Washington State Health Insurance Pool (WSHIP)

2024 WSHIP Benefit Plans Summary and Comparison Chart

(Non-Medicare Plans)

DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET	Preferred Provider	HSA Qualified Preferred Provider
Annual Deductible (Individual)	Choices: $500, $1,000, $2,500 or $5,000 ($2,500 and $5,000 plans have a separate $500 Prescription Drug deductible)	$3,000 (Combined Medical and Prescription Drug deductible)
Coinsurance	20% Network 40% Non-Network	20% Network 40% Non-Network
Annual Out-of-Pocket Expense Limits (Individual) *The maximum amount you pay yearly including deductible and coinsurance*	**$500 Plan:** $1,000 Network $2,000 Non-Network $ 500 Prescription Drug **$1,000 Plan:** $1,650 Network $3,300 Non-Network $ 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	$ 5,250 Network $10,500 Non-Network (Combined Medical and Prescription Drug out-of-pocket limit)
PRESCRIPTION DRUGS	**$500 Plan:** Generic: $2 copay Preferred Brand: 10% up to $50 Non-Preferred: 15% up to $100 **$1,000 Plan:** Generic: $5 copay Preferred Brand: 15% up to $50 Non-Preferred: 20% up to $100 **$2,500 and $5,000 Plans:** Drug Deductible: $500 Generic: 20% Preferred Brand: 30% Non-Preferred: 50%	20% (After annual combined Medical & Prescription Drug deductible is met)

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

2024 WSHIP Benefit Plans Summary and Comparison Chart (continued)

MEDICAL BENEFITS	Preferred Provider		HSA Qualified Preferred Provider	
COINSURANCE (% You Pay) AND LIMITS PCY (1)	*Network*	*Non-Network*	*Network*	*Non-Network*
PREVENTIVE CARE				
Preventive care exams and immunizations *(deductible waived)*	0% / 40%		0% / 40%	
PROFESSIONAL SERVICES				
Office, inpatient, and outpatient professional services	20% / 40%		20% / 40%	
DIAGNOSTIC SERVICES				
Diagnostic x-ray & laboratory services	20% / 40%		20% / 40%	
Mammography *(deductible waived)*	0% / 40%		0% / 40%	
HOSPITAL SERVICES				
Inpatient (2) and outpatient facility services	20% / 40%		20% / 40%	
EMERGENCY CARE				
Emergency room	20% / 20%		20% / 20%	
OTHER SERVICES				
Acupuncture	20% / 40% 12 visits PCY		20% / 40% 12 visits PCY	
Ambulance	20% / 40%		20% / 40%	
Chemical Dependency	20% / 40%		20% / 40%	
Diabetes Education *(certified only; deductible waived)*	0%		0%	
Habilitative Services	20% / 40% 30 Inpatient days PCY 25 Outpatient visits PCY		20% / 40% 30 Inpatient days PCY 25 Outpatient visits PCY	
Home Health Care (2)	20% / 40% 130 visits PCY		20% / 40% 130 visits PCY	
Hospice and Respite Care	20% / 40%		20% / 40%	
Massage Therapy *(when prescribed by a physician)*	20% / 40% 12 visits PCY		20% / 40% 12 visits PCY	
Maternity Services	20% / 40%		20% / 40%	
Medical Supplies and Equipment (3)	20% / 40%		20% / 40%	
Mental Health Services (2)	20% / 40%		20% / 40%	
Oral Surgery	20% / 40%		20% / 40%	
Rehabilitation Therapy Services (Physical, Speech, Occupational, and Respiratory) (2)	20% / 40% 30 Inpatient days PCY 25 Outpatient visits PCY		20% / 40% 30 Inpatient days PCY 25 Outpatient visits PCY	
Skilled Nursing Facility (2)	20% / 40% 100 days PCY		20% / 40% 100 days PCY	
Spinal Manipulations	20% / 40%		20% / 40%	
Tobacco Cessation *(WSHIP's program only)*	0%		0%	
Temporomandibular Joint (TMJ) Disorders	20% / 40%		20% / 40%	
Transplant Surgery (3)	20% / 40%		20% / 40%	

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

2024 WSHIP Benefit Plans Summary and Comparison Chart (continued)

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 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 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 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

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