

EXHIBIT 2

CERTIFICATE OF COVERAGE WASHINGTON HEALTH PROGRAM 2010 MEMBER HANDBOOK

Keep this book handy for quick reference.



2010 Member Handbook
(Certificate of Coverage)



Washington Health ID # _____

Health plan ID # _____

Health plan phone # _____

HCA 27-200 (4/10)

Washington Health: Mon.- Fri. 8 a.m.-5p.m. 1-800-660-9840

Washington Health TTY: Mon.-Fri. 8 a.m.-5p.m. 1-888-923-5622

Contact Information

	Customer Service Hours	Customer Service Phone Numbers	Website Address
Washington Health Program	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-660-9840 TTY: 1-888-923-5622	www.washingtonhealth.hca.wa.gov
Community Health Plan of Washington	Mon. - Fri. 8 a.m. - 6 p.m.	1-800-440-1561 TTY: 1-866-816-2479	www.chpw.org

Premium payments are due by the 5th day of the month before the actual month of coverage; the amount and due date are shown on each month's bill. Your bill is sent about six weeks before the month to be covered by that payment. For example, the bill for August coverage is sent mid-June and payment is due July 5.

Washington Health	Mailing Addresses
Premium payments	P.O. Box 34270, Seattle, WA 98124-1270
General correspondence	P.O. Box 42683, Olympia, WA 98504-2683
Washington Health appeals (see page 20)	P.O. Box 42690, Olympia, WA 98504-2690

If you have any questions about...	Contact...
<ul style="list-style-type: none"> • Adding and/or dropping coverage • Address changes • Your monthly premium • Your bill from Washington Health • Refunds • Basic Health (Subsidized) 	<p>Washington Health at 1-800-660-9840 to talk to a health benefits representative or go to www.washingtonhealth.hca.wa.gov.</p>
<ul style="list-style-type: none"> • A bill for medical care • Choosing a provider • Covered services • Services received from providers • Waiting period 	<p>Community Health Plan of Washington at 1-800-440-1561 to talk to a representative or go to www.chpw.org.</p>
<ul style="list-style-type: none"> • Your medical care • Referrals to specialists 	<p>Your primary care provider.</p>

When you call or write to us...

Include your name, Washington Health ID number, address, and a daytime phone number. Be sure to note the date of the call, the name of the person you talked to, and the organization you contacted. If you have Washington Health through a financial sponsor, first contact your financial sponsor representative. Your representative may have the information you need, or may need to know about the change you're making.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2714. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Keep *Member Alerts* and other updates here

Member Alerts are important updates to this Member Handbook and are one way Washington Health provides you with official notice of program changes; you will receive them periodically, usually with your monthly billing statement. Keep these updates handy, along with this Member Handbook and other information you receive from Washington Health, so that you have the information you need to make the most of your Washington Health coverage.

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Introduction

Washington Health offers quality, low-cost health coverage to eligible people who live in Washington State. It is a Basic Health Plan managed by the Washington State Health Care Authority (HCA). The HCA contracts with health plans to offer Washington Health. Each health plan works with hospitals, clinics, pharmacies, physicians, and other providers to serve our members.

You must give Washington Health the information needed to determine your continued eligibility for the program. You must also give your health plan all the information it needs to process claims, including medical records.

You must follow your health plan's rules to get the benefits described in this handbook. Rules may be different between health plans. Be sure to read your health plan's materials for details, and call the plan if you have questions about your benefits.

This handbook is your "certificate of coverage." It describes what Washington Health covers, what it doesn't cover, and the rules you must follow when using your coverage. This handbook is subject to state laws and rules governing Washington Health.

Keep this Member Handbook handy or go online to www.washingtonhealth.hca.wa.gov when you have a question about your benefits. Washington Health may send other important documents, such as Member Alerts and open enrollment materials. These may include updates to this handbook. Always keep them with your Member Handbook.



Throughout this handbook, "you" generally refers to the main subscriber on the Washington Health Program account or to an adult who will be reading and referring to coverage information on behalf of an enrolled child. Washington Health Program, a Basic Health Program, will be referred to as Washington Health in this handbook.

Chapter One: Eligibility for Washington Health

Washington Health is available to anyone who lives in Washington and:

- Is not eligible for free or purchased Medicare.
- At the time of enrollment, is not confined to an institution.
- Is ineligible for coverage under the Washington State Health Insurance Pool (WSHIP) or qualifies to bypass the standard health questionnaire under state law.
- Is not receiving Washington Department of Social and Health Services (DSHS) medical assistance (Medicaid) or subsidized Basic Health benefit.

Family members who should be listed as dependents on your account include:

- Your spouse living in the same house and not legally separated from you.
- Your child under age 26, including stepchild, legally adopted child, and a child placed in your home for purposes of adoption or under your legal guardianship.
- Your child under age 26, enrolling for Washington Health coverage, and in your custody under an informal guardianship agreement that is signed by the child's parent(s) and allows you to get medical care for the child. To request coverage for a child living with you under such an agreement, you must provide a copy of the guardianship agreement and proof that you are providing at least 50 percent of the child's support. You cannot list a child who is in your home under a foster care agreement.
- Your child, stepchild, legally adopted child, or legal dependent of any age who cannot take care of him- or herself due to disability.

You must provide proof of disability. If the dependent with a disability is not your birth or adopted child, you must also provide proof of legal guardianship.

Family members who are not eligible for coverage on your account may be able to enroll separately—for example, a child who reaches age 26 and is not disabled. This family member must complete a separate application and Standard Health Questionnaire (SHQ).

Premiums

Premium payments are due by the 5th day of each month before the actual month of coverage; the amount and due date are shown on each month's bill. Your bill is sent about six weeks before the month to be covered by that payment. For example, the bill for August's coverage is sent mid-June and payment is due July 5.

If the entire premium is not paid on time, Washington Health will send you a late notice. This notice will include the bill for both the past due amount (called the delinquent balance) and the premium for the next month's coverage. Washington Health must receive payment for each amount due by the due date given, or your coverage will be suspended for one month. Partial payment or checks that cannot be processed (for example, insufficient funds or missing a signature) will be considered nonpayment and may cause you to lose coverage. For more information, refer to page 7.

Washington Health through your sponsor

Sponsors may enroll sponsored members in Washington Health. Your sponsor pays your premium, but may collect part of it from you. Your main contact with Washington Health will be through your sponsor.

If your sponsor doesn't pay the premium on time, or if you no longer qualify for coverage through them, you may be disenrolled. If all members in your sponsoring organization are disenrolled, Washington Health will offer you individual coverage; however, you may have a break in coverage and may be expected to complete another application as well as Standard Health Questionnaire (SHQ).

Standard Health Questionnaire

As required by law, most applicants applying for Washington Health coverage must complete and pass the Standard Health Questionnaire (SHQ), or health screen. Developed by the Washington State Health Insurance Pool (WSHIP), the SHQ is used to ask about applicants' recent coverage and medical history. Washington Health will use the SHQ to determine eligibility for coverage.

Following application for coverage and a completed SHQ, if the enrollee does not pass the health screen, that person will be denied coverage for Washington Health and referred to WSHIP for coverage. Applicants who are denied coverage may appeal to the Health Care Authority (please see Chapter 5 for further details).

Chapter Two: Making Changes and Maintaining Eligibility

Changes to your account could affect your Washington Health coverage. Report changes to Washington Health within the timelines noted in this chapter. You may use the Change Form included with your monthly bill to make some account changes. To get other forms, call 1-800-660-9840 or visit our website. You may also write to Washington Health at the address shown on page ii.

Changing health plans

Open enrollment is the time each year when you can change your health plan (if there is more than one plan available in your area), except as noted elsewhere in this section. During open enrollment, Washington Health will send you information about any changes to your coverage, and will tell you about health plans in your area and their monthly premiums. You'll be notified before each open enrollment and given instructions for making changes. If you are enrolled through a sponsor, make sure the sponsor knows about changes in your family too, as it may affect the amount you pay for your coverage. Contact your sponsor if you have questions.

Other than during open enrollment, you may only change health plans under certain conditions. These are explained later in this chapter. You cannot change health plans because your provider is no longer with your health plan. (An exception may be made in some cases if you can prove that you need to continue a current course of treatment with a specific provider.) When you change health plans, remember each health plan contracts with different providers and has its own list of prescription drugs. Call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription

drugs, contact the health plan to see if they will be covered.

Changes in health plans are only approved if coverage is lost in your service area.

If, under this situation, you change health plans, any services you had approved under your previous health plan will need to be reviewed and approved again by your new health plan. Also, your yearly deductible and out-of-pocket maximum will start over. Check with your health plan for further information.

Washington Health will do its best to make sure your health plan is available throughout the year. However, if your health plan becomes unavailable, you will be asked to choose one of the plans in your county.

Changing between maximum benefit limits

With Washington Health, you have the option of selecting either a \$75,000 or \$100,000 maximum benefit for each covered family member per calendar year. You and your family member(s) have the same maximum benefit level selected during the enrollment process. Once you reach your selected maximum benefit of either \$75,000 or \$100,000, you are responsible for 100% of any and all charges. Changes between the two benefit limits are allowed, however, a new application and Standard Healthcare Questionnaire must be completed and is subject to approval. If approved, deductibles will start over and the benefits accrued under the previous plan will transfer to the new benefit limit.

Address changes

You must give Washington Health your new address within 30 days of a change. You may call Washington Health at 1-800-660-9840, complete and return the Change Form included with your bill, or write to Washington Health at PO Box 42683, Olympia, WA 98504-2683. Include your Washington Health ID number, your name, new address and county, your old address, and your new phone number. Be sure to say if your new address is permanent or temporary (less than three months), and if your mailing address is different from your street address.

