Preferred Provider: 0% / 40%

#### HOSPITAL SERVICES
- Inpatient (2) and outpatient facility services
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%

#### EMERGENCY CARE
- Emergency room
  - Preferred Provider: 20% / 20%
  - HSA Qualified Preferred Provider: 20% / 20%

#### OTHER SERVICES
- Acupuncture
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Ambulance
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Chemical Dependency
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Diabetes Education (certified only; deductible waived)
  - Preferred Provider: 0%
  - HSA Qualified Preferred Provider: 0%
- Habilitative Services
  - Preferred Provider: 20% / 40%
    - 30 Inpatient days PCY
    - 25 Outpatient visits PCY
  - HSA Qualified Preferred Provider: 20% / 40%
    - 30 Inpatient days PCY
    - 25 Outpatient visits PCY
- Home Health Care (2)
  - Preferred Provider: 20% / 40%
    - 130 visits PCY
  - HSA Qualified Preferred Provider: 20% / 40%
    - 130 visits PCY
- Hospice and Respite Care
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Massage Therapy (when prescribed by a physician)
  - Preferred Provider: 20% / 40%
    - 12 visits PCY
  - HSA Qualified Preferred Provider: 20% / 40%
    - 12 visits PCY
- Maternity Services
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Medical Supplies and Equipment (3)
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Mental Health Services (2)
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Oral Surgery
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Rehabilitation Therapy Services (Physical, Speech, Occupational, and Respiratory) (2)
  - Preferred Provider: 20% / 40%
    - 30 Inpatient days PCY
    - 25 Outpatient visits PCY
  - HSA Qualified Preferred Provider: 20% / 40%
    - 30 Inpatient days PCY
    - 25 Outpatient visits PCY
- Skilled Nursing Facility (2)
  - Preferred Provider: 20% / 40%
    - 100 days PCY
  - HSA Qualified Preferred Provider: 20% / 40%
    - 100 days PCY
- Spinal Manipulations
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Tobacco Cessation (WSHIP’s program only)
  - Preferred Provider: 0%
  - HSA Qualified Preferred Provider: 0%
- Temporomandibular Joint (TMJ) Disorders
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%
- Transplant Surgery (3)
  - Preferred Provider: 20% / 40%
  - HSA Qualified Preferred Provider: 20% / 40%

#### NOTES:
- (1) PCY = Per Calendar Year;
- (2) A prior review for Medical Necessity is recommended;
- (3) Pre-approval is required.
**COVERED PRESCRIPTION DRUGS**

Prescription drug services are administered by Express Scripts; 1-800-859-8810. Prescriptions must be obtained from WSHIP’s network of pharmacies. For your long-term prescriptions, you can often save time and money by filling your prescriptions through our mail order pharmacy program.

Most plans have different copays or coinsurance for generics, preferred brands and non-preferred brand-name drugs; and some drugs require a coverage review (prior-authorization). A copy of our prescription drug formulary and information about coverage reviews and the mail order program is available at [www.wship.org](http://www.wship.org) or by calling 1-800-859-8810.

**LIMITED COVERED SERVICES**

The following are limited covered services:
- Acupuncture
- Habilitative Services
- Home Health Care
- Massage Therapy
- Rehabilitation Services
- Skilled Nursing Facility
- Investigational and Experimental Services

**EXCLUSIONS TO COVERED SERVICES**

Benefits are not provided for treatment, surgery, services, drugs or supplies for any of the following:
- Cosmetic and Reconstructive Services (with some exceptions)
- Counseling, Educational or Training Services (except Diabetes Education)
- Custodial Care
- Dental Care
- Fertility or Infertility; and Sterilization Reversal
- Foot Care (routine care)
- Governmental Medical Facilities
- Military and War-Related Conditions; and Illegal Acts
- Not Medically Necessary Care
- Obesity and Weight Control
- Services For Which You Do Not Have to Pay
- Sexual Dysfunction
- Transportation or Travel
- Vision and Hearing Services
- Work-Related Conditions
- Services or supplies not specifically listed as covered in the Plan Policy

**ELIGIBILITY**

To be eligible for WSHIP, you must meet all of the following requirements:
- You are a resident of Washington State;
- You were enrolled in WSHIP prior to December 31, 2013 and have not had a termination of WSHIP coverage since then or you live in a Washington State county where an individual benefit plan is not offered during defined open enrollment or special enrollment periods; and
- You are not eligible for Medicaid or Medicare coverage.

**CHANGING PLANS AFTER YOU ENROLL**

Once you enroll in a plan, you may only switch plans every January 1st and you may only change to a plan that has the same or higher deductible and is not more comprehensive than your current plan.

**PROVIDER NETWORKS**

Provider network services are provided by First Choice Health for medical services. Visit [www.fchn.com](http://www.fchn.com) or call 1-800-231-6935 for network information. The retail and mail order pharmacy network is provided by Express Scripts; visit [www.wship.org](http://www.wship.org) or call 1-800-859-8810 for pharmacy network information.

**CARE MANAGEMENT**

For Care Management services, call 1-800-549-7549. Services include medical necessity reviews and case and disease management programs.

**PRIOR REVIEWS FOR MEDICAL NECESSITY**

A medical necessity review should be requested by you or your provider before all admissions to a hospital, skilled nursing facility or other covered facility, and for outpatient services listed on your ID card. This review lets you and your provider know ahead of time if the service is Medically Necessary. We do not pay for any services that are determined by WSHIP to be not Medically Necessary. To request a review, call 1-800-549-7549.

**MINIMUM ESSENTIAL COVERAGE DESIGNATION**

Minimum essential coverage is designated by federal regulations to include state high risk pool coverage established before November 26, 2014 in any state. This includes WSHIP and means that WSHIP plans are designated as minimum essential coverage and satisfy the individual responsibility requirement of the Affordable Care Act and Internal Revenue Code. WSHIP benefits may not be the same as health plans in the individual market.

**HOW TO CONTACT US**

Customer Service: 1-800-877-5187
Mail: PO Box 1090, Great Bend, KS 67530
[www.wship.org](http://www.wship.org)

**NOTE:** This information is not a contract, nor does it cover all exclusions or limitations. Once you enroll, you will receive a copy of your Plan Policy which will outline your coverage in detail. For a sample copy of the Plan Policy, contact Customer Service or go to [www.wship.org](http://www.wship.org)