



PO Box 1090  
Great Bend, KS 67530  
Fax: (620) 793-1199  
www.wship.org

Questions? Call 1-800-877-5187  
¿Preguntas? Teléfono 1-800-877-5187

November 2017

## IMPORTANT NOTICE

**Re: - Basic Plan Premium Rate Change Effective January 1, 2018  
- Eligibility Verification Form Due December 15, 2017**

Dear «First»,

This letter contains important information about your premium rate change that is effective January 1, 2018 and Eligibility Verification Form that must be returned to us by December 15 to renew your WSHIP coverage. We have also included important reminders about Medicare Advantage Plans and Medicare Part D.

Please read this information carefully and contact us at **1-800-877-5187** if you have any questions.

### **2018 WSHIP Premium Rates**

Your WSHIP monthly premium rate will be changing effective January 1, 2018. By law, we are required to base our rates on what other carriers in the state charge for similar benefits. Please consult the enclosed rate chart to find your new rate.

### **Eligibility Verification Form Due December 15, 2017**

WSHIP is required to verify continued eligibility of all enrollees. This eligibility verification requirement is combined with our yearly rate notice to simplify the process of returning this important information to us. Please return the enclosed purple form by December 15.

### **Important Reminder for Enrollees under Age 65**

Medicare enrollees under age 65 (e.g., enrollees with kidney disease or a disability) generally have additional options for Medicare Supplement coverage when they turn age 65 and premiums may be much lower than WSHIP's premiums. If you will be turning age 65 this year, we encourage you to explore these options several months prior to turning age 65. You cannot be turned down or charged a higher premium because you have a pre-existing condition as long as you enroll during Medicare's guaranteed issue period. For more information, call 1-800-MEDICARE, visit [www.medicare.gov](http://www.medicare.gov) on the web, or call the Insurance Commissioner's SHIBA HelpLine at 1-800-562-6900.

## Medicare Advantage Plans

You may wish to consider enrolling in a Medicare Advantage Plan instead of continuing your WSHIP coverage. Premiums for Medicare Advantage Plans may be less than WSHIP's premiums. You cannot be denied coverage due to health status except for end stage renal disease (ESRD). Some Medicare Advantage Plans include prescription drug coverage, while with others you must enroll separately in a Medicare Prescription Drug Plan (PDP). We encourage you to contact an insurance agent for additional information. Be sure to also check with your doctor and other health care providers to see which Medicare Advantage Plans they accept. For more information, call 1-800-MEDICARE, visit [www.medicare.gov](http://www.medicare.gov) on the web, or call the Insurance Commissioner's SHIBA HelpLine at 1-800-562-6900. Open enrollment for Medicare Advantage Plans is October 15 through December 7.

## Open Enrollment for Medicare Part D

As a reminder, you may enroll or change Medicare Part D Prescription Drug Plans (PDPs) during Medicare's open enrollment period which begins October 15 and ends December 7. For more information, call 1-800-MEDICARE, visit [www.medicare.gov](http://www.medicare.gov) on the web, or call the Insurance Commissioner's SHIBA HelpLine at 1-800-562-6900. If you do not wish to enroll, or you wish to keep your current Medicare Part D Plan, you do not need to do anything.

## Questions?

If you have questions or need assistance during this year's WSHIP open enrollment, please call WSHIP Customer Service at **1-800-877-5187**. Information is also available at [www.wship.org](http://www.wship.org).

## Enclosures:

- **2018 WSHIP Premium Rates**
- **Eligibility Verification Form (Purple Paper) – RETURN by December 15**
- **Summary of Benefits**
- **Personalized Schedule of Benefits**
- **Return Envelope**

### ***IMPORTANT!***

**Please RETURN Eligibility Verification Form by December 15 to renew your WSHIP coverage.**

**Washington State Health Insurance Pool (WSHIP)  
2018 Monthly Premium Rates**

**MEDICARE BASIC PLAN**

		Age	Basic Plan
Income Level			Regular Rates ----- <i>Table B1</i>
<b>Full Premium</b>	Under 65		\$415
	65+		\$332
<b>You were enrolled in a prior medical benefit plan during the 63-day period prior to application to WSHIP with continuous enrollment for 18 months.</b>	Under 65		\$415
	65+		\$276
<b>You have been enrolled in WSHIP continuously for 36 months or more.</b>	Under 65		\$415
	65+		\$315
<b>You have been enrolled in WSHIP for 36 months or more <u>AND</u> had 18 months of continuous enrollment in a prior medical benefit plan.</b>	Under 65		\$415
	65+		\$263

Information and premium rates contained herein are subject to change with a 30-day advance notification.