If you move out of Washington State, you will be disenrolled from Washington Health. If you move out of your health plan's service area, you will have to select a new health plan. If only one health plan is available, you will be assigned to that plan. While you are waiting to be transferred to your new health plan, you will need to keep using your old health plan for anything except emergency services. When you change health plans, your deductible and out-of-pocket maximum will start over.

Please note: Washington Health double-checks addresses with the U.S. Postal Service, so be sure to file any change of address with your post office.

Dependent living away from home

If your dependent is living away from home, as described below, Washington Health will cover only emergency care while the dependent is out-of-state or staying in a county that is not served by your health plan. Routine services should be scheduled when the dependent is home.

Out-of-county

If your child lives in a different county, you may be able to choose a health plan that provides service to both your home county and the county the dependent lives in. When necessary, Washington Health allows your dependent to enroll in a different health plan under a separate account so the dependent may receive services in the county where the dependent lives. You will be sent a separate bill for their account.

Out of state

If your child is a Washington State resident, but lives away from home part of the time (to attend college, for example),

they may be eligible to receive Washington Health coverage as long as they remain a Washington State resident and return to Washington State during scheduled breaks. You may be required to provide proof of out-of-state tuition or verify that the child's residence is in Washington State.



Family changes

Eligible family members may enroll at any time by completing and submitting a Family Changes Form and the SHQ, if not exempted. Adding, enrolling, or removing a family member may change your monthly premium. Washington Health will send you written confirmation of any changes to your account.

To make any family changes to your account, call 1-800-660-9840 or visit Washington Health's website to request the Family Changes Form. When you notify Washington Health of a change in family size (such as birth, marriage, divorce, or death), you will be required to submit proof of your Washington State residence.

Removing a family member: Washington Health needs notice of the following changes within the required timeframes.

- Change in dependent status: If you lose eligibility as a dependent, you must notify Washington Health within 30 days of the qualifying event.

- **Transfer of a former dependent to separate account:** You must notify Washington Health within 30 days of the date the person is no longer an eligible dependent. A former dependent who is taken off the parents' account may apply for coverage on a separate account and will need to complete the SHQ.

When coverage begins for added family members

Coverage for your new family members will begin on the first day of the month after eligibility has been determined and full payment is received.

Recertification

State law requires Washington Health to periodically review members' eligibility for this program. This is called "recertification." Under this process, Washington Health members must send in proof of Washington State residency. Being selected for recertification does not mean Washington Health believes you have given us the wrong information; it is a legal requirement for all of our members.

If you get a recertification notice, Washington Health must receive all documents requested by the due date given. Otherwise, you and your covered family members may lose your coverage for at least 12 months. If you reapply for Washington Health at the end of the 12 months, you will have to provide proof of eligibility at that time and complete an application and SHQ.

To complete your recertification, you must send proof that you live in Washington State. We will send you more details when we select you for recertification.

Legal penalties

If you intentionally provide false or misleading information or withhold information, Washington Health may take additional legal action, such as:

- Prosecution for perjury.
- Immediate disenrollment back to the date your coverage would have been affected. This means we may bill you for the total cost of your health coverage since that date.

In addition, if your health plan has paid for services during a time you were enrolled through fraud, the health plan may demand repayment of services from you.

Chapter Three: Suspension, Disenrollment, and Reenrollment

Suspension

If you (or your sponsor) do not pay your premium on time, you will lose coverage for one month (suspension). If your premium is paid in full by the due date on your notice of suspension, you will be reenrolled the following month. If you lose coverage for one month, any payments you have made toward your deductible and out-of-pocket maximums for services provided prior to the suspension will continue to count toward your annual limits. No claims incurred during the suspension period will be paid by the health plan.

Disenrollment

To stop Washington Health for yourself, a family member, or your entire family, call 1-800-660-9840, or write to Washington Health, PO Box 42683, Olympia, WA 98504-2683. You must include:

- Your name and Washington Health ID number.
- The name of each person you want to disenroll.
- The reason you want to disenroll (especially if due to other insurance, Medicare, or Medicaid).
- The date you want coverage to end. We need to receive your request to disenroll at least 10 days before the first of the month you want coverage to end.

You are no longer eligible for Washington Health and will be disenrolled if you:

- Leave Washington State with no plan to return, or if you are gone for more than three months in a row.
- Become eligible for free or purchased Medicare coverage, regardless of whether you actually have Medicare coverage.
- Receive Washington Department of Social Services (DSHS) medical services (Medicaid)

- If you are on, or receive, Basic Health (BH) coverage

If you are disenrolled because you became ineligible (as previously described) and your circumstances change, you may reapply for Washington Health coverage.

You will be disenrolled from Washington Health and will not be allowed back in for at least 12 months if you:

- Are suspended for nonpayment three times in a 12-month period, or do not reenroll the month following a one-month suspension.
- Owe the state for a Basic Health Plan subsidy overpayment or have been sent to collections as a result of nonpayment for Basic Health Plan coverage.
- Do not provide documents Washington Health asks for to check your eligibility.
- Take part in any abuse, intentional misconduct, or fraud against Washington Health or your health plan or its providers, or knowingly give information to Washington Health that is false or misleading.
- Intentionally withhold required information.

You may also be disenrolled from Washington Health if you:

- Purposely put the safety or property of Washington Health or your health plan, or their staff, providers, patients, or visitors, at risk.

Disenrollment from sponsor coverage

If you are no longer eligible for sponsored coverage, but still qualify for Washington Health, we will offer you coverage on your own account. If you get an offer from us, you must tell us and pay your premium by the due date if you want to transfer to your own account.



Reenrollment

The reenrollment process depends on the reason your Washington Health coverage ended and the amount of time since you last had coverage. When you reapply for Washington Health, you may be required to send in a new application, proof residency, proof of other continuous coverage, and a completed Standard Health Questionnaire (SHQ) for all applicants.

Generally, when you disenroll from Washington Health, you must wait at least 12 months before you can reenroll. However, the 12-month wait for reenrollment may be waived if you:

- Left for other coverage, and you reapply for Washington Health within 30 days of losing other continuous coverage (you will be required to provide proof of other continuous coverage).
- Move out of the state, then move back to stay.
- Were disenrolled because you were no longer eligible for Washington Health coverage, but you are now eligible again.

Reenrollment after disenrollment to Medicaid or Basic Health coverage

If you leave Washington Health for Medicaid or Basic Health coverage, and then lose the coverage, you may be eligible to reenroll in Washington Health. If you choose to re-apply, you may be required to complete a new application, complete an SHQ, and provide proof of Washington State residency.

Chapter Four: Rights, Responsibilities, and Privacy

Washington Health member rights

As a Washington Health member, you have the right to:

- Get understandable notices or have the materials explained or interpreted.
- Receive timely information about your health plan.
- Get courteous, prompt answers from your health plan and Washington Health.
- Be treated with respect.
- Have your privacy protected by Washington Health, your health plan, and its providers.
- Get information about all medical services covered by Washington Health.
- Choose your health plan and primary care provider from among available health plans and their contracted networks.
- Receive proper medical care, consistent with Appendix A of this handbook, without discrimination no matter what your health status or condition, sex, ethnicity, race, marital status, sexual orientation, or religion.
- Get all medically necessary covered services and supplies listed in the Washington Health 'Schedule of Benefits', subject to the limits, exclusions, and cost-sharing described in Appendix A.
- Take part in decisions about your and your child's health care, including having a candid discussion of appropriate or medically necessary treatment options, regardless of cost or coverage.
- Get medical care without a long delay.
- Refuse treatment and be told of the possible results of refusing.
- Expect your and your child's records and conversations with providers to be kept confidential.
- Get a second opinion by another provider in your health plan when you disagree with the initial provider's recommended treatment plan.
- Make a complaint about the health plan or providers and receive a timely answer.
- File an appeal with your health plan or Washington Health if you are not satisfied with the program's or health plan's decision (see pages 12–13).
- Receive a review of a Washington Health appeal decision.
- Change your primary care provider (call your health plan for assistance).

Informed consent

You have the right to give your consent to treatment or care. Be sure to ask your provider about the side effects of your or your child's care. You have the right to know about them, and give your consent before getting care.

Advance directives

"Advance directives" put your health care choices into writing. They may also name someone to speak for you if you are not able to speak. Before signing such a document, talk to a lawyer. Washington State law has two kinds of advance directives:

1. Durable Power of Attorney for Health Care – Names someone to make medical decisions for you if you are not able to make them for yourself.
2. A Directive to Physicians (Living Will) – A document that lets you tell your doctor what you do or do not want done if you have a terminal condition or are permanently unconscious.

Privacy

Personal health information

Washington Health will not release any personal health information that is provided verbally, electronically, or in writing to anyone but you or your health plan without your prior written authorization.

Account information

Without your written permission, Washington Health cannot release personal account details such as eligibility, enrollment, monthly premium, or payment to anyone but you or your health plan.

Exceptions:

- If your financial sponsor is paying your premium, limited information may be released to your representative. Ask your representative for details.
- Information about a dependent minor child will be released to either parent.
- Providing information to law enforcement.

If you want to let someone else (such as a friend or a relative) access or make changes to your account, you need to send written permission to Washington Health. Be sure to sign and date your letter and include the person's name, their relationship to you, and what information you want released to them or changes they can make. Only the information you specify will be released. You will also need to tell us if this permission is for a specific time period or for as long as you are enrolled in Washington Health. When this person calls, they'll need your Washington Health ID number, and will be asked for other identifying information.

