



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

Questions? Call 1-800-877-5187

Enrollment Information

(Non-Medicare Plans)

Important – Please Read!

Please review this information carefully and **return your completed application, along with a copy of all required documents and your applicable premium payment to the address above.** (You may fax your application, provided the original and premium payment are sent by mail within 5 days.)

Applicants are encouraged to use a licensed insurance agent. If you do not have an agent, use the **WSHIP Agent Directory** to locate an agent who is knowledgeable about the WSHIP application process. Call Customer Service at 1-800-877-5187 to request a copy, or go to www.wship.org.

About WSHIP

The Washington State Health Insurance Pool (WSHIP) is an independent, non-profit health plan created by the Washington State Legislature. We offer individual health insurance coverage to state residents rejected for coverage by health carriers due to medical reasons. Our benefit plans, premiums, eligibility rules, and other program requirements are governed by state law. A Board of Directors with representatives for consumers, employers, insurance agents, health carriers, health care providers, and the Insurance Commissioner oversee the organization. WSHIP is administered by Benefit Management Inc. (BMI), working with Medco for pharmacy services, First Choice Health for provider network services, and Qualis Health for care coordination and disease management programs.

Eligibility

To be eligible for WSHIP's Non-Medicare Plans you must meet all of the following requirements:

- You must be a resident of Washington state;
- You must have been rejected for coverage by a health carrier based upon the results of the Standard Health Questionnaire or live in a Washington county where individual benefit plans are not offered; and
- You must not be eligible for Medicare coverage.

Your dependent children may be covered by WSHIP provided that you are eligible for and are enrolled in WSHIP. Coverage for dependent children is available under a separate policy. Your dependents are not required to have been rejected due to their score on the Standard Health Questionnaire. Dependent children must be unmarried and under the age of 19. Coverage can be extended for dependent children age 19 and older who are disabled.

Questions? Contact Customer Service at **1-800-877-5187** or go to www.wship.org.

Instructions

1. Review the benefit plans information carefully and compare options.
2. Select the plan and deductible that is best for you.
3. Review the premium rate charts to determine your monthly premium.
4. Fill out the WSHIP application completely.
5. Sign and date your application and attach copies of all required documents.
6. Enclose a check for your applicable premium and mail your application and supporting documents to us in the enclosed return envelope. (You may fax your application if originals and payment are sent by mail within 5 days.)

HOW TO CONTACT US

Call Customer Service at 1-800-877-5187

(8 AM to 5 PM Pacific Time, Monday – Friday)

Visit our website at www.wship.org

Write to us at: PO Box 1090, Great Bend KS 67530

Benefit Plans & Premiums

Benefit Plans

WSHIP offers five plans for you to choose from. All plans include coverage for preventive care, major medical, and prescription drugs; they also include annual out-of-pocket expense limits. Disease management programs and case management services are also included.

The **Preferred Provider Plans** allow you to choose any provider but pay a higher level of benefits for services provided by network providers (80%) than non-network providers (60%); these plans have the lowest premiums. The **Standard Plan** pays the same level of benefits (80%) for services provided by network and non-network providers.

Provider network services are provided by First Choice Health, a leading independent PPO Network in Washington with a growing presence in Oregon, Idaho, Montana and Alaska. When you are traveling, you also have access to network providers in all 50 states. Visit www.fchn.com or call 1-800-231-6935 for network information. The pharmacy network is provided by Medco. Medco is our pharmacy benefit manager and has the nation's largest mail order pharmacy operations, including over 1,100 specialist pharmacists trained in specific chronic conditions, and more than 60,000 participating retail pharmacies; visit www.medco.com or call 1-800-859-8810 for pharmacy network information.

WSHIP Benefit Plan Choices

1. **Preferred Provider Plan** is a comprehensive plan with deductible options of \$500, \$1,000, \$2,500 or \$5,000. You pay 20% coinsurance for services provided by network providers, and specified copays for prescription drugs.
2. **HSA Qualified Preferred Provider Plan** is a comprehensive High Deductible Health Plan (HDHP) that can be used with a federally qualified Health Savings Account (HSA). It has a combined medical and prescription drug deductible of \$3,000. You pay 20% coinsurance for services provided by network providers, and 20% for prescription drugs.
3. **Limited Preferred Provider Plan “A”** is a less comprehensive plan with a \$1,500 deductible. You pay 20% coinsurance for services provided by network providers, and specified copays for prescription drugs. This plan pays a maximum of \$3,000 for prescription drugs per calendar year.
4. **Limited Preferred Provider Plan “B”** is similar to Plan “A” but has no maternity coverage and a \$2,000 benefit maximum for prescription drugs per calendar year.
5. **Standard Plan** is a comprehensive plan with deductible options of \$500, \$1,000 or \$1,500. You pay 20% coinsurance for services provided by network and non-network providers, and specified copays for prescription drugs. This plan has higher premiums than our preferred provider plans.

A Benefit Plans Summary and Comparison Chart is included in this packet. A complete policy and a copy of our Preferred Prescriptions drug list (formulary) are available on our website at www.wship.org; or you may request a copy from Customer Service.

Premiums

Monthly premium rates are included in this packet. Premiums are based on your age and use of tobacco products. State law requires WSHIP premiums to be 110%-150% of the average of what the largest carriers in the state charge for their individual plans with benefits similar to WSHIP. Premiums cover about one third of the cost of providing coverage; health carriers pay the remaining costs. (WSHIP is not state-funded.)

How the HSA Qualified Plan Works

WSHIP's HSA Qualified Preferred Provider Plan is a High Deductible Health Plan (HDHP) that can be used with a federally qualified Health Savings Account (HSA).

This plan has a **combined** medical and prescription drug annual deductible of \$3,000.

Although persons age 65 and older may enroll in this plan if they are not enrolled in Medicare, they may not set up a tax-deferred Health Savings Account.

IMPORTANT: Once you become enrolled in a WSHIP high-deductible plan, you cannot later choose to enroll in a lower-deductible plan.

How a Health Savings Account (HSA) Works

You must make arrangements through a financial institution for your Health Savings Account. Banks, credit unions, and other financial institutions are permitted to be trustees or custodians of your HSA account. The U.S. Dept. of Treasury has information about Health Savings Accounts; go to www.treas.gov (click on "Health Savings Accounts"); or contact your bank. (WSHIP does not provide this information or make recommendations.)

Tax Savings – An HSA provides you with tax savings through:

- tax deductions when you contribute to your account;
- tax-free earnings through investment; and
- tax-free withdrawals for qualified medical expenses.

How WSHIP's HSA Qualified Preferred Provider Plan Works

- WSHIP's HSA Qualified Preferred Provider Plan allows you to choose any provider but pays a higher level of benefits for services provided by network providers (80%) than non-network providers (60%).
- You pay 20% of eligible medical expenses, up to the out-of-pocket maximum of \$5,250 per calendar year, when you receive services from a network provider. If you receive services from a non-network provider, you pay 40%, up to a maximum of \$10,500 per calendar year.
- All prescription drugs must be obtained from a network pharmacy. **You are responsible for paying the pharmacy the full amount of your prescription when you pick it up** and WSHIP will reimburse you for covered prescription drugs when your deductible is met. Prescription drugs are subject to your combined medical and prescription drug annual deductible, and a 20% coinsurance, up to the out-of-pocket limit. **You must provide your WSHIP ID card to the pharmacist each time you have a prescription filled** or you may not be reimbursed for amounts which exceed WSHIP's allowed amount.