WASHINGTON STATE HEALTH INSURANCE POOL

PO Box 1090
Great Bend, KS 67530
1-800-877-5187
Fax # 620-793-1199

Tray
Enrollee Name
Address 1,
Address 2
City, State zip
Bar code

IMPORTANT
This form must be SIGNED and RETURNED by
DUE DATE: DECEMBER 15, 2017

WSHIP ELIGIBILITY VERIFICATION FORM (Basic and Basic Plus Plans) WSHIP must confirm that you continue to meet eligibility requirements. Your prompt response is appreciated. Failure to respond may lead to termination of your coverage. If you have questions, please call WSHIP at 1-800-877-5187.

WASHINGTON STATE RESIDENCY

1. Please provide your physical address and information below.

Table with 3 columns: Physical Address of your current residence - Required, Mailing Address if different than physical address, Billing Address of 3rd party paying premiums (if applicable). Includes fields for Name, Address, City, State & Zip, Telephone Number, Cell Number, Email Address, and Secondary Contact information.

OTHER COVERAGE INFORMATION

2. Please indicate your Medicare coverage below:

Medicare: Part A [ ] Part B [ ] Part D [ ] Not Eligible for Medicare\* [ ]

\* If you are 65 or older but not eligible for Medicare, please enclose proof of ineligibility.

3. Are you currently enrolled in a Medicare Prescription Drug Plan (PDP)? Yes [ ] No [ ]

If yes, please enclose a copy of your PDP card and indicate name and effective date below:

Name of Medicare PDP \_\_\_\_\_ Effective Date \_\_\_\_\_

4. Are you enrolled in any other coverage such as Medicaid or a group health plan? Yes [ ] No [ ]

Name of other insurer \_\_\_\_\_ Effective Date \_\_\_\_\_

If you have other coverage and will CANCEL YOUR WSHIP POLICY, what is the effective date for cancellation?

\_\_\_\_\_

PLEASE SIGN BELOW: I attest that my responses on this form are true and complete.

X
Signature
Printed Name: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Date Signed
Enrollee ID # <<participant>>

SIGNATURE REQUIRED - Stamped addressed envelope enclosed



# Summary – Effective January 1, 2018

## Basic Plan (Medicare)

This plan is for qualified individuals enrolled in Medicare Part A and Part B. It pays as secondary insurance and covers patient responsibility for Medicare-eligible expenses. This plan does not provide prescription drug coverage except supplemental benefits for drugs covered under Medicare Part B.

**WSHIP covers 100% of your Medicare deductible and coinsurance on Medicare-eligible expenses**

MEDICAL BENEFITS					
<b>ANNUAL DEDUCTIBLE</b> per individual PCY (1)	None				
<b>COINSURANCE</b> (amount you pay for Covered Services <u>not</u> covered by Medicare)	0% for Services covered by Medicare 20% for Covered Services <u>not</u> covered by Medicare				
<b>OUT-OF-POCKET LIMIT</b> PCY (The maximum amount you pay yearly including deductible and coinsurance.)	<table border="1"> <thead> <tr> <th>per Individual</th> <th>per Family</th> </tr> </thead> <tbody> <tr> <td>\$850</td> <td>\$1,700</td> </tr> </tbody> </table>	per Individual	per Family	\$850	\$1,700
per Individual	per Family				
\$850	\$1,700				