The HCA privacy notice is available on request by calling 360-923-2822 or online at www.hca.wa.gov.

Washington Health member responsibilities

As a Washington Health member, you and/or your enrolled dependents have the responsibility to:

- Understand your obligations while participating in Washington Health.
- Accurately and promptly report changes that may affect your premium or eligibility, such as an address change, or a change in family status, and send in the required forms and documents. (Read Chapters Two and Three for timelines and instructions.)
- Choose a health plan in your area.
- Choose a primary care provider from your health plan before receiving services.
- Work with your health plan to help get any third-party payments for medical care.
- Tell your health plan about any outside sources of health care coverage or payment, such as insurance coverage for an accident.
- Tell your or your child's primary care provider about medical problems, and ask questions about things you do not understand.
- Decide whether to receive a treatment, procedure, or service.
- Get medical services from (or coordinated by) your or your child's primary care provider, except in an emergency or in the case of a referral.
- Get a referral from the primary care provider before you or your child goes to a specialist.
- Pay copayments in full at the time of service.
- Pay your Washington Health premiums in full by the due date.
- Pay your deductible and coinsurance in full when they are due.



- Keep appointments and be on time, or call the provider's office when you or your child will be late or can't keep the appointment.
- Keep your family members' medical ID cards with the family member at all times, or with you if your children are young.
- Notify the health plan or primary care provider within 24 hours, or as soon as is reasonably possible, of any emergency services provided outside the health plan.
- Use your selected health plan and primary care provider to coordinate services for your family's medical needs.
- Comply with requests for information, including requests for medical records or information about other coverage, by the date requested.
- Cooperate with your primary care provider and referred providers in regards to your treatment plan.

Chapter Five: Grievances, Complaints, and Appeals

If you have a grievance or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find the toll-free numbers on the inside front cover of this book. If you have a complaint about an action taken by Washington Health, call 1-800-660-9840. If you call Washington Health or your health plan, be sure to note the date of the call, the name of the person you talked to, and whether that person was with Washington Health or your health plan.

Your health plan is required to give you information on its grievance and appeals process:

- When you enroll.
- Annually and/or whenever there is a change to their grievance and appeal process.
- When the health plan sends you a notice of a denial of a benefit or service, or notice of an appeal decision.

Grievances against your health plan

If you disagree with a decision made by your health plan (such as a denial of a claim or benefits interpretation) or have a grievance regarding your health plan's services, providers, or facilities, you must follow your health plan's procedures for resolving the problem. These matters cannot be appealed to Washington Health. The health plan will help you with this process.

If you file a grievance with your health plan, the health plan must respond in writing within 30 days after receiving it. If you file a grievance against a health plan's service, provider, or facility, Washington State law determines the information the health plan may provide you regarding the resolution of your grievance.

Appeals to your health plan

If you are denied a service, or the health plan changed a service that was already approved, you may file an appeal. An appeal is a request for the health plan to review its decision. You may file an appeal or a grievance in writing, in person at the health plan's office, or over the phone. The health plan will help you with this process.

When you file an appeal with your health plan:

- Within five working days, the health plan will send you a letter saying they've received your appeal.
- Within 14 calendar days, your health plan must respond to you in writing with either a decision or notification of a reason for a delay. However, unless you agree to an additional delay, the decision must be made within 30 calendar days after the health plan receives your appeal.

If waiting for a decision could put your health at risk, you can ask, or have your provider ask, for an expedited (quick) review. The health plan will make a decision within 72 hours after receiving an expedited appeal.

If you have gone through your health plan's appeal process and disagree with its decision, or if your health plan has not responded to you within the timelines referenced above, you have the right to request a review of the decision by an Independent Review Organization (IRO). This is done through your health plan and at no cost to you. Your health plan is required by law to give the IRO all information used in making its decision within three business days of receiving the request. You may also be required to provide additional information or documentation needed for the IRO's decision. If waiting for a decision could put your health at risk, you can ask for an expedited (quick) review. The IRO will make a decision within 72 hours. The health plan will let you know the outcome.

You may choose someone, including an attorney or provider, to serve as your personal representative to act on your behalf for the appeal. The health plan must receive written consent from you allowing this person to represent you before the person can act on your behalf. Contact your health plan for additional information.

Complaints against Washington Health

If you have a complaint or want an explanation of an action Washington Health has taken on your account, write to Washington Health at PO Box 42683, Olympia, WA 98504-2683, or call 1-800-660-9840.

Appeals to Washington Health

If you disagree with a Washington Health decision, such as premium calculation, premium adjustment or penalty, change of health plan, denial of Washington Health eligibility, scoring of the SHQ or loss of Washington Health coverage, you may file a written appeal with Washington Health within 30 calendar days of the notice of the decision. Write to Washington Health Appeals, PO Box 42690, Olympia, WA 98504-2690, stating you want to file an appeal. Your letter must include your name, address, Washington Health ID number, a daytime phone number, a summary of the decision you are appealing, and a statement explaining why you believe the decision was incorrect. You must also include copies of any evidence that will help explain or prove that the decision should be changed. If your appeal is not received within 30 calendar days of the notice of the decision, you will lose your right to appeal that decision.

In your appeal, you may ask to explain in person or by phone why you believe the decision was incorrect and should be changed. Be sure to let us know if you will need an interpreter and, if so, what language and dialect you speak. Also let us know if you will need any assistance due to disability.

Washington Health will confirm that your appeal was received. If you have asked to explain your appeal over the phone or in person, our Appeals Department will contact you to schedule a conference. The conference will be recorded to ensure an accurate record, and you will be questioned as well as given an opportunity to explain your point of view. You should be prepared to give detailed information to support your position that the decision was in error.

Your appeal will be reviewed carefully, and Washington Health will mail a written notice of the decision to you within 60 calendar days of receiving your appeal. If additional time is required to investigate your appeal, Washington Health will notify you in writing, and a decision date will be set.

If you disagree with Washington Health's decision on your appeal, you may request a further review of that decision verbally or by writing to: Washington Health Appeals, PO Box 42690, Olympia, WA 98504-2690. Washington Health must receive your request for review within 30 calendar days of the date on the notice of Washington Health's appeal decision. You should explain that you are asking for a review of Washington Health's appeal decision. You must provide additional written evidence to show why you believe the appeal decision was incorrect. Also provide a summary of the decision you are contesting, why you believe the decision was incorrect, and a daytime phone number where we can reach you. In addition, the request must include all evidence that has not yet been provided and on which you will rely to explain why Washington Health acted incorrectly. If your request for a review is not received within 30 calendar days of the notice of the appeal decision, you will lose your right for a review.

The Office of Administrative Hearings will review Washington Health's appeal decisions regarding disenrollment due to nonpayment. A presiding officer appointed by the Administrator of the Health Care Authority will review Washington Health's appeal decisions on all other issues, based on the record of the appeal and any evidence you send. Be sure to include all information you want considered. The presiding officer may contact you for further information, but you generally will not be offered an opportunity to explain in person or by phone at this point in the process. The HCA will notify you in writing of the final decision.

You may choose someone, including an attorney or provider, to serve as your personal representative to act on your behalf for the appeal. Washington Health must receive written consent from you allowing this person to represent you before the person can act on your behalf. Contact Washington Health for additional information.

Chapter Six: Health Plans and Providers

How the health plans work

All health plans offer the same basic benefits and require you to choose a primary care provider (PCP) to coordinate or provide your care. Costs, providers and facilities, covered prescription drugs, and referral practices, may differ by health plan.

Each health plan contracts with a number of providers, facilities, and affiliates. These organizations make up the health plan's "provider network." Services received from this network are referred to as "in-network" and a specific set of benefits, copayments, deductibles, and coinsurance apply. Please see Chapter 5 of this Certificate of Coverage for more details.

If you or your child require a care provider or specialist who does not belong in your health plan's network, you will be referred out of the health plan's network. This is referred to as "out of network." In order to avoid extra costs, you must get your health plan's prior approval to be treated by a provider who is "out-of-network," except in an emergency (see page 16). If you are authorized to receive care from an "out-of-network" provider, you can expect to pay the same coinsurance and deductibles as if you were "in-network."

Self-referring, or receiving services without pre-authorization from your health plan to an "out-of-network" provider is permitted, however, you should expect to pay higher coinsurance levels, be subject to a higher deductible, and may be balance billed by the provider. Balance billing is the difference between the cost your health plan allows for the service (usually is a discounted amount) and the full cost of the provider's service. By self-referring, you are responsible for the full amount between allowed and billed (such amounts do not apply to your annual out-of-pocket maximum).

To ensure you do not pay more than expected for a treatment outside of the health plan's "in-network," be sure to check with your health plan before treatment.

In instances of an emergency where hospital care is required, "out-of-network" benefit limits do not apply. Please be sure to notify your health plan within 24 hours of hospitalization.

Using Out-of-Network Providers Costs You Money

When you see a out-of-network provider:

- Washington Health pays only 50% of the allowed amount to out-of-network providers. The allowed amount is the amount network providers agree to accept as payment in full. Out-of-network providers can charge more than the Washington Health allowed amount. You will pay 50% of the allowed amount plus the amount above the allowed amount.
- In most cases, any money you pay to a out-of-network provider won't count toward your annual out-of-pocket limit.
- You may have to pay up front and send the claim to your health plan.

When does my coverage begin?