WASHINGTON STATE HEALTH
INSURANCE POOL

Washington State Health Insurance Pool (WSHIP) 2011 WSHIP Benefit Plans Summary and Comparison Chart (Non-Medicare Plans)

DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET	Preferred Provider	HSA Qualified Preferred Provider	Limited "A" Preferred Provider	Limited "B" Preferred Provider	Standard Plan
Annual Deductible (Individual)	Choices: \$500, \$1,000, \$2,500 or \$5,000 ((\$2,500 and \$5,000 plans have a separate \$500 Prescription Drug deductible)	\$3,000 (Combined Medical and Prescription Drug deductible)	\$1,500 (Medical only deductible)	\$1,500 (Medical only deductible)	Choices: \$500, \$1,000 or \$1,500 (Medical only deductible)
Coinsurance	20% Network 40% Non-Network	20% Network 40% Non-Network	20% Network 40% Non-Network	20% Network 40% Non-Network	20%
Annual Out-of-Pocket Expense Limits (Individual) <i>The maximum amount you pay yearly including deductible and coinsurance</i>	\$500 Plan: \$1,000 Network \$2,000 Non-Network \$ 500 Prescription Drug \$1,000 Plan: \$1,650 Network \$3,300 Non-Network \$ 850 Prescription Drug \$2,500 Plan: \$5,000 Network \$7,500 Non-Network \$5,000 Prescription Drug \$5,000 Plan: \$10,000 Network \$15,000 Non-Network \$ 5,000 Prescription Drug	\$ 5,250 Network \$10,500 Non-Network (Combined Medical and Prescription Drug out-of-pocket limit)	\$4,000 Network \$6,000 Non-Network	\$6,500 Network \$9,750 Non-Network	\$500 Plan: \$1,000 Medical \$ 500 Prescription Drug \$1,000 Plan: \$1,650 Medical \$ 850 Prescription Drug \$1,500 Plan: \$2,000 Medical \$1,000 Prescription Drug
PRESCRIPTION DRUGS	\$500 Plan: Generic: \$2 copay Preferred Brand: 10% up to \$50 NonPreferred: 15% up to \$100 \$1,000 Plan: Generic: \$5 copay Preferred Brand: 15% up to \$50 NonPreferred: 20% up to \$100 \$2,500 and \$5,000 Plans: Drug Deductible: \$500 Generic: 20% Preferred Brand: 30% NonPreferred: 50%	20% (After annual combined Medical & Prescription Drug deductible is met)	Generic: \$10 copay Preferred Brand: 30% NonPreferred: 50% Prescription Drug Benefit Maximum: \$3,000	Generic: \$10 copay Preferred Brand: 30% NonPreferred: 50% Prescription Drug Benefit Maximum: \$2,000	\$500 Plan: Generic: \$2 copay Preferred Brand: 10% up to \$50 NonPreferred: 15% up to \$100 \$1,000 Plan: Generic: \$5 copay Preferred Brand: 15% up to \$50 NonPreferred: 20% up to \$100 \$1,500 Plan: Generic: \$10 copay Preferred Brand: 20% up to \$50 NonPreferred: 25% up to \$100

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

2011 WSHIP Benefit Plans Summary and Comparison Chart (continued)

MEDICAL BENEFITS	Preferred Provider		HSA Qualified Preferred Provider		Limited "A" Preferred Provider		Limited "B" Preferred Provider		Standard Plan
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	
COINSURANCE (% You Pay) AND LIMITS									<i>Network and Non-Network</i>
PREVENTIVE CARE <i>(deductible waived)</i>									
Preventive care exams and immunizations	0% \$500 PCY (1)		0% \$500 PCY		0% \$500 PCY		0% \$500 PCY		0% \$500 PCY
PROFESSIONAL SERVICES									
Office, inpatient, and outpatient professional services	20% / 40%		20% / 40%		20% / 40%		20% / 40%		20%
DIAGNOSTIC SERVICES									
Diagnostic x-ray & laboratory services	20% / 40%		20% / 40%		20% / 40%		20% / 40%		20%
Mammography <i>(deductible waived)</i>	0% / 40%		0% / 40%		0% / 40%		0% / 40%		0%
HOSPITAL SERVICES									
Inpatient (2) and outpatient facility services	20% / 40%		20% / 40%		20% / 40%		20% / 40%		20%
EMERGENCY CARE									
Emergency room	20% / 40%		20% / 40%		20% / 40%		20% / 40%		20%
OTHER SERVICES									
Acupuncture	20% / 40% 12 visits PCY		20% / 40% 12 visits PCY		20% / 40% 12 visits PCY		20% / 40% 8 visits PCY		20% 12 visits PCY
Ambulance	20% / 40%		20% / 40%		20% / 40% \$2,000 PCY		20% / 40% \$2,000 PCY		20%
Chemical Dependency	20% / 40% 30 Inpatient days PCY 28 Outpatient visits PCY		20% / 40% 30 Inpatient days PCY 28 Outpatient visits PCY		20% / 40% 30 Inpatient days PCY 28 Outpatient visits PCY		20% / 40% 30 Inpatient days PCY 28 Outpatient visits PCY		20% 30 Inpatient days PCY 28 Outpatient visits PCY
Diabetes Education <i>(certified only; deductible waived)</i>	0%		0%		0%		0%		0%
Home Health Care (2)	20% / 40% 130 visits PCY		20% / 40% 130 visits PCY		20% / 40% 130 visits PCY		20% / 40% 130 visits PCY		20% 130 visits PCY
Hospice and Respite Care	20% / 40% Hospice: not limited Respite: \$7,500 PCY		20% / 40% Hospice: not limited Respite: \$7,500 PCY		20% / 40% Hospice: not limited Respite: \$7,500 PCY		20% / 40% Hospice: not limited Respite: \$7,500 PCY		20% Hospice: not limited Respite: \$7,500 PCY
Massage Therapy <i>(when prescribed by a physician)</i>	20% / 40% 12 visits PCY		20% / 40% 12 visits PCY		20% / 40% 12 visits PCY		20% / 40% 12 visits PCY		20% 12 visits PCY
Maternity Services	20% / 40%		20% / 40%		20% / 40%		NOT COVERED		20%
Medical Supplies and Equipment (3)	20% / 40%		20% / 40%		20% / 40% \$2,500 PCY		20% / 40% \$2,500 PCY		20%
Mental Health Services (2)	20% / 40%		20% / 40%		20% / 40%		20% / 40%		20%
Oral Surgery	20% / 40%		20% / 40%		20% / 40%		20% / 40%		20%
Rehabilitation Therapy Services (Physical, Speech, Occupational, and Respiratory) (2)	20% / 40%		20% / 40%		20% / 40% 30 visits PCY		20% / 40% 20 visits PCY		20%
Skilled Nursing Facility (2)	20% / 40% 100 days PCY		20% / 40% 100 days PCY		20% / 40% 60 days PCY		20% / 40% 30 days PCY		20% 100 days PCY
Spinal Manipulations	20% / 40%		20% / 40%		20% / 40% 10 visits PCY		20% / 40% 10 visits PCY		20%
Tobacco Cessation <i>(WSHIP's program only)</i>	0% (one PCY)		0% (one PCY)		0% (one PCY)		0% (one PCY)		0% (one PCY)
Temporomandibular Joint (TMJ) Disorders	20% / 40% \$1,000 lifetime max		20% / 40% \$1,000 lifetime max		20% / 40% \$1,000 lifetime max		20% / 40% \$1,000 lifetime max		20% \$1,000 lifetime max
Transplant Surgery (3)	20% / 40% \$350,000 lifetime max		20% / 40% \$350,000 lifetime max		20% / 40% \$350,000 lifetime max		20% / 40% \$350,000 lifetime max		20% \$350,000 lifetime max

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

2011 WSHIP Benefit Plans Summary and Comparison Chart (continued)

COVERED PRESCRIPTION DRUGS

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

Most plans have different copays or coinsurance for generics, preferred brands and brand name drugs; and some drugs require a coverage review (prior-authorization). A copy of our prescription drug formulary and information about coverage reviews and Medco By Mail is available at www.wship.org or www.medco.com, or by calling Medco at 1-800-859-8810.