COVERED SERVICES	COVERAGE LIMITATIONS	YOU PAY if <u>not</u> covered by Medicare
<b>PREVENTIVE CARE</b> (coinsurance waived)		
Preventive care exams and immunizations	\$500 PCY	0%
<b>PROFESSIONAL SERVICES</b>		
Office, inpatient, and outpatient professional services		20%
<b>DIAGNOSTIC SERVICES</b>		
Diagnostic x-ray & laboratory services		20%
Mammography (coinsurance waived)		0%
<b>HOSPITAL SERVICES</b>		
Inpatient (2) and outpatient facility services		20%
<b>EMERGENCY CARE</b>		
Emergency room		20%
<b>OTHER SERVICES</b>		
Acupuncture	12 visits PCY	20%
Ambulance		20%
Chemical Dependency	30 Inpatient days PCY 28 Outpatient visits PCY	20%
Diabetes Education (certified only; coinsurance waived)		0%
Home Health Care (2)	130 visits PCY	20%
Hospice and Respite Care	Hospice: not limited Respite: \$7,500 PCY	20%
Massage Therapy (when prescribed by a physician)	12 visits PCY	20%
Maternity Services		20%
Medical Supplies and Equipment (3)		20%
Mental Health Services (2)		20%
Oral Surgery		20%
Physical, Speech, Occupational, and Respiratory Therapies (2)		20%
Skilled Nursing Facility (2)	100 days PCY	20%
Spinal Manipulations		20%
Tobacco Cessation (WSHIP's designated provider only)		0% - WSHIP program
Temporomandibular Joint (TMJ) Disorders	\$1,000 lifetime maximum	20%
Transplant Surgery (3)	\$350,000 lifetime maximum	20%
<b>PRESCRIPTION DRUGS</b> are <b>NOT COVERED</b> except for drugs covered under Medicare Part B.		

- NOTES:** (1) PCY = Per Calendar Year  
 (2) A prior review for Medical Necessity is recommended if service is not covered by Medicare  
 (3) Pre-approval is required

## PRESCRIPTION DRUGS

WSHIP's Medicare Basic Plan does not provide coverage for prescription drugs (except for drugs covered under Medicare Part B). Prescription drug services are administered by Express Scripts; 1-800-859-8810.

## LIMITED COVERED SERVICES

- Preventive Care
- Acupuncture
- Chemical Dependency
- Home Health Care and Respite Care
- Massage Therapy
- Skilled Nursing Facility
- Temporomandibular Joint (TMJ) Disorders
- Transplant Surgery
- 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
- Prescription Drugs (except for drugs covered under Medicare Part B)
- 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's Basic Plan, you must meet all of the following requirements:

- You are a resident of Washington State;
- You are enrolled in Medicare Part A and Part B;
- You were rejected for coverage by a health carrier, offered substantially reduced coverage on a Medicare supplemental insurance policy, or you do not have comprehensive Medicare supplement coverage available to you; and
- You do not have access to a reasonable choice of Medicare Advantage Plans (Part C).

## PRE-EXISTING CONDITIONS

This plan contains a 6-month waiting period for pre-existing conditions; the waiting period may be credited or waived based on your prior health care coverage, subject to approval by WSHIP. The pre-existing condition waiting period does not apply to prenatal care services or benefits for outpatient prescription drugs.

## 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).

# WASHINGTON STATE HEALTH INSURANCE POOL (WSHIP)

## SCHEDULE OF BENEFITS

Effective January 1, 2018

### Basic Plan

Please read this Schedule carefully. Your benefits are based on the information provided on this Schedule. If you believe there could be an error, notify our Administrator immediately at 1-800-877-5187 or write to us at PO Box 1090, Great Bend, KS 67530. You must include your name and policy number in any communication.

**Enrollee Name:** «FNAME» «LNAME»

**Policy Number:** «POLICY\_»

**Coverage Effective Date:** «EFFECTIVE\_DATE»

**Deductible:** None

**Coinsurance and Out-of-Pocket Expense Limits:**

Your Policy's coinsurance and out-of-pocket limits are contained in the table below.

Coinsurance*	Medical Out-of-Pocket Expense Limit	Prescription Drug Out-of-Pocket Expense Limit
0% for Medical and Prescription Drug Services covered by Medicare	Individual: \$ 850 Family: \$1,700	Individual: \$150 Family: \$300
20% for Medical Covered Services not covered by Medicare Parts A or B		
Prescription drug coverage is limited to products covered under Medicare Part B		

This Policy does not have a deductible.

This Policy has separate out-of-pocket expense limits for Medical Services and Prescription Drugs. Once Your out-of-pocket expense limit has been reached, We will pay Covered Services at a rate of 100% for the remainder of the Calendar Year.

\*There is no medical coinsurance; and deductible is waived on preventive care services, diabetes education (certified providers only), and mammography.