Washington Health notifies you in writing when your coverage is effective. Take note of the effective date of coverage shown in the letter you receive. Washington Health will not cover any services received before your coverage begins.

ID cards

After you enroll in Washington Health, the health plan will send ID cards to you and your enrolled family members. Some health plans may require you to choose a PCP before they issue your ID card.

The card has important information, including the number to call if you are hospitalized or have questions. If you need care before you receive the card, contact the health plan at the number listed on the inside front cover of this handbook. Remember to keep your enrollment confirmation letter from Washington Health; it can serve as your temporary identification until you receive your card(s).

The right to object to certain services

Religiously sponsored health plans or health care providers have the right to not provide benefits or services for termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your health plan objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another provider, with no added cost to you. Contact your health plan for more information.

If you object to having coverage for termination of pregnancy or other services, you may notify Washington Health in writing. Benefits will not be provided to you for those services; however, your premium will not change.

Primary care provider (PCP)

Each covered family member must enroll in the same health plan, but may choose a different PCP within your health plan. Except in an emergency, your PCP will provide or coordinate all your health care, including referrals to specialists. Primary care providers may be family or general practitioners, internists, pediatricians, or other providers approved by your health plan. You may change your PCP during the year. Contact your health plan for details on changing providers or for a current list of providers. You may contact a provider and ask whether he/she accepts Washington Health and contracts with your health plan. When you call a provider, be sure to mention the health plan name and Washington Health, and ask if the provider is accepting new patients.

To be covered by your health plan, your PCP must provide all health care services, unless:

- You are referred to another provider by your PCP (in most cases, the referral must be approved by your health plan);
- You need emergency care, as described on page 16; or
- You self-refer for women's health care services to a provider who contracts with your health plan.

If you have questions, call your health plan at the number listed on the inside front cover of this handbook.

Women's health care services

The following women's health care services are covered by Washington Health without a PCP referral or health plan preauthorization:

- Maternity care, including prenatal, delivery, and postnatal care. For more information on maternity care, see page 21.
- Routine gynecological exams.
- Examination and treatment of disorders of the female reproductive system, except as specifically excluded.
- Other health problems discovered and treated during the course of a woman's health care visit, as long as the treatment is within the provider's scope of practice, and the service provided is not excluded.

You may seek these services from any women's health care provider who contracts with your health plan. Services provided by hospitals or outpatient surgical centers may require preauthorization from your health plan. Also, any follow-up services for conditions not directly related to maternity care, routine gynecological exams, or disorders of the female reproductive system may require referral and preauthorization by your health plan.

Chapter Seven: Covered Services and Member Costs

The list of services covered under Washington Health, called the “Schedule of Benefits,” is in Appendix A of this handbook. If you have questions about a particular medical condition or Washington Health benefit, contact your health plan directly at the number listed on the inside front cover of this handbook.

Emergency care

Emergency care is covered 24 hours a day, seven days a week. (See page 33 for the definition of “emergency.”) To receive emergency care benefits, it is important to follow these steps:

- Depending on how serious the problem is, go directly to the nearest emergency room, call 911, or call your PCP.
- If you are admitted to a hospital or other health care facility, call (or have a friend, family member, or care provider call) your health plan or PCP within 24 hours or as soon as is reasonably possible.
- See (or be referred by) your PCP for follow-up care.

Important: If you do not follow these instructions, and the provider bills for a higher amount than your health plan would pay “in-network,” you may be subject to higher cost sharing and balance billing. If the case is determined not to be an emergency (whether or not you follow the instructions), you may be responsible for all costs.

Preexisting condition waiting period

Generally, you must wait nine months from the day your coverage begins before Washington Health will cover preexisting conditions, except for maternity care and prescription drugs. Children under the age of 19 are exempt from preexisting conditions. For more information, see “Limitations

and exclusions” on page 29. The preexisting condition waiting period does not apply to children up to age 19. A preexisting condition is defined as an illness, injury, or condition for which, in the nine months immediately preceding a member’s effective date of enrollment in Washington Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member;
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.

If you were enrolled in health care coverage that was similar to Washington Health at any time during the three months just before you applied for or were enrolled in Washington Health, your waiting period for treatment of a preexisting condition may be waived or shortened as described in “Limitations and exclusions” beginning on page 29.

If you had to wait for Washington Health coverage, you may receive up to three months’ credit toward the waiting period. (This does not apply to the waiting period for organ transplant services.)

Organ transplants

You must be a Washington Health member for 12 months in a row before an organ transplant for a preexisting condition will be covered, except for children under 19 years of age. See pages 22–23 for details.

Maternity care

If you or an enrolled family member becomes pregnant, Washington Health will provide you with information on the Maternity Benefits Program available through DSHS. Washington

Health provides maternity-related services. (See page 27.) However, deliveries occurring within the first six months of initial enrollment or re-enrollment are subject to a \$5,000 deductible and coinsurance. The maternity benefit applies only to the facility and delivery charges. Prenatal care, postpartum, care, and well-baby care are covered in accordance to the normal benefits schedule. Please see Appendix A for more details.

Member costs

Each member enrolled in Washington Health is responsible for sharing health care cost for coverage, as follows:

Copayment – A set dollar amount you pay when receiving specific services, such as in-network office visits, generic prescription drugs, and emergency room visits.

Deductible – The amount you pay before your health plan starts to pay for covered services. The deductible has to be met every calendar year for each member enrolled in Washington Health. Families (defined as subscriber, spouse and dependents) enrolled in Washington Health are subject to a single family deductible, regardless of the number of dependents covered. Your deductible does not apply towards your out-of-pocket maximum.

Coinsurance – For certain services, you will be responsible for paying a percentage of the cost for services received. Your health plan pays the remaining percentage. The percentage you pay will depend on whether care was received “in-network” or “out-of-network.”

Out-of-pocket maximum – The most coinsurance you will pay in a calendar year for each member or family unit. When you reach your out-of-pocket maximum, you do not have to pay any further coinsurance costs for covered benefits and services received during that year. Your health plan will pay 100% of the coinsurance for all covered benefits and services.



What doesn't count toward your annual medical out-of-pocket maximum

The following costs are not counted toward your annual medical out-of-pocket preauthorization:

- Annual medical and prescription drug deductibles.
- Services that aren't covered because you didn't comply with preferred or preauthorized requirements.
- Charges beyond benefit maximums, limits, and the health plans allowed amount.
- Copayments for emergency room care.
- Coinsurance, copayments, and ancillary charges for prescriptions.
- Amounts that are balanced billed for services received from out-of-network providers, except when preauthorized by your health plan, do not count toward your annual out-of-pocket maximum.

Maximum Benefit - There is either a \$75,000 or \$100,000 maximum benefit for each covered member or family member per calendar year. The subscriber and dependent(s) must be on the same maximum benefit plan selected during the enrollment process. Once you reach your selected annual maximum benefit of either \$75,000 or \$100,000, you are responsible for 100% of any and all charges. If you choose to change to a different maximum benefit level, you will need to complete the application process again, including the Standard Health Questionnaire.

If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for yourself and covered family members will start over with your new health plan. Your maximum benefit, however, will not start over with your new health plan. See the “Schedule of Benefits” on page 19.

If you receive a bill for covered services

If you receive care from a provider who contracts with your health plan (in-network), the provider will usually bill the health plan directly.

You will receive a bill from a provider who has provided

services to you that require a deductible and coinsurance. In most cases, your health plan will first send you an Explanation of Benefits (EOB) which will explain what service you received, what the allowed amount is for that service, what the health plan has paid, and what you have to pay. The EOB will also provide information about how much you have paid toward your deductible and out-of-pocket maximum. The provider or facility where you have received services will then send you a bill. You must pay the provider or facility directly. If you receive a bill but have not yet received an EOB, or if you have questions about your bill, contact the provider's office or your health plan.

You may receive a bill from a provider or a facility. It is best to mail the bill directly to your health plan (at the address listed on the back of your identification card). Be sure to call your provider to verify they have the correct health plan information on record for you. Benefits may be denied if your health plan receives the bill more than 12 months after the date you received services.

If a third party is responsible for your injury or illness

You or your representative are required to notify your health plan if your provider charges the health plan for treatment of an injury or illness that is the result of another person's or organization's action or failure to act (for example, a fall, an auto accident, or an accident at work). The other person or organization responsible for your injury or illness is called the "third party."

You must notify your health plan promptly, in writing, to the degree you know, of all of the following:

- The facts of the injury or illness, including the name and address of any third party you think may be responsible for the injury or illness.
- The name and address of the third party's insurance company.
- The name and address of any attorneys who will be representing the third party.

- If you plan to file a claim or lawsuit against the third party, the name and address of the person who will be representing you.
- Adequate advance notice of any trial, hearing, or possible settlement of your claim against the third party.
- Any changes in your condition or injury.
- Any additional information reasonably requested by the health plan.

If you bring a claim or legal action against a liable third party, you must seek recovery of the benefits paid by your health plan.

After you have been fully compensated for all damages you experienced as a result of the injury or illness, your health plan has a right to reimbursement up to the amount of the benefits the health plan has paid, from any recovery you receive. You are required to pay the health plan only the amount that is left over after you have been fully compensated for all of your damages (including pain and suffering and lost wages), up to the amount of the benefits paid.

If your health plan seeks to recover benefits directly from the third party, you must cooperate fully and not do anything to impair your health plan's right of recovery. Your health plan may bring suit against the third party in your name, or may join as a party in a lawsuit or claim you have filed. Your health plan will not be required to pay for legal costs you incur, and you will not be required to pay legal costs incurred by your health plan. However, your health plan may agree to share the cost if they choose to be represented by your attorney.