LIMITED COVERED SERVICES

- Preventive Care
- Acupuncture
- Chemical Dependency
- Home Health Care and Respite Care
- Massage Therapy
- Skilled Nursing Facility
- Tobacco Cessation
- Temporomandibular Joint (TMJ) Disorders
- Transplant Surgery
- Ambulance (on Limited PPO Plans A & B only)
- Medical Supplies and Equipment (on Limited PPO Plans A & B only)
- Prescription Drugs (on Limited PPO Plans A & B only)
- Rehabilitation Therapy Services (on Limited PPO Plans A & B only)
- Spinal Manipulations (on Limited PPO Plans A & B only)

EXCLUSIONS TO COVERED SERVICES

Benefits are not provided for treatment, surgery, services, drugs or supplies for any of the following:

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

ELIGIBILITY

To be eligible for WSHIP you must meet all of the following requirements:

- You must be a resident of Washington state;
- You must have been rejected for coverage by a health carrier based upon the results of the Standard Health Questionnaire or live in a Washington county where individual benefit plans are not offered; and
- You must not be eligible for Medicare coverage.

PRE-EXISTING CONDITIONS

All plans contain a 6-month waiting period for pre-existing conditions; the waiting period may be credited or waived based on your prior health care coverage, subject to approval by WSHIP.

CHANGING PLANS AFTER YOU ENROLL

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

PROVIDER NETWORKS

Provider network services are provided by First Choice Health for medical services. Visit www.fchn.com or call 1-800-231-6935 for network information. The retail and mail order pharmacy network is provided by Medco; visit www.medco.com or call 1-800-859-8810 for pharmacy network information.

CARE MANAGEMENT

Care management services are provided by Qualis Health; 1-800-549-7549. Services include medical necessity reviews and case and disease management programs.

PRIOR REVIEWS FOR MEDICAL NECESSITY

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

To request a review, call 1-800-549-7549.

HOW TO CONTACT US

Customer Service: 1-800-877-5187

Mail: PO Box 1090, Great Bend KS 67530

www.wship.org

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

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**Washington State Health Insurance Pool (WSHIP)
2011 Monthly Premium Rates**

PREFERRED PROVIDER PLANS (PPO Plans)

There are two rate charts below; please refer to the chart that is applicable to your smoker/tobacco use status as indicated in the heading of each chart.

Age	Non-Smoker / Non-Tobacco User Premiums						
Plan	Preferred Provider Plan <i>Table 1</i>				Limited "A" Preferred Provider Plan <i>Table 2</i>	Limited "B" Preferred Provider Plan <i>Table 3</i>	HSA Qualified Preferred Provider Plan <i>Table 4</i>
	Deductible	\$500	\$1,000	\$2,500	\$5,000	\$1,500	\$1,500
Child*	\$397	\$343	\$186	\$151	\$277	\$259	\$188
<25**	\$448	\$388	\$198	\$160	\$308	\$288	\$200
25-29	\$516	\$447	\$224	\$182	\$354	\$331	\$226
30-34	\$588	\$510	\$258	\$209	\$404	\$378	\$261
35-39	\$668	\$579	\$303	\$245	\$463	\$435	\$306
40-44	\$771	\$668	\$358	\$290	\$538	\$506	\$363
45-49	\$936	\$812	\$436	\$353	\$654	\$617	\$441
50-54	\$1,130	\$980	\$523	\$424	\$789	\$744	\$529
55-59	\$1,326	\$1,150	\$616	\$501	\$927	\$873	\$626
60-64	\$1,562	\$1,354	\$726	\$588	\$1,090	\$1,025	\$733
65+	\$1,562	\$1,354	\$726	\$588	\$1,090	\$1,025	\$733

Age	Smoker / Tobacco User Premiums						
Plan	Preferred Provider Plan <i>Table 5</i>				Limited "A" Preferred Provider Plan <i>Table 6</i>	Limited "B" Preferred Provider Plan <i>Table 7</i>	HSA Qualified Preferred Provider Plan <i>Table 8</i>
	Deductible	\$500	\$1,000	\$2,500	\$5,000	\$1,500	\$1,500
Child*	\$434	\$375	\$205	\$165	\$302	\$282	\$205
<25**	\$522	\$452	\$230	\$186	\$359	\$335	\$231
25-29	\$600	\$521	\$261	\$211	\$412	\$385	\$263
30-34	\$681	\$591	\$299	\$243	\$468	\$438	\$303
35-39	\$776	\$673	\$352	\$285	\$538	\$506	\$355
40-44	\$898	\$778	\$416	\$337	\$626	\$589	\$421
45-49	\$1,084	\$940	\$504	\$410	\$757	\$714	\$512
50-54	\$1,312	\$1,137	\$607	\$492	\$916	\$863	\$613
55-59	\$1,537	\$1,333	\$714	\$579	\$1,074	\$1,012	\$724
60-64	\$1,817	\$1,575	\$842	\$684	\$1,268	\$1,192	\$854
65+	\$1,817	\$1,575	\$842	\$684	\$1,268	\$1,192	\$854

The rates contained in these charts are the lowest rates allowable by law.

* Child rate for dependent child of parent or guardian also enrolled in WSHIP

** <25 rate for child enrolled without parent or guardian enrolled in WSHIP

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

**Washington State Health Insurance Pool (WSHIP)
2011 Monthly Premium Rates**

STANDARD PLAN (Non-PPO Plan)