Washington Health can disenroll you for intentional misconduct if you:

- Intentionally withhold from your health plan information you have about a legally responsible third party.
- Restrict your health plan's ability to collect from a legally responsible third party.

Appendix A: Schedule of Benefits

This “Schedule of Benefits” lists benefits for Washington Health members. Services are subject to all provisions of this “Schedule of Benefits,” including limitations, exclusions, deductibles, coinsurance, and copayments. Except as specifically stated otherwise, all services and benefits under Washington Health must be provided, ordered, or authorized by the health plan or its contracting providers. Even if your provider authorizes a service, your health plan may also need to preauthorize the care.

Services in addition to those listed in this “Schedule of Benefits” may be provided at the sole discretion of the health plan through the health plan’s medical management or case management program if providing the service will result in a lower total out-of-pocket cost to the health plan. Additional services may be subject to copayments, deductibles, coinsurance, and limitations.

If you have a question about the benefits listed, or are not sure if a service is covered, you should call the health plan’s customer service department.

I. Medically necessary services, supplies, or interventions

Whether a service is covered depends on if it is medically necessary. Washington Health provides coverage for services, supplies, or interventions that are otherwise included as a “covered service,” as set forth in Section II, that are not excluded and are medically necessary. A covered service is “medically necessary” if it is recommended by your treating provider and your health plan’s medical director or provider designee, and if all of the following conditions are met:

- A. The purpose of the service, supply, or intervention is to treat a medical condition.
- B. It is the most appropriate level of service, supply, or intervention considering the potential benefits and harm to the patient.
- C. The level of service, supply, or intervention is known to be effective in improving health outcomes.
- D. The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.
- E. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

A health “intervention” is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation), or to maintain or restore functional ability. For purposes of this definition of “medical necessity,” a health intervention means not only the intervention itself, but also the medical condition and patient indications for which it is being applied.

“Effective” means that the intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

An intervention, supply, or level of service may be medically indicated yet not be a covered benefit or meet the standards of this definition of “medical necessity.” Your health plan may choose to cover interventions, supplies, or services that do not meet this definition of “medical necessity”; however, the health plan is not required to do so.

“Treating provider” means a health care provider who has personally evaluated the patient.

“Health outcomes” are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person’s life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

“New interventions” for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (see “existing interventions” below).

“Scientific evidence” consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

For “existing interventions,” the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of “medical necessity.” If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the Washington Health definition of “medical necessity” in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

A level of service, supply, or intervention is considered “cost effective” if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

II. Covered services

The following services are covered when they are medically necessary. All services, supplies, and interventions are subject to the appropriate copayment, deductible, and coinsurance. (See Section III. Copayments, deductibles, and coinsurance.)

A. Hospital care

The following hospital services are covered:

1. Semi-private room and board, including meals; private room and special diets; and general nursing services.
2. Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room, anesthesia, radiology, laboratory, and other diagnostic services.
3. Normal newborn baby care following birth while in a contracting facility. Covered services include, but are not limited to, nursery and laboratory services.
4. Drugs and medications administered while an inpatient.
5. Special duty nursing.
6. Dressings, casts, equipment, oxygen services, and radiation and inhalation therapy.

If a member is hospitalized in a non-contracting facility, the health plan has the right to require transfer of the member to a contracting health plan facility at the health plan’s expense, when the member’s condition is sufficiently stable to enable safe transfer.

If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Personal comfort items such as telephone, guest trays, and television are not covered.

B. Medical and surgical care

The following medical and surgical services are covered. The health plan may require that certain medical and surgical services be provided on an outpatient basis.

1. Surgical services.
2. Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.
3. Dressings, casts, and use of cast room; anesthesia and anesthesia-related oxygen services.
4. Blood, blood components, and fractions (such as plasma, platelets, packed cells, and albumin), and their administration.
5. Provider visits, including diagnosis and treatment in the hospital, outpatient facility, or office; consultations, treatment, and second opinions by the member's PCP, or by a referral provider. Normal newborn baby care following birth while in a contracting facility. Covered services include, but are not limited to, routine newborn exams and laboratory services.
Pharmaceuticals that are or would normally be an intrinsic part of a provider visit (inpatient or outpatient) are covered as part of the provider visit.
6. Radiation therapy; chemotherapy.
7. Inpatient and outpatient chiropractic, occupational, and physical therapy services are covered for only post-operative treatment of reconstructive surgery when received within one year following surgery. A combined maximum of 12 visits per calendar year are covered, but no more than six visits can be covered for chiropractic care. Diagnostic or other imaging procedures solely for determination of therapy services are not covered.
8. Prescription drugs and medications as defined in "Pharmacy benefit."
9. Family planning services provided by the member's PCP or women's health care provider. Contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps, and long-acting progestational agents) determined most appropriate by the PCP or women's health care provider for use by the member are also covered. Over-the-counter supplies such as condoms and spermicides are covered only when part of a health plan protocol at the health plan's discretion. Elective sterilization is covered.
10. Durable medical equipment, prosthetics, orthotics, and related supplies.

C. Maternity care

Deliveries occurring within the six-month maternity deductible window are subject to a \$5,000 deductible and coinsurance. The maternity deductible window applies only to initial enrollment or re-enrollment in Washington Health. The maternity deductible applies only to facility charges and services received related to the actual delivery. It does not apply to other maternity-related services, such as full prenatal care, postpartum care, care for pregnancy complications, well-child newborn care, and termination of pregnancy.

The following services are subject to copays, coinsurance, or deductibles: diagnosis of pregnancy; delivery; postpartum care; care for complications of pregnancy; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; medications; anesthesia; and termination of pregnancy (including voluntary termination of pregnancy).

D. Chemical dependency

Members are eligible to receive residential and outpatient chemical dependency treatment from a health plan-approved treatment program and subject to a maximum benefit of \$5,000 in a 24 consecutive calendar month period up to a lifetime benefit maximum of \$10,000. Covered residential and outpatient treatment includes services such as diagnostic evaluation and education, and organized individual and group counseling. The hospital inpatient deductible and coinsurance applies to intensive inpatient services. Health plans may use lower copayments, if applicable, for group sessions.

(NOTE: Court-ordered treatment will be covered only if determined by the health plan to meet the Washington Health definition of "Medical Necessity.")

In determining the \$5,000 limit, the health plan reserves the right to take credit for chemical dependency benefits paid by any other group medical plan on behalf of a member during the immediate preceding 24 consecutive calendar month period. In determining the \$10,000 lifetime limit, the health plan reserves the right to take credit for chemical dependency benefits paid under Washington Health on behalf of the member from July 1, 2010.

E. Mental health services

Mental health services are covered as follows:

Inpatient care in a participating hospital or other appropriate licensed facility approved by the health plan is covered in full (subject to deductible and coinsurance) up to 10 days per calendar year.

Outpatient care, including individual and family counseling, is covered in full up to 12 visits per calendar year after the copayment per visit for individual sessions. Health plans may use lower copayments, if applicable, for group sessions. Visits for the sole purpose of medication management are exempted from the 12-visit limit, and are instead covered as other provider visits.

(NOTE: Court-ordered treatment will be covered only if determined by the health plan to meet the Washington Health definition of "Medical Necessity.")

F. Organ transplants

Services related to organ transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care, are covered. Deductible, coinsurance, and copayments apply by specific service. (See Section III. Copayments, deductibles, and coinsurance.) This benefit includes covered donor expenses.

Heart, heart-lung, liver, bone marrow including peripheral stem cell rescue, cornea, kidney, and kidney-pancreas human organ transplants are covered when the Washington Health definition of "Medical Necessity" is met.

Organ transplant recipient: All services and supplies related to the organ transplant for the member receiving the organ, including transportation to and from a health plan-designated facility (beyond that distance the member would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the member has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

Organ transplant donor: The donor's initial medical expenses relating to harvesting of the organ(s), as well as the costs of treating complications directly resulting from the procedure(s), are covered, provided the organ recipient is a member of the health plan, and provided the donor is not eligible for such coverage under any other health care plan or government-funded program.

Organ transplant waiting period: Members must be enrolled in Washington Health for 12 consecutive months before they are eligible to receive benefits for covered transplant procedures, except for children under the age of 19. The waiting period applies to the transplant procedure including any immediate pre- and post-operative hospital care related to the transplantation, but does not apply to ongoing follow-up care including prescription drugs.

If a member satisfies the 12 consecutive months' waiting period (no breaks in coverage for 12 consecutive months)

and subsequently has a break in Washington Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

The waiting period will not apply:

1. If the transplant is required due to a condition which is not a preexisting condition;
2. For children under the age of 19;
3. For children, under the age of 19, placed in the home for purposes of adoption.

Limitations: Transplants that are not preauthorized or are not performed in a health plan-designated medical facility are not covered. No benefits are provided for charges related to locating a donor, such as tissue typing of family members.

All services are subject to the appropriate copayment, deductible, coinsurance, and annual maximum benefit.

G. Emergency care

An emergency is a sudden or severe health problem that needs treatment right away; there is not time to talk to your doctor.

“Emergency” is defined as:

“The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.”

The health plan reserves the right to determine whether the symptoms indicate a medical emergency. Acute detoxification is covered for up to 72 hours.

1. In-service-area emergency. In the event a member experiences a medical emergency, care should be obtained from a health plan in-network provider. If, as a result of such emergency, the member is not able to use a health plan in-network provider, the member may obtain emergency services from an out-of-network health care provider. Follow-up care must be coordinated with the member’s PCP. In the case of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If the member fails to meet the notification requirements, coverage may be limited to in-network charges and allowed amounts. The member may be financially responsible for any remaining amounts owed or balance billing.