		Non-Smoker / Non-Tobacco User Premiums								
		Standard Plan			Standard Plan Low Income¹					
Income Level	Age	Regular Rates Table 9			251% - 300% of FPL² Table 10			250% or less of FPL² Table 11		
		\$500	\$1,000	\$1,500	\$500	\$1,000	\$1,500	\$500	\$1,000	\$1,500
Deductible										
Full Premium	Child*	\$541	\$468	\$407	\$460	\$398	\$346	\$397	\$343	\$299
	<25**	\$610	\$529	\$461	\$519	\$450	\$392	\$448	\$388	\$338
	25-29	\$703	\$610	\$532	\$598	\$519	\$452	\$516	\$447	\$390
	30-34	\$802	\$695	\$606	\$681	\$591	\$515	\$588	\$510	\$444
	35-39	\$911	\$790	\$688	\$775	\$671	\$584	\$668	\$579	\$504
	40-44	\$1,052	\$911	\$793	\$894	\$775	\$674	\$771	\$668	\$581
	45-49	\$1,277	\$1,107	\$963	\$1,085	\$941	\$818	\$936	\$812	\$706
	50-54	\$1,541	\$1,336	\$1,162	\$1,310	\$1,136	\$988	\$1,130	\$980	\$852
	55-59	\$1,809	\$1,568	\$1,364	\$1,538	\$1,333	\$1,160	\$1,326	\$1,150	\$1,000
	60-64	\$2,130	\$1,846	\$1,607	\$1,810	\$1,569	\$1,366	\$1,562	\$1,354	\$1,178
65+	\$2,130	\$1,846	\$1,607	\$1,810	\$1,569	\$1,366	\$1,562	\$1,354	\$1,178	
You were enrolled in a prior medical benefit plan during the 63-day period prior to application to WSHIP with continuous enrollment for 18 months.	Child*	\$451	\$390	\$339	\$397	\$343	\$299	\$397	\$343	\$299
	<25**	\$509	\$441	\$384	\$448	\$388	\$338	\$448	\$388	\$338
	25-29	\$586	\$508	\$443	\$516	\$447	\$390	\$516	\$447	\$390
	30-34	\$668	\$579	\$505	\$588	\$510	\$444	\$588	\$510	\$444
	35-39	\$760	\$658	\$573	\$668	\$579	\$504	\$668	\$579	\$504
	40-44	\$876	\$759	\$661	\$771	\$668	\$581	\$771	\$668	\$581
	45-49	\$1,064	\$922	\$802	\$936	\$812	\$706	\$936	\$812	\$706
	50-54	\$1,284	\$1,113	\$969	\$1,130	\$980	\$852	\$1,130	\$980	\$852
	55-59	\$1,507	\$1,307	\$1,137	\$1,326	\$1,150	\$1,000	\$1,326	\$1,150	\$1,000
	60-64	\$1,775	\$1,538	\$1,339	\$1,562	\$1,354	\$1,178	\$1,562	\$1,354	\$1,178
65+	\$1,775	\$1,538	\$1,339	\$1,562	\$1,354	\$1,178	\$1,562	\$1,354	\$1,178	
You have been enrolled in WSHIP continuously for 36 months or more.	Child*	\$514	\$445	\$387	\$437	\$378	\$329	\$397	\$343	\$299
	<25**	\$580	\$503	\$438	\$493	\$427	\$373	\$448	\$388	\$338
	25-29	\$668	\$580	\$505	\$568	\$493	\$429	\$516	\$447	\$390
	30-34	\$762	\$660	\$575	\$647	\$561	\$489	\$588	\$510	\$444
	35-39	\$866	\$750	\$653	\$736	\$638	\$555	\$668	\$579	\$504
	40-44	\$999	\$866	\$753	\$849	\$736	\$640	\$771	\$668	\$581
	45-49	\$1,213	\$1,051	\$915	\$1,031	\$894	\$777	\$936	\$812	\$706
	50-54	\$1,464	\$1,269	\$1,104	\$1,244	\$1,079	\$939	\$1,130	\$980	\$852
	55-59	\$1,718	\$1,490	\$1,296	\$1,461	\$1,266	\$1,102	\$1,326	\$1,150	\$1,000
	60-64	\$2,023	\$1,754	\$1,526	\$1,720	\$1,491	\$1,297	\$1,562	\$1,354	\$1,178
65+	\$2,023	\$1,754	\$1,526	\$1,720	\$1,491	\$1,297	\$1,562	\$1,354	\$1,178	
You have been enrolled in WSHIP for 36 months or more AND had 18 months of continuous enrollment in a prior medical benefit plan.	Child*	\$428	\$371	\$322	\$397	\$343	\$299	\$397	\$343	\$299
	<25**	\$483	\$419	\$365	\$448	\$388	\$338	\$448	\$388	\$338
	25-29	\$557	\$483	\$421	\$516	\$447	\$390	\$516	\$447	\$390
	30-34	\$635	\$550	\$479	\$588	\$510	\$444	\$588	\$510	\$444
	35-39	\$722	\$625	\$544	\$668	\$579	\$504	\$668	\$579	\$504
	40-44	\$833	\$721	\$628	\$771	\$668	\$581	\$771	\$668	\$581
	45-49	\$1,011	\$876	\$762	\$936	\$812	\$706	\$936	\$812	\$706
	50-54	\$1,220	\$1,058	\$920	\$1,130	\$980	\$852	\$1,130	\$980	\$852
	55-59	\$1,432	\$1,241	\$1,080	\$1,326	\$1,150	\$1,000	\$1,326	\$1,150	\$1,000
	60-64	\$1,686	\$1,461	\$1,272	\$1,562	\$1,354	\$1,178	\$1,562	\$1,354	\$1,178
65+	\$1,686	\$1,461	\$1,272	\$1,562	\$1,354	\$1,178	\$1,562	\$1,354	\$1,178	

* Child rate for dependent child of parent or guardian also enrolled in WSHIP

** <25 rate for child enrolled without parent or guardian enrolled in WSHIP

¹ You must complete a Low Income Application and receive approval prior to being eligible for Low Income Rates.

If you are approved for a Low Income Discount, you will be notified of your adjusted premium rate.

² FPL = Federal Poverty Level

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

**Washington State Health Insurance Pool (WSHIP)
2011 Monthly Premium Rates**

STANDARD PLAN (Non-PPO Plan)

		Smoker / Tobacco User Premiums								
		Standard Plan			Standard Plan Low Income¹					
Income Level	Age	Regular Rates Table 12			251% - 300% of FPL² Table 13			250% or less of FPL² Table 14		
		\$500	\$1,000	\$1,500	\$500	\$1,000	\$1,500	\$500	\$1,000	\$1,500
Deductible										
Full Premium	Child*	\$591	\$511	\$445	\$503	\$434	\$378	\$434	\$375	\$326
	<25**	\$711	\$617	\$538	\$605	\$524	\$457	\$522	\$452	\$394
	25-29	\$819	\$710	\$619	\$696	\$604	\$526	\$600	\$521	\$454
	30-34	\$929	\$806	\$702	\$790	\$685	\$597	\$681	\$591	\$515
	35-39	\$1,059	\$918	\$799	\$900	\$780	\$679	\$776	\$673	\$586
	40-44	\$1,224	\$1,061	\$923	\$1,041	\$902	\$785	\$898	\$778	\$677
	45-49	\$1,479	\$1,282	\$1,115	\$1,257	\$1,089	\$948	\$1,084	\$940	\$818
	50-54	\$1,789	\$1,551	\$1,350	\$1,521	\$1,318	\$1,147	\$1,312	\$1,137	\$990
	55-59	\$2,096	\$1,817	\$1,581	\$1,781	\$1,545	\$1,344	\$1,537	\$1,333	\$1,160
	60-64	\$2,478	\$2,148	\$1,870	\$2,106	\$1,826	\$1,589	\$1,817	\$1,575	\$1,371
65+	\$2,478	\$2,148	\$1,870	\$2,106	\$1,826	\$1,589	\$1,817	\$1,575	\$1,371	
You were enrolled in a prior medical benefit plan during the 63-day period prior to application to WSHIP with continuous enrollment for 18 months.	Child*	\$493	\$426	\$370	\$434	\$375	\$326	\$434	\$375	\$326
	<25**	\$593	\$514	\$448	\$522	\$452	\$394	\$522	\$452	\$394
	25-29	\$682	\$592	\$516	\$600	\$521	\$454	\$600	\$521	\$454
	30-34	\$774	\$671	\$585	\$681	\$591	\$515	\$681	\$591	\$515
	35-39	\$882	\$765	\$666	\$776	\$673	\$586	\$776	\$673	\$586
	40-44	\$1,020	\$884	\$769	\$898	\$778	\$677	\$898	\$778	\$677
	45-49	\$1,232	\$1,068	\$929	\$1,084	\$940	\$818	\$1,084	\$940	\$818
	50-54	\$1,491	\$1,293	\$1,125	\$1,312	\$1,137	\$990	\$1,312	\$1,137	\$990
	55-59	\$1,747	\$1,514	\$1,318	\$1,537	\$1,333	\$1,160	\$1,537	\$1,333	\$1,160
	60-64	\$2,065	\$1,790	\$1,558	\$1,817	\$1,575	\$1,371	\$1,817	\$1,575	\$1,371
65+	\$2,065	\$1,790	\$1,558	\$1,817	\$1,575	\$1,371	\$1,817	\$1,575	\$1,371	
You have been enrolled in WSHIP continuously for 36 months or more.	Child*	\$562	\$486	\$422	\$477	\$413	\$359	\$434	\$375	\$326
	<25**	\$676	\$586	\$511	\$574	\$498	\$434	\$522	\$452	\$394
	25-29	\$778	\$675	\$588	\$661	\$573	\$500	\$600	\$521	\$454
	30-34	\$883	\$765	\$667	\$750	\$651	\$567	\$681	\$591	\$515
	35-39	\$1,006	\$872	\$759	\$855	\$741	\$645	\$776	\$673	\$586
	40-44	\$1,163	\$1,008	\$877	\$989	\$857	\$746	\$898	\$778	\$677
	45-49	\$1,405	\$1,218	\$1,059	\$1,194	\$1,035	\$900	\$1,084	\$940	\$818
	50-54	\$1,699	\$1,473	\$1,282	\$1,445	\$1,252	\$1,090	\$1,312	\$1,137	\$990
	55-59	\$1,991	\$1,726	\$1,502	\$1,692	\$1,467	\$1,277	\$1,537	\$1,333	\$1,160
	60-64	\$2,354	\$2,041	\$1,776	\$2,001	\$1,735	\$1,510	\$1,817	\$1,575	\$1,371
65+	\$2,354	\$2,041	\$1,776	\$2,001	\$1,735	\$1,510	\$1,817	\$1,575	\$1,371	
You have been enrolled in WSHIP for 36 months or more AND had 18 months of continuous enrollment in a prior medical benefit plan.	Child*	\$468	\$405	\$352	\$434	\$375	\$326	\$434	\$375	\$326
	<25**	\$563	\$488	\$426	\$522	\$452	\$394	\$522	\$452	\$394
	25-29	\$648	\$562	\$490	\$600	\$521	\$454	\$600	\$521	\$454
	30-34	\$736	\$638	\$556	\$681	\$591	\$515	\$681	\$591	\$515
	35-39	\$838	\$727	\$633	\$776	\$673	\$586	\$776	\$673	\$586
	40-44	\$969	\$840	\$731	\$898	\$778	\$677	\$898	\$778	\$677
	45-49	\$1,171	\$1,015	\$883	\$1,084	\$940	\$818	\$1,084	\$940	\$818
	50-54	\$1,416	\$1,228	\$1,068	\$1,312	\$1,137	\$990	\$1,312	\$1,137	\$990
	55-59	\$1,659	\$1,439	\$1,252	\$1,537	\$1,333	\$1,160	\$1,537	\$1,333	\$1,160
	60-64	\$1,962	\$1,701	\$1,480	\$1,817	\$1,575	\$1,371	\$1,817	\$1,575	\$1,371
65+	\$1,962	\$1,701	\$1,480	\$1,817	\$1,575	\$1,371	\$1,817	\$1,575	\$1,371	

* Child rate for dependent child of parent or guardian also enrolled in WSHIP

** <25 rate for child enrolled without parent or guardian enrolled in WSHIP

¹ You must complete a Low Income Application and receive approval prior to being eligible for Low Income Rates.

If you are approved for a Low Income Discount, you will be notified of your adjusted premium rate.

² FPL = Federal Poverty Level

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

Frequently Asked Questions

When will my coverage be effective?

If your completed application is faxed or postmarked on or before the last day of the month, WSHIP coverage will be effective the 1st of the next month. Some exceptions may apply.

Is there a waiting period for coverage of pre-existing conditions?

Yes, there is a 6-month waiting period. In certain circumstances, we will waive or credit this waiting period based on your current or prior creditable coverage.

May I be turned down for coverage?

No, as long as you meet all of the eligibility requirements.

May I apply for WSHIP if I have an existing insurance policy?

Yes. WSHIP will coordinate benefits and pay secondary to your other coverage.

May I keep my WSHIP coverage if I become eligible for Medicare?

No, but you may be able to enroll in WSHIP's Medicare-eligible Basic Plan if you meet its eligibility requirements. You will need to inform us of your Medicare coverage and we will assist you in determining your options.

May I keep my WSHIP coverage if I receive assistance from Medicaid?

No. Some exceptions may apply depending upon the type of DSHS medical assistance you receive.

What will happen if I move?

If you move to another location within Washington, you are still eligible for WSHIP (unless your eligibility is based upon the unavailability of individual coverage in your county). You need to send us a change of address to ensure that you receive important notices about your policy including our required yearly Eligibility Verification Form. If you move out of the state of Washington, you must notify us immediately; you will no longer be eligible for WSHIP and your coverage will terminate.

When does the policy end?

The policy terminates:

- When you send us written notice requesting termination
- For nonpayment of your premium within the 31-day grace period
- When you are no longer a resident of Washington state
- When you become eligible for Medical Assistance (except under certain circumstances)
- When you become eligible for Medicare
- When you reach your \$2 million dollar lifetime benefit maximum
- When you fail to respond to our inquiry about your eligibility or place of residence
- When you commit a material fraud upon or against WSHIP

How are premiums determined?

By law, WSHIP premiums must be based on an average of what the largest carriers in the state charge for their individual plans with benefits similar to WSHIP (not on the use of your health care services).

Are there any discounts available?

Yes, premium discounts are available on the Standard Plan only (if the discount does not result in a premium less than 110% of the standard risk rate) if:

- 1) you have been enrolled in a prior medical benefit plan during the 63 day period prior to application with continuous enrollment for 18 months in the medical plan;
- 2) you have been enrolled in WSHIP for more than 36 months; or
- 3) you have been enrolled in WSHIP for more than 36 months and had 18 months of continuous enrollment in a prior medical plan.

A low income discount is also available on the Standard Plan only if your gross family income is less than 301% of the Federal Poverty Level (FPL) Guidelines and the discount does not result in a premium less than 110% of the standard risk rate. You must submit a Low Income Application and be approved. Please contact Customer Service for an application if you are enrolling in the Standard Plan and think you may qualify for this discount.

Premiums for all Preferred Provider Plans are already as low as the law allows (and they are lower than the Standard Plan low income rates).

What is the process and who determines if I qualify for the low income discount?

WSHIP will send the Low Income Discount Application to you or you may download and print it from our website. We will contact you if additional information is needed. The Low Income Discount Application is then processed by, and eligibility for the discount is determined by, the Washington State Health Care Authority. WSHIP will notify you of their determination.

Should I contact Health Care Authority about my Low Income Discount Application?

No, all communication regarding your application should be directed to WSHIP.

What are my payment options?

You may choose to be billed quarterly, semi-annually or annually and submit payment to WSHIP, or you can choose to have automatic bank withdrawals made monthly. You will indicate your payment option on the application. Please be sure to enclose the amount of premium that is applicable to the payment frequency you selected. For example, if you selected quarterly, multiply the monthly rate by three months and enclose that amount with your application.

How do I change my payment option selection?

Request it in writing. If received by the 20th of the month, it will become effective the 1st of the following month. If you are changing to automatic withdrawal from your bank account, you will need to send us a Bank Service Plan Authorization Form and a voided check or bank MICR form.

What if I am currently paying a smoker/tobacco-user premium and I quit using tobacco products?

You must be tobacco-free for 12 months to be eligible for the non-smoker rate. If your tobacco use status changes, please notify us and we will send you a tobacco use affidavit form to fill out and return. The premium will be reduced on the 1st of the following month after the affidavit for being tobacco-free for 12 months is received. If you begin using tobacco products you must notify us immediately. There are no retroactive premium adjustments based on tobacco use status.

What will happen if I do not return my yearly Eligibility Verification Form?

WSHIP must verify your eligibility for coverage on an ongoing basis. An Eligibility Verification Form will be sent to you at least yearly and must be returned to us by the date requested or your policy will be terminated. Please keep an eye out for this important form and return it promptly to avoid losing your coverage. (You must also notify us of addresses changes.)

Can I re-enroll in WSHIP after termination?

If you fail to pay the premium or you voluntarily leave WSHIP, you will not be eligible to reapply until 12 months after termination date. (You can re-apply without meeting the 12 month criteria if you terminated due to having employment-related coverage which was subsequently lost.)

II. INTERNAL APPEAL PROCESS

A. Appeal to WSHIP's Administrator (First Level)

1. The person, or his or her authorized representative, must notify WSHIP's administrator of his or her request for appeal within 90 days of the event giving rise to the appeal. If the complaint concerns a carrier's application of the SHQ scoring tool, the person should include his or her completed SHQ and the carrier's scoring, if available. We have delegated the administrator's responsibility for first level appeals related to pharmacy benefit coverage issues to our Pharmacy Benefit Manager.
2. Within five business days, the WSHIP administrator will respond to the person in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested.
3. WSHIP's administrator will investigate the complaint, considering all information submitted by the person, and make its decision within 30 days of receipt of the complete information needed to respond to the appeal.
4. WSHIP's administrator will notify the person of its decision in writing and inform the person of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If WSHIP's administrator fails to make its decision within 30 days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and the person may appeal to the next level.
5. If the complaint concerns the carrier's application of the SHQ scoring tool or the timing of the notice of rejection and WSHIP's administrator determines that the carrier erred, WSHIP's administrator will also forward its written decision to the carrier and recommend that the carrier take appropriate action.
6. If a complaint involves denial of coverage of a service, and the person provides written notice to WSHIP's administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize the person's life, health or ability to regain maximum function, WSHIP's administrator will provide its written decision within 72 hours of receipt of the appeal request.