2. Out-of-service-area emergency. The health plan shall bear the cost of out-of-service-area emergency care for covered conditions. In the event of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If the member fails to meet the notification requirements, coverage may be limited to in-network charges and allowed amounts. The member may be financially responsible for any remaining amounts owed or balance billing.

The health plan may, at its discretion, appoint a consultant when out-of-service-area care is necessary, who will have authority to monitor the care rendered and make recommendations regarding the treatment plan. The health plan may otherwise secure information which it deems necessary concerning the medical care and hospitalization provided to the member for which payment is requested.

3. Transfer and follow-up care. If a member is hospitalized in an out-of-network facility, the health plan reserves the right to require transfer of the member to an in-network facility, when the member’s condition is sufficiently stable to enable safe transfer. If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Follow-up care that is a direct result of the emergency must be obtained from an in-network provider, unless the health plan in conjunction with your PCP has authorized or referred treatment to an out-of-network provider.

4. Prescription drugs. Prescription drugs purchased from an out-of-network facility or pharmacy are covered subject

to the applicable pharmacy copayment, coinsurance, and balance billing. When dispensed or prescribed in connection with covered emergency treatment and distributed from an in-network facility or pharmacy will be subject to copayment and coinsurance.

5. Emergency ambulance transportation. Medically necessary ambulance transportation is covered in an emergency, or to transfer a member when preauthorized by the health plan.

H. Skilled nursing and home health care benefits

As an alternative to hospitalization in an acute care facility, the health plan, at its discretion, may authorize benefits for the services of a skilled nursing facility or home health care agency.

I. Hospice services

Hospice services are covered.

J. Plastic and reconstructive services

Plastic and reconstructive services (including implants) will be provided only under the following conditions:

1. To correct a physical functional disorder resulting from a congenital disease or anomaly;
2. To correct a physical functional disorder following an injury or incidental to covered surgery; and
3. For a member who is receiving benefits in connection with a mastectomy:
 - a. Reconstruction of the breast on which the mastectomy was performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. Prostheses (internal and external) and physical complications of all stages of mastectomy.

Please contact your health plan for specific coverage information.

K. Preventive care

Preventive care services are covered at no expense to members.

L. In-Network and Out-of Network Providers Services

Each health plan contracts with a number of providers, facilities, and affiliates. These organizations make up the health plan's "provider network". Services received from this network are referred to as "in-network" and a specific set of benefits, copayments, deductibles, and coinsurance apply. Generally, services received "in-network" are discounted and offer lower cost to members.

"Out-of-Network" means a person, practitioner, or entity with no written agreement with your health plan and who is not employed by your health plan to provide health care services.

Care received from primary care specialists, specialists, primary care sites, hospitals, and other facilities which are not contracted with your health plan are referred to as "out-of-network." If you receive care "out-of-network," and have not been referred by your in-network provider or health plan, you may be subject to higher cost sharing including higher deductibles, coinsurance, and copays. You may be subject to additional costs including balance billing.

M. Pharmacy benefit

The health plan may limit the drugs covered through use of a list called a "formulary." Each health plan's formulary includes all major therapeutic classes of drugs. Drugs not in the formulary will be covered if the health plan's medical staff determines that no formulary drugs are an acceptable medication for the patient.

In addition to the formulary described above, each health plan will have the following five therapeutic classes of drugs covered under the first tier, subject to a \$10 or \$20 copay (depending on where the prescription is filled, i.e., in-network or out-of-network); inhaled short-acting beta-agonists, inhaled steroids, inhaled anticholinergic bronchodilators,

beta-blockers for severe heart failure, and anti-platelet clotting inhibitors for patients after intra-arterial stent placement. The members' copay will be \$10 or \$20 (depending on where the prescription is filled), regardless (or independent) of the drug's generic or name brand status.

If you have a question about the pharmacy benefit, are not sure if a drug is covered, or believe a nonformulary drug should be covered, call the health plan's customer service department.

Washington Health covers drugs of all types, including prescribed creams, ointments, and injections, at the copayment levels shown. Prescriptions are not subject to the deductible and will not apply towards the annual out-of-pocket maximum.

Members are responsible for the copay, or the actual cost of the drug, whichever is less.

In regards to Tier 2, out-of-network prescription benefits, the health plan pays based on the discounted amount it normally pays for the drug (allowed amount) and the drug's tier in the formulary. If the out-of-network pharmacy charges more than the allowed amount, you will pay the difference, plus your copay or coinsurance.

Prescriptions are limited to a 30-day supply.

Drugs for cosmetic purposes are excluded unless preauthorized.

(See table below for more pharmacy copayment information.)

In-Network (Community Health Plan Clinics and Affiliates)	Out-of-Network
Tier 1 – Copayment: \$10	Tier 1– Copayment: \$20
Generic drugs contained in the health plan's formulary. All oral contraceptives in the health plan's formulary. Diabetic supplies, including syringes and needles, diabetic test strips, lancets, and insulin. Inhaled short-acting beta-agonists. Inhaled steroids. Inhaled anticholinergic bronchodilators. Beta-blockers for severe heart failure. Anti-platelet clotting inhibitors for patients after intra-arterial stent placement.	Generic drugs contained in the health plan's formulary. All oral contraceptives in the health plan's formulary. Diabetic supplies, including syringes and needles, diabetic test strips, lancets, and insulin. Inhaled short-acting beta-agonists. Inhaled steroids. Inhaled anticholinergic bronchodilators. Beta-blockers for severe heart failure. Anti-platelet clotting inhibitors for patients after intra-arterial stent placement.
Tier 2 – Copayment: 50%	Tier 2 – Copayment: 50%
Brand-name drugs in the health plan's formulary and drugs not in the health plan's formulary.	Brand-name drugs in the health plan's formulary and drugs not in the health plan's formulary.

N. Oxygen

Oxygen will be covered when prescribed by a contracted provider and when authorized by a contracted health plan. The health plan, at its discretion, may require an assessment to determine if oxygen therapy is still an appropriate treatment before authorizing continued oxygen treatment.

Coverage for oxygen will include the rental of oxygen equipment, oxygen contents, and supplies for the delivery of oxygen.

Portable oxygen is not covered when provided only as a backup to a stationary oxygen system.

Oxygen is not subject to a copay or coinsurance, and is excluded from the coinsurance applicable to Durable Medical

Equipment.

III. Copayments, deductibles, and coinsurance

Each member or family unit is responsible for paying a deductible per calendar year before some benefits and services will be covered (see page 28). For those in-network services with a coinsurance, once the deductible has been met, the health plan pays 70% of allowed charges and the member pays 30% of allowed charges. For those out-of-network services which are authorized or referred by the health plan or in-network provider and once the deductible has been met, the health plan pays 50% of allowed charges and the member is responsible 50% of the allowed charges. For those out-of-network services which were not authorized by the health plan or referred by an in-network provider, and once the deductible has been met, the health plan pays 50% of the allowed charges and the member is responsible for 50% of the allowed charges. In addition, the member may be responsible for the full amount of what is allowed for the service(s) received and what the provider charges for the services. In other words, the non-discounted amount for the services provided, or billed amount. This is referred to as balance billing.

No amount paid toward the deductible will be applied toward the out-of-pocket maximum. Once the out-of-pocket maximum has been reached, the health plan pays 100% toward all covered benefits and services until the annual benefit maximum is reached.

An maximum benefit applies to all services per member per calendar year. Once the member reaches the annual benefit maximum of either \$75,000 or \$100,000 (depending on the coverage level selected), the member is responsible for 100% of any and all charges.

The member is responsible for paying any required copayment, deductible, and/or coinsurance directly to the provider of a covered service unless instructed by the health plan to make payment to another party. Copayments, deductibles, and coinsurance payments must be paid in full, or service may be denied or rescheduled.

Only the cost sharing specifically listed in the following tables will be charged to members for covered services. Members may be charged a missed appointment fee by a provider if they repeatedly fail to keep appointments, or to give timely notice when it is necessary to cancel appointments.

Medical Plan (PCY=Per Calendar Year)			
Covered Benefit	CATEGORY 1 In-Network Community Health Plan Clinic and Affiliates	CATEGORY 2 Out-of-Network ^o	Description
Annual Benefit Maximum	Health 75 - \$75,000 Health 100 - \$100,000	Health 75 - \$75,000 Health 100 - \$100,000	Total maximum amount the plan will pay per person in any calendar year
Annual Deductible	\$500 per member/ \$1,500 per family	\$1,000 per member/ \$3,000 per family	The amount you pay every year before the plan pays for covered services
Annual Out-of-Pocket Maximum <i>(Deductible does not apply)</i>	\$3,000 per member/ \$9,000 per family	\$5,000 per member/ \$15,000 per family	The set limit after which your plan pays 100% of the allowable charge
Coinsurance	30%	50%	Percentage of allowed charges you pay after you meet the deductible

Preventive Care*	Covered in Full	Deductible, then 50%	Includes preventative immunizations, medical exams, sports physicals, women's health, well baby exams
Preventive Screenings*	Covered in Full	Deductible, then 50%	PAP Smear, PSA Testing, Colorectal Cancer Screening, Cholesterol Screening, Bone Density Testing
Ambulance Transportation	Deductible, then 30%	Administered as Category 1	Includes transport to the nearest facility equipped to provide appropriate care
Chemical Dependency++	Deductible, then 30%	Deductible, then 50%	Diagnostic evaluation and education, organized individual and group counseling
Diagnostic Imaging and Laboratory Services	Deductible, then 30%	Deductible, then 50%	Includes x-rays, ultrasounds, CAT scans, MRIs, lab tests, and interpretations
Durable Medical Equipment	Deductible, then 30%	Deductible, then 50%	Includes orthotics, prosthetics, and related supplies
Emergency Room**	\$100 Copay/Visit	\$100 Copay/Visit	Includes the services of the facility and supplies
Home Health Care, Hospice	Deductible, then 30%	Deductible, then 50%	Specialized care services administered inpatient and outpatient
Hospital Care	Deductible, then 30%	Deductible, then 50%	Hospital room and board, surgery, anesthesia, intensive and coronary care, laboratory tests, radiology services, drugs while in hospital
Mammograms	Covered in Full	Deductible, then 50%	Radiological procedure and explanation of results once every 12 months
Maternity Services***	\$5,000 Deductible, and 30% Coinsurance	\$5,000 Deductible, and 50% Coinsurance	Delivery and associated hospital care
Mental Health +++	Deductible, then 30%	Deductible, then 50%	Individual and family counseling
Office Visits (Including Urgent Care)	Clinic - \$10 Copay Affiliate - Deductible, then 30%	Deductible, then 50%	Includes examination, consultation, evaluation, and treatment plan
Organ Transplants ^	Deductible, then 30%	Deductible, then 50%	Professional and facility fees, diagnostic tests and exams, surgery, and follow-up care
Prescription Drugs	Tier 1 (Generic): \$10 Tier 2 (Brand Name and Non-Formulary): 50%	Tier 1 (Generic): \$20 Tier 2 (Brand Name and Non-Formulary): 50%	Drugs and medicine requiring a prescription including injectibles, contraceptive drugs, devices, and supplies

Rehabilitation+	Deductible, then 30%	Deductible, then 50%	Includes physical, occupational, and chiropractic services
Skilled Nursing Facility	Deductible, then 30%	Deductible, then 50%	Includes room and board, ancillaries, and professional fees

*Benefits provided at 100% allowable charges, not subject to deductible or coinsurance (except for out-of-network, non-contracted provider)

** Entire Emergency Room Visit subject to deductibles and coinsurance, Copay waived if admitted to the hospital

*** Deliveries occurring within the first six months of initial enrollment or re-enrollment are subject to \$5,000 deductible and coinsurance, otherwise subject to deductible and co-insurance

+ Up to a combined maximum of 12 visits per year (of those no more than 6 can be for chiropractic care). Allowed only when used as post-operative treatment following reconstructive surgery (within one year after date of surgery).

++ Benefits limited to \$5,000 every 24 months or \$10,000 lifetime maximum

+++ Limited to 10 inpatient visits per year and 12 outpatient visits per year (office visits to manage medication do not count toward 12 visit maximum)

^ 12 month waiting period applies, except for newborns or for a condition that is not pre-existing

°Non-contracted out-of-network providers may charge more than the allowed charges. In those cases, the plan pays 50% of the allowed charges and the member pays the remaining balance.

NOTE: Members who self-refer to an out-of-network provider in cases of non-emergencies may be subject to balance billing.

Benefits and services subject to the deductible and coinsurance

Before your health plan pays the coinsurance for the following benefits, you must pay your annual deductible. The annual in-network deductible is \$500 per person per calendar year, or up to \$1,500 per family unit per calendar year, except for maternity delivery services. Maternity delivery services, is subject to a \$5,000 deductible and co-insurance for deliveries occurring within the first 6 months of enrollment or re-enrollment.

The annual out-of-network deductible is \$1,000 per person per calendar year, or up to \$3,000 per family unit per calendar year if services are received without a referral or authorization from the health plan. If a referral or authorization is received by the member to an out-of-network provider, then in-network cost sharing applies.

Once you meet your deductible, all coinsurance payments will be applied toward your annual out-of-pocket maximum. The annual in-network out-of-pocket maximum is \$3,000 per person per calendar year or \$9,000 per family unit per calendar year. The annual out-of-network out-of-pocket maximum is \$5,000 per person per calendar year or \$15,000 per calendar year per family if services are received without a referral or authorization from the health plan. If a referral or authorization is received by the member to an out-of-network provider, then in-network out-of-pocket maximums apply.

Both the \$75,000 and \$100,000 annual benefit maximum applies per person per calendar year to the benefits and services listed on page 29.

Once the per person or per family out-of-pocket maximum has been reached, the health plan pays 100% of allowed charges for all covered benefits and services with a coinsurance up to the maximum annual benefit limit. Any charges received in excess of the annual maximum benefit level are the responsibility of the member.

IV. Limitations and exclusions

A. Limitations

1. Preexisting condition waiting period

a. A preexisting condition is defined as: "Any illness, injury, or condition for which, in the nine months immediately preceding a member's effective date of enrollment in Washington Health:

- (1) Treatment, consultation, or a diagnostic test was recommended for or received by the member; or
- (2) Medication was prescribed or recommended for the member.

b. Waiting period

Washington Health will not provide benefits for services or supplies rendered for a member age 19 or over at the time of enrollment any preexisting condition during the first nine consecutive months following the member's effective date of coverage. A member will not be required to begin a new nine consecutive-month waiting period if:

- (1) Coverage is suspended for not longer than one month during the waiting period, and
- (2) The member does not have more than two (2) one-month breaks in coverage during the waiting period.

Coverage for preexisting conditions will not be available until the member is actually covered by Washington Health for a total of nine months except as otherwise provided in this document.

If the member is confined in a health care facility for treatment of a preexisting condition at the time the member's nine-month waiting period ends, benefits for that condition will be provided only for covered services rendered after the end of the waiting period, except as otherwise provided for in this document.

c. Exceptions to waiting period

(1) The following services are not subject to the waiting period:

- Maternity care, although the maternity delivery deductible and coinsurance applies.
- Prescription drugs as defined in "Pharmacy Benefit."
- Oxygen.
- Routine diabetic care.

The 9-month pre-existing condition waiting period is waived for a Washington Health member who is under 19 at the time of enrollment, or who is diagnosed as a diabetic, or who is identified as a borderline diabetic by their contracted provider. The waiting period is waived only for the following covered benefits and services:

Diabetes education services approved by the health plan for members who meet the following criteria (up to ten hours per calendar year):

- Diagnosed diabetics;
- Diabetics whose treatment changes from diet control to oral diabetes medication, or from oral diabetes medication to injectable medication;
- Diabetics with inadequate glycemic control as evidenced by an HbA1c level of 8.5% or more on two consecutive laboratory results three or more months apart during a 12-month period;
- Persons identified by their provider as being at high risk for complications from inadequate glycemic control.

Yearly eye exam for diabetic retinopathy;

Outpatient services related specifically to routine care. (Examples: Office visits and laboratory services.)

All other services are subject to the appropriate waiting period as defined in the Washington Health "Schedule of Benefits."

d. Credit toward the waiting period

Credit toward the waiting period will be given:

- (1) If Washington Health delays the member's enrollment (up to a maximum of three months), and the member has been determined eligible.
- (2) For any continuous period of time during which a member was covered under similar health coverage if:
 - That coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage under Washington Health, or within the three-month period immediately preceding enrollment in Washington Health; and
 - The coverage terminated not later than the first of the month following the effective date of coverage in Washington Health.

If similar coverage was in effect both prior to the date of application or reservation and the date of enrollment, credit will be given for the longer period of continuous coverage.

"Similar coverage" includes Basic Health, all DSHS programs which have the Medicaid scope of benefits, the DSHS program for the medically indigent, Indian Health Services, most coverages offered by health carriers, and most self-insured plans.

2. Maternity Window Deductible

There is a six-month maternity window for delivery benefits beginning with the date of enrollment or re-enrollment. Deliveries occurring within this maternity window are subject to a \$5,000 deductible and coinsurance. The maternity deductible applies only to the delivery expense and only to the initial enrollment or re-enrollment period. It does not apply to other maternity-related services, such as full prenatal care, postpartum care, care for pregnancy complications, well-child newborn care, and termination of pregnancy.

3. Major Disaster or Epidemic

If the health plan is prevented from performing any of its obligations hereunder in whole or part as a result of a major epidemic, act of God, war, civil disturbance, court order, labor dispute, or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing and contracting providers and personnel. Upon the occurrence of any such event, if the health plan is unable to fulfill its obligations either directly or through contracting providers, it shall arrange for the provision of alternate and comparable performance.

4. Coordination of Benefits

The benefits available under Washington Health shall be secondary to the benefits payable under the terms of any health plan that provides benefits for a Washington Health member except where in conflict with Washington State or federal law.

B. Exclusions

The services listed below are not covered:

1. Services that do not meet the Washington Health definition of "Medical Necessity" for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.
2. Services not provided, ordered, or authorized by the member's health plan or its contracting providers, except in an emergency.
3. Services received before the member's effective date of coverage.
4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
5. Hospital charges for personal comfort items; or a private room unless authorized by the member's health plan; or services such as telephones, televisions, and guest trays.
6. Emergency facility services for nonemergency conditions.
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
8. Sleep studies, except the initial sleep study authorized by the contracted health plan. Only one sleep study per member per calendar year is covered.
9. Transportation except as specified under "Organ transplants" and "Emergency care."
10. Immunizations, except as covered under preventive care. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
11. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the "Plastic and reconstructive services" benefit.
12. Sex change operations.
13. Investigation of or treatment for infertility or impotence.
14. Reversal of sterilization.
15. Artificial insemination.
16. In-vitro fertilization.
17. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under "Preventive care."
18. Hearing aids.
19. Routine foot care.
20. Speech and recreation therapy.
21. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.
22. Medical services, drugs, supplies, or surgery directly related to the treatment of obesity, including morbid obesity (such as, but not limited to, gastroplasty, gastric stapling, or intestinal bypass).

23. Weight loss programs.
24. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits."
25. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with Washington State or federal law or regulation; or the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.
26. Conditions resulting from acts of war (declared or not).
27. Direct complications arising from excluded services.
28. Replacement of lost or stolen medications.
29. Evaluation and treatment of learning disabilities, including dyslexia.
30. Any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracting provider, and authorized in advance by the health plan.

C. Changes to covered services and premiums

Washington Health may from time to time revise this "Schedule of Benefits." In designing and revising this "Schedule of Benefits," Washington Health will consider the effects of particular benefits, copayments, deductibles, coinsurance, out-of-pocket maximums, limitations, and exclusions on access to medically necessary primary health care services, as well as the cost to members and to the state. Generally accepted practices of the health insurance and managed health care industries will also be taken into account.

Washington Health will provide you with written notice of any planned revisions to your Washington Health premiums or the benefit plan at least 30 days prior to the effective date of the change. This notice may be included with your premium statement, open enrollment materials or other mailing, or may be a separate notice. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first-class postage paid, directed to you at the mailing address you provided to Washington Health.

Appendix B: Definitions of Terms

Allowable Charges

The amount the health plan pays to contracted in-network providers.

Appeal

A formal request for the health plan or Washington Health to review its decision.

Balance Billing

When you visit an out-of-network provider without a referral or authorization from your health plan, you are subject to paying additional fees. In addition to copays, deductibles, coinsurance, and annual out-of-pocket maximums, you will pay the difference between the amount your health plan allows for the service and what the provider chooses to bill for the service, which generally does not contain any discounts.

Basic Health Plan

A health care coverage program administered by the Health Care Authority (HCA).

Certificate of coverage

A description of your health care coverage and benefits. This handbook serves as your certificate of coverage.

Coinsurance

A percentage you pay for certain services after you have paid your annual deductible.

Copayment or copay

A set dollar amount you pay when you receive specific services. Copays are not subject to a deductible and do not apply toward your deductible, coinsurance, or out-of-pocket maximum.

Deductible

The amount you pay before your health plan starts to pay for services with coinsurance. The deductible will not apply toward your out-of-pocket maximum.

Department of Social and Health Services (DSHS)

The state agency that administers Medicaid and other medical assistance programs.

Dependents

Same as family members.

Disenrollment

Losing Washington Health coverage without the option of reenrolling the following month. This can be due to nonpayment by the due date given in the suspension notice; more than two suspensions in a 12-month period; loss of eligibility; or for failure to abide by any of your responsibilities as a Washington Health member.

Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Enrollment

The process of submitting completed application forms, being determined eligible, and being accepted into the Washington Health Program.

Explanation of benefits (EOB)

Each health plan is required to send an EOB each time you receive medical services. The EOB is a detailed statement that explains the service(s) you received, the allowed amount for each service, the amount the health plan pays, and the amount you are responsible to pay. The EOB will also track the amount you have paid towards each covered family member's annual deductible and out-of-pocket maximum.

Family members

Family members who should be listed as dependents on your account include:

- Your spouse living in the same house and not legally separated from you.
- Your child under age 26, including stepchild, legally adopted child, and a child placed in your home for purposes of adoption or under your legal guardianship.
- Your child under age 26, enrolling for Washington Health coverage, and in your custody under an informal guardianship agreement that is signed by the child's parent(s) and allows you to get medical care for the child. To request coverage for a child living with you under such an agreement, you must provide a copy of the guardianship agreement and proof that you are providing at least 50 percent of the child's support. You cannot list a child who is in your home under a foster care agreement.
- Your child, stepchild, legally adopted child, or legal dependent of any age who cannot take care of him- or herself due to disability. You must provide proof of disability. If the dependent with a disability is not your birth or adopted child, you must also provide proof of legal guardianship.

Family size

The number of family members eligible to be listed on a Washington Health account.

Family Unit

Three or more qualified members of a subscriber's family (which may or may not include the subscriber). A family unit is charged a single deductible and out-of-pocket maximum regardless of the number of dependents on the account.

Formulary

A list of approved prescription drugs developed by each health plan.

Grievance

A written or an oral complaint submitted by or on behalf of a covered person to their health plan or Washington Health.

Health Care Authority (HCA)

The state agency responsible for Washington Health and Basic Health Plan administration.

Health plan

An organization which offers health care coverage and contracts with the HCA to provide your care. You choose your health plan when you join Washington Health.

In-Network Provider

Each health plan contracts with a number of providers, specialists, facilities, and affiliates. These organizations make up the health plan's "provider network". Services received from this network are referred to as "in-network" and a specific set of benefits, copayments, deductibles, and coinsurance apply. Generally, services received "in-network" are discounted and offer lower cost to members.

Inpatient

A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

Maternity Benefits Program

A DSHS administered program offering full maternity services to eligible pregnant women meeting DSHS income guidelines.

Maternity Window Deductible

A six-month maternity window for delivery benefits. Deliveries occurring within this maternity window are subject to a \$5,000 deductible and coinsurance. The maternity waiting period applies only to initial enrollment or re-enrollment. It does not apply to other maternity-related services, such as full prenatal care, delivery, postpartum care, care for pregnancy complications, well-child newborn care, and termination of pregnancy.

Maximum Benefit

An annual maximum benefit applies to all services per member per calendar year. Once you reach your selected annual benefit limit of either \$75,000 or \$100,000, you are responsible for any and all charges.

Medicare

The federal health benefit program for people who are age 65 and over, and for some people with disabilities. (If you are eligible for free or purchased Medicare coverage, you are not eligible for Washington Health.)

Member

A person enrolled in and receiving health care coverage through Washington Health.

Non-compliance

Failure to provide documentation or information requested by Washington Health by the due date.

Non-Contracted Provider

A person, practitioner, or entity that has no written agreement with the health plan and is not employed by the health plan to provide health care services

Out-of-pocket maximum

The most coinsurance you will have to pay each calendar year for each covered member or family unit. Only your coinsurance costs apply toward your out-of-pocket maximum. After you have paid the out-of-pocket maximum, you

do not have to pay coinsurance costs for the remainder of the calendar year.

Out-of-Network

Care received from primary care specialists, specialists, primary care sites, hospitals, and other facilities which are not contracted with your health plan are referred to as "out-of-network." If you receive care "out-of-network," and have not been referred by your in-network provider or health plan, you may be subject to higher cost sharing including higher deductibles, co-insurance, and co-pays. You may be subject to additional costs including balance billing.

Outpatient

A nonhospitalized patient receiving covered services away from a hospital, such as in a physician's office or the patient's own home, or in a hospital outpatient or hospital emergency department or surgical center.

Personal eligibility statement (PES)

The notice Washington Health sends you showing the current status of your account. You will receive a PES when there is a change to your account. This statement may include a bill for additional premiums you must pay as a result of a change.

Preexisting condition

An illness, injury, or condition for which, in the nine months immediately preceding a member's effective date of enrollment in Washington Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member;
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.

Premium

Your monthly payment for Washington Health coverage.

Primary care provider (PCP)

Your personal health care provider. Your primary care provider can be a family or general practitioner, internist, pediatrician, or other provider approved by your health plan. To receive benefits, your primary care provider must provide or coordinate your care. If you need to see a specialist, your primary care provider will refer you.

Provider

A health care professional (such as a doctor, nurse, internist, etc.) or facility (such as a hospital, clinic, etc.).

Recertification

Periodic review of your family's eligibility.

Service area

The geographic area served by a health plan that provides coverage for Washington Health members.

Specialist

A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Standard Health Questionnaire (SHQ)

This is a written screening Washington Health uses to determine when applicants are eligible for coverage through the Washington State Health Insurance Pool (WSHIP). WSHIP helps people who are not eligible for individual coverage to find health insurance. For more information, see WSHIP.org.

Student

A person enrolled full time in an accredited secondary school, college, university, technical college, or school of nursing, as determined by the school registrar.

Subscriber

The person on a Washington Health account who is responsible for payment of premiums and other cost sharing, and to whom Washington Health sends all notices and communications. The subscriber may be a

Washington Health member or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage.

Suspension of coverage

The process of losing health coverage for one month after a monthly premium has not been paid or has been paid in full after the due date. If your coverage is suspended more than two times in a 12-month period, you will be disenrolled and cannot reenroll for at least 12 months.

Tier

A category of drugs related to the pharmacy benefit. Your cost for prescriptions depends on the category (or tier) the prescription falls within. Tier 1 is the category of prescriptions that costs you the least.

Washington resident

A person physically residing and maintaining a residence in the state of Washington. You must be a Washington resident to be eligible for Washington Health. To be considered a Washington resident, members who are temporarily out of Washington for any reason:

- May be required to prove their intent to return to Washington State; and
- May not be out of Washington State for more than three consecutive calendar months.

Dependent children who are attending school out of state may be considered residents if they are out of state during the school year, as long as their primary residence is in Washington State and they return to Washington State during breaks. Dependent children attending school out of state may be required to provide proof that they pay out-of-state tuition, vote in Washington, and file income taxes using a Washington address.

Your residence may be a home you own or are purchasing or renting, a shelter or other physical location where you are staying in lieu of a home, or another person's home.

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