B. Appeal to WSHIP's Grievance Committee (Second Level)

1. The person, or his or her authorized representative, must notify WSHIP's administrator of his or her request for appeal to WSHIP's grievance committee within 90 days of an adverse decision by WSHIP's administrator and include a written description of the complaint.
2. Within five business days, WSHIP's administrator will respond to the person in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested. Within two business days of sending this notice, WSHIP's administrator will forward the appeal, with all relevant information from its files, to the WSHIP's grievance committee.
3. WSHIP's grievance committee will investigate the complaint, considering all information submitted by the person, and make its decision within 30 days of its receipt of the complete information needed to respond to the appeal. The grievance committee may engage independent medical and legal experts to assist in the review process.
4. WSHIP's grievance committee will notify the person of its decision in writing and inform the person of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If WSHIP's grievance committee fails to make its decision within 30 days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and the person may appeal to the next level (if applicable).

5. If the complaint concerns the carrier's application of the SHQ scoring tool or the timing of the notice of rejection and WSHIP's grievance committee determines that the carrier erred, the grievance committee will also forward its written decision to the carrier and recommend that the carrier take appropriate action.
6. If a complaint involves denial of coverage of a service, and the person provides written notice to WSHIP's administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize the person's life, health, or ability to regain maximum function, WSHIP's grievance committee will provide its written decision within 72 hours of its receipt of the appeal request.

III. EXTERNAL APPEAL PROCESS (Third Level)

- A. If WSHIP's grievance committee affirms a decision to deny, modify, reduce, or terminate coverage of or payment for health services, the person may appeal the decision to an IRO by notifying the WSHIP administrator within 30 days of receipt of the grievance committee's written decision.
- B. The administrator will gather all relevant documents and deliver them to the IRO within three business days of receiving the person's request for appeal.
- C. The IRO, made up of persons not associated with WSHIP, will review the complaint and make a decision. The IRO will provide its decision in writing to the person and WSHIP within 20 days of the person's request for appeal. WSHIP will pay the charges for the IRO's review and written report.

IV. ENROLLMENT AND SERVICES DURING APPEAL PROCESS

- A. A person denied enrollment by a carrier based on his or her SHQ results may apply for coverage under WSHIP while a review is in progress.
- B. If the complaint is from a WSHIP enrollee contesting a coverage decision and such decision was based on a finding of no medical necessity, WSHIP will continue to provide the service until the appeal is completed. Upon completion of the appeal process, if WSHIP continued to provide the service in question and it is determined that the coverage was properly denied, WSHIP may charge the enrollee for the cost of the services provided.

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Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review this notice carefully.

The privacy of your personal health and financial information is very important to us.

I. OUR COMMITMENT TO PRIVACY

Washington State Health Insurance Pool (WSHIP) is required by law to maintain the privacy of your personal health and financial information (PHI) and to provide you with notice of its legal duties and privacy practices with respect to your PHI.

In the course of administering your health benefits, WSHIP collects personal health and financial information from you and your health care providers. These records are used and maintained by WSHIP, but the PHI contained in the records belongs to you.

II. HOW DO WE PROTECT YOUR INFORMATION?

We maintain physical and electronic security safeguards to protect your personal health and financial information (PHI) against unauthorized access. We have policies and procedures in place to make certain we only share the minimum amount of PHI necessary and only with those parties who have a legitimate business need for the information. We have a privacy director who develops procedures to protect your PHI, educates our staff, and tests and enforces our privacy protection mechanisms.

We will not disclose PHI except as permitted by law.

III. TO WHOM IS YOUR PHI DISCLOSED & WHY?

To effectively administer your health benefits, WSHIP must share some of your personal health and financial information (PHI). The law permits WSHIP to use or disclose your PHI for the following reasons:

- **For treatment:** WSHIP may disclose your medical information when requested by a doctor, hospital or other provider requiring the information to appropriately treat you.
- **For payment:** WSHIP may use or disclose your PHI to pay or deny your claims for provider services that may or may not be covered by your WSHIP benefits. This may include exchanging eligibility, benefits or prior authorization information with your health care providers or pharmacy benefits carrier or providing information to your other insurance carrier (if applicable).
- **For healthcare operations:** WSHIP may use or disclose your PHI as required to operate the WSHIP program. For example, PHI may be used in determining the cost of your premiums, to collect your premiums, to support grievance or quality review boards, for audit or accreditation programs or for necessary business purposes. WSHIP may disclose your PHI to the WSHIP care management contractor to enable the contractor to contact you to offer care management assistance, and WSHIP may contact you about treatment alternatives and other health benefits and services.
- **To business associates:** WSHIP contracts with qualified third parties (“business associates”) to perform insurance-related functions on our behalf. For example, WSHIP business associates include the WSHIP administrator, pharmacy benefit manager, care management contractor, and network contractor. WSHIP may disclose protected health information with these business associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on our behalf. We are

required to have contracts with our business associates that require them to provide the same privacy protections that we provided for your PHI.

- **For the creation of data:** WSHIP may use your PHI for the creation of a historical database that is de-identified (not traceable back to you).
- **To you or to your designee upon your authorization:** WSHIP will release your PHI to you or someone who has the legal right to act for you (your personal representative). You retain the right to give us permission, by a written authorization, to use your PHI or release it to whomever you choose for any purpose. If you give us such an authorization, you have the right to cancel it at any time.

WSHIP considers the activities described above necessary for the proper administration of your health plan. There are also other limited circumstances in which WSHIP must release your PHI. These include:

- **As required by law:** WSHIP may use or disclose your PHI when required to do so by law. For example, we will disclose your PHI to the Secretary of the U.S. Department of Health and Human Services (HHS), should HHS choose to ensure we are in compliance with federal law. Additionally, we may disclose your PHI for the purpose of law enforcement, to correctional institutions as allowed by law, or as otherwise required by state laws.
- **For public health purposes:** WSHIP may use or disclose your PHI to avert a serious threat to your health and safety or the health and safety of others such as reporting disease outbreaks to the department of health.
- **For emergency situations and disaster relief purposes:** If you are unavailable to agree to disclosure due to an emergency situation or one of disaster relief, WSHIP may use or disclose your PHI as reasonably indicated for your best interest.
- **For public safety:** WSHIP may disclose your medical information to appropriate authorities if we reasonably believe you to be a victim of abuse, neglect, domestic violence or other crimes.
- **For judicial and administrative proceedings:** WSHIP may disclose your PHI in the course of any administrative or judicial proceeding. Examples of this include: in response to a court order, subpoena or summons.
- **For health oversight activities:** WSHIP may disclose your PHI to a health oversight agency for activities authorized by law, including investigation of activities involving fraud and abuse, audits, inspections or licensure.
- **For research:** WSHIP may use or disclosure your PHI for limited research purposes as approved by the WSHIP Board.
- **For military and national security:** WSHIP may disclose PHI of enrollees who are armed forces personnel for activities deemed necessary by military command authorities. Furthermore, we may disclose to authorized federal officials, that PHI required for national security activities authorized by the national Security Act (50 U.S. C. 401, *et seq.*).
- **For change of ownership:** WSHIP may use or disclose your PHI to facilitate the change over or acquisition of WSHIP by another insurer.

IV. WHAT ARE MY INDIVIDUAL RIGHTS?

By law, WSHIP must have your written permission (an “authorization”) to use or give out your PHI for any reason that is not described in this Privacy Notice. If you give us an authorization, you have the right to revoke (or cancel) it at any time. Revoking or changing an authorization must be done in writing and shall not affect any uses or disclosures of PHI already performed while the authorization was in effect.

In addition to the right to authorize any specific use or disclosure, you also have the following individual rights (listed below):

- **You have the right to request a copy of our current notice of privacy practices.** Under the law, we are required to provide you with a written copy of this Privacy Notice. You may request a copy of our current Privacy Notice at anytime. You may obtain this Privacy Notice on our web site at www.wship.org or you may request this notice in written form by contacting our Customer Service department.

- **You have the right to request a restriction.** If you have paid for a health care item or service out of pocket in full, you may request WSHIP to restrict the disclosure of your PHI if the PHI pertains solely to that health care item or service. WSHIP must agree to limit the disclosure of your PHI if the disclosure is to a health plan for the purposes of carrying out payment or health care operations as described in this notice. WSHIP is not required to agree to limit the disclosure of your PHI if the disclosure is for treatment. For all other health care items and services which you have not paid for out of pocket in full, you may submit a written request that WSHIP place restrictions and limit the use or disclosure of your PHI. WSHIP may not be able to agree to all requested restrictions, but we will review your request and notify you in writing.
- **You have the right to request a copy of or access to your records.** WSHIP must provide you, or your personal representative, with access to your PHI maintained by WSHIP, except for psychotherapy notes and information we compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding. You also have the right to request we provide copies to you or your personal representative. You must make this request in writing. WSHIP will respond to your request within 30 days unless you have agreed upon an alternative time period. If you have requested copies, a fee for materials, staff time and postage will be charged. Should you prefer, WSHIP can prepare a summary report of your PHI for a fee. WSHIP may limit the information that you can inspect or copy if we have reason to believe that it is necessary to protect you or another person from harm. If we limit your right to inspect or copy, you can ask for a review of that decision. To request copies of records, or information regarding any applicable fees, please contact us by using the information at the end of this notice.
- **You have the right to request and obtain an accounting of disclosures.** You have the right to request a list of those third parties who received a disclosure of your PHI from WSHIP within six (6) years of the date of your request. WSHIP will provide you this information within 30 days of receiving your written request. This list will not include any disclosures that were made to you or your personal representative, disclosures you authorized, disclosures made for treatment, payment or health care operations activities as described in this notice, incidental disclosures, disclosures made for law enforcement purposes, disclosures to a correctional institution, disclosures made for national security or intelligence purposes, or disclosures made prior to the mandatory effective date of this requirement: April 14, 2003. This service may be subject to a fee. To request an accounting of disclosures, or information regarding any applicable fees, please contact us by using the information at the end of this notice.
- **You have the right to be notified of a security breach involving your records.** WSHIP is required to notify you in the event that your unsecured PHI is acquired, accessed, used or disclosed. WSHIP must provide you this notification within 60 days after we discover the security breach, unless we are instructed to delay the notification by law enforcement. We may not be required to notify you of unintentional or inadvertent disclosures of your PHI.
- **You have the right to request an amendment.** You have the right to request that WSHIP amend your medical records that you feel are incorrect or incomplete. You must submit your request in writing to the address listed at the end of this notice. This request must include the reason for the requested amendment. WSHIP may accept or deny your request for amendment and will provide you with a written explanation. If WSHIP denies your request, you may respond with a written statement of disagreement and request the statement be appended to the medical record.
- **You have the right to request confidential communications.** If you would like to request that WSHIP communicate with you in confidence, in a different manner or at an alternative location, (for example: you may request that we send materials to a P.O. Box instead of your home address), please submit your request, including the reason for the request, in writing to the address listed at the end of this notice. WSHIP will accommodate all reasonable requests if we are able.
- **You have the right to submit a complaint.** In the event that an accidental or inappropriate disclosure of your PHI occurs, you have the right to expect WSHIP to mitigate or correct any loss or damage you may suffer. If you feel that WSHIP has violated your privacy rights set out in this notice, you or your personal representative may complain directly to WSHIP by using the information at the end of this notice, or to the Secretary of the U.S. Department of Health & Human Services (HHS). A Customer Service Representative will provide you with the address to HHS upon request and assist you in filing your complaint. Filing a complaint with WSHIP or HHS will not affect your benefits or services provided by WSHIP. We shall not retaliate in any way if you choose to file a complaint.

For more information regarding filing a complaint, exercising any of the above-described rights or any questions relating to our Privacy Notice, please contact our privacy director or a Customer Service Representative using the information at the end of this notice.

V. CHANGES TO THIS NOTICE OR THE PRIVACY PRACTICES OF WSHIP

All rights and privacy practices described in this Privacy Notice will take effect on January 1, 2010 and remain in effect until replaced by an updated Privacy Notice. WSHIP is required by law to follow the privacy practices described in this notice for as long as it is in effect.

WSHIP reserves the right to change the way we use or disclose your personal health and financial information (PHI). If WSHIP makes any changes to the privacy practices described in this notice, WSHIP will provide an updated notice via www.wship.org. Upon its effective date, the new notice provisions will be effective for any uses or disclosures by WSHIP.

VI. CONTACT INFORMATION

Address: WSHIP Administrator, Attn: Privacy Director
P.O. Box 1090
Great Bend, KS 67530

Customer Service: If you have any questions regarding this Privacy Notice, please call the toll-free Customer Service number at 1-800-877-5187.



WASHINGTON STATE HEALTH INSURANCE POOL

Application

Non-Medicare Plans

Questions? Call 1-800-877-5187

Please type or PRINT in black ink. All sections must be filled out completely. Your premium and required documents should be included with your signed application. Timely and complete submission of all documents will expedite the enrollment process. (You may Fax your application if the original and premium payment are sent by mail within 5 days.) You must be a resident of Washington state and meet other eligibility criteria to apply. If you are eligible for Medicare, do not fill out this application; request our Medicare-Eligible Basic Plan application.

SECTION 1: AGENT INFORMATION		<i>If you are applying through an Agent, the Agent must provide the information below and sign this section.</i>	
Agent Name		Firm or Agency	
Agent Mailing Address		City	State Zip Code
Agent Phone ()		Agent Email Address	
Agent's Washington State License Number		<input type="checkbox"/> Copy of current license attached* <input type="checkbox"/> Copy of current license on file with WSHIP* * Must be attached or on file to receive agent commission	
Agent's Tax I.D. Number		<input type="checkbox"/> Pay commission to firm <input type="checkbox"/> W-9 form attached <input type="checkbox"/> Pay commission to agent <input type="checkbox"/> W-9 form on file with WSHIP	
Agent Statement: I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application and the Standard Health Questionnaire (if applicable) has been completed truthfully by the Applicant(s).			
Agent Signature: X _____		Date Signed: _____	

SECTION 2: APPLICANT INFORMATION			
Last Name	First Name	MI	Social Security Number - -
<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (MM / DD / YYYY) / /		Age
Street Address (required; must attach proof)		City	State Zip Code
County of Residence	Home Phone ()	Work Phone or Cell Phone ()	
Email Address	Secondary Contact Person Name*	Secondary Contact Person Phone ()	
Name of Custodial Parent / Guardian if Applicant is a Minor or Not Legally Competent			
(If different from above) Billing Address and Name of Organization Responsible for Payment (if applicable)			
Billing Address		City	State Zip Code
Organization Paying Premiums	Organization Contact Person	Organization Contact Person Phone ()	
Receiving DSHS Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach your DSHS or Healthy Options ID card.			

* Secondary contact is a person who will know how to get in touch with you if we are unable to reach you. This person is not a personal representative unless a Personal Representative Form has been submitted for him/her.

SECTION 3: PLAN SELECTION

Check one box to indicate your plan selection and deductible option:

- | | |
|--|--|
| 1. Preferred Provider Plan | Deductible: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
(4 options) |
| 2. HSA Qualified Preferred Provider Plan
(combined medical & pharmacy deductible) | Deductible: <input type="checkbox"/> \$3,000 |
| 3. Limited Preferred Provider Plan "A" | Deductible: <input type="checkbox"/> \$1,500 |
| 4. Limited Preferred Provider Plan "B" | Deductible: <input type="checkbox"/> \$1,500 |
| 5. Standard Plan | Deductible: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500
(3 options) |

NOTE: Once enrolled, you may only switch plans effective January 1st each year and you may only change to a plan that has the same or higher deductible.

SECTION 4: DEPENDENT INFORMATION *(if more than two, list on separate sheet or copy page)*

If you are eligible for WSHIP and enroll, you can elect to cover your dependent children. They do not have to be rejected by a health carrier. Dependent children must be unmarried, and under age 19 (unless disabled).

Additional premiums are required for each dependent.

List dependents to be covered below: **(only list dependents you want covered by WSHIP)**

A	Dependent Last Name	First Name	MI	Social Security Number - -
	Relationship to Applicant	Birth Date (MM / DD / YYYY) / /		Age
	Disabled and 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, receiving Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date: / /	
	Receiving DSHS Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <u>attach</u> your DSHS or Healthy Options ID card.			

B	Dependent Last Name	First Name	MI	Social Security Number - -
	Relationship to Applicant	Birth Date (MM / DD / YYYY) / /		Age
	Disabled and 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, receiving Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date: / /	
	Receiving DSHS Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <u>attach</u> your DSHS or Healthy Options ID card.			

Is Applicant or any Dependent listed above currently insured through WSHIP? Yes No

If yes, name of person(s):

Relationship to Applicant: _____ Policy Number: _____

SECTION 5: OTHER COVERAGE*WSHIP will pay secondary to any other coverage unless preempted by federal law.*Do you or any person named on this application have any other medical or hospital insurance including public programs such as Medicare or Medicaid? Yes No**If yes, complete the following for each person(s) and attach copy of identification card(s):
(if more than one coverage, list on separate sheet or copy page)**

Last Name	First Name	MI	Social Security Number - -
Insurer Name	Insurer Phone ()	Policy Number	
Description of Coverage	Effective Date: / /	Termination Date: / /	
Is it a Group Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is it your intent to replace it with this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, remember to cancel your other coverage.)</i>		

SECTION 6: ELIGIBILITY INFORMATION**I certify that I am eligible for coverage because I meet the following THREE requirements:****1 I AM A RESIDENT OF THE STATE OF WASHINGTON**

"Resident" means a person who is domiciled in Washington state for purposes other than obtaining insurance. Domicile denotes a person's permanent home and place of habitation. Evidence of residency includes, but is not limited to, one of the documents listed below. WSHIP may request additional proof of residency.

I have included a copy of one of the following documents as proof of residency (proof must match your home street address in Section 2):

Check one box to indicate the document you are including. Do not send original; it will not be returned.

- A bill in your name from any public utility at your dwelling in Washington state (excludes cell phone bills)
- Receipts for rent, mortgage or lease payments for your dwelling in Washington state
- A Washington state driver's license or state identification card
- Proof of registration and payment in Washington of taxes and fees on motor vehicles
- Proof of employment in Washington state
- A voter registration card
- A federal tax return as a resident of Washington state
- Bank statement (excludes credit card statements)

2 I MEET ONE OF THE ELIGIBILITY CATEGORIES LISTED BELOW:

Check one box below for the eligibility category you are applying under:

 I WAS REJECTED FOR OTHER HEALTH COVERAGE FOR MEDICAL REASONS

I received notification of rejection for coverage from a Washington state licensed health carrier based on the results of the Standard Health Questionnaire (SHQ). WSHIP will accept a denial notice for up to 90 days from the date of the denial. Applicants may be required to reapply to a health carrier if the denial was received more than 90 days from the WSHIP application date.

I have included a copy of the health carriers' rejection notice and SHQ scoring page. Please do not include the entire SHQ, only the scoring page (last page of questionnaire).

 I RESIDE IN A COUNTY WITHOUT INDIVIDUAL COVERAGE

I reside in one of the state of Washington counties where individual health benefit plans are not marketed to the general public by a health carrier. **Name of county:**_____.

3 I AM NOT ELIGIBLE FOR MEDICARE

YOU ARE NOT ELIGIBLE FOR WSHIP COVERAGE IF ANY OF THE FOLLOWING APPLY:

- You have terminated coverage in WSHIP within the last 12 months, unless you can show that you had continuous other coverage from the date WSHIP coverage terminated, which has been involuntarily terminated for any reason other than non-payment of premiums.
- WSHIP has paid out two million dollars in benefits on your behalf.
- You are an inmate of a public institution.
- You have coverage under a public program that duplicates WSHIP benefits.
- You do not reside in Washington state (except qualified resident dependent children temporarily living outside of Washington state).
- You have become eligible for medical assistance after June 30, 2008.

SECTION 7: PRE-EXISTING CONDITIONS PROVISION

WSHIP plans have a **six-month waiting period** for pre-existing conditions following the policy effective date. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage.

To help us determine if you qualify for a waiver or credit towards the pre-existing condition waiting period, **complete the following and attach a copy of your Certificate of Coverage from your current or prior health carrier.**

If you do not have a Certificate of Coverage, you may provide other documentation (such as a letter from the employer, group administrator or prior health carrier), to demonstrate prior coverage beginning and ending dates.

(if more than one coverage, list on separate sheet or copy page)

Name of Health Carrier		Telephone Number of Health Carrier ()
Name of Subscriber (contract holder)		ID Number of Subscriber
Names of all Persons on Prior Coverage		
Date Coverage Began		Date Coverage Ended
Deductible Amount \$	Out-of-Pocket Maximum Per Year \$	<i>(If available, please attach a copy of the Summary of Benefits for this coverage.)</i>
Type of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA <input type="checkbox"/> Other _____		
Type of benefits (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Hospital Only <input type="checkbox"/> Accident Only		

REDUCTION OR WAIVER OF PRE-EXISTING WAITING PERIOD

The pre-existing condition waiting period will be waived or credited to the extent you have been covered under a previous medical plan in the following circumstances:

- Applicants will receive a pre-existing condition wait credit for time spent in their immediate previous group or non-catastrophic individual plan, if application is made to WSHIP or a health plan carrier within 63 days of termination of that previous plan. (A catastrophic plan means a plan that has a yearly \$1,820 or more deductible and \$3,640 or more out-of-pocket expense limit; or provides benefits for hospital inpatient/outpatient services and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.)
- WSHIP will waive the pre-existing condition wait for any person living in a county without individual coverage who is eligible for such waiver under the standards of the Federal Health Insurance Portability Act (18 months "creditable coverage" and application to WSHIP or a member health plan carrier was made within 63 days of termination).

SECTION 8: TOBACCO USE INFORMATION

The tobacco-user rate will apply if you have used tobacco products within the past 12 months prior to this application.

Check the applicable box below. Not checking a box will result in paying the higher rate.

- I have used tobacco products during the prior 12 months. Yes No

NOTE: Tobacco products include cigarettes, cigars, chewing or pipe tobacco or any other tobacco products regardless of the frequency or method of use. If your tobacco use status changes, you must notify WSHIP immediately and complete a Tobacco Use Affidavit form. There will be no retroactive adjustments to rates based on tobacco use status.

SECTION 9: PAYMENT INFORMATION

Choose one of the premium payment options below:

- MONTHLY BANK DRAFT** 1 month premium due with application
You must also fill out the **Bank Service Plan Authorization Form** included in this application and attach a VOIDED check if you select this option.
- QUARTERLY** 3 months premiums due with application
- SEMI-ANNUAL** 6 months premiums due with application
- YEARLY** 12 months premiums due with application

To determine your premium amount:

1. Use the enclosed **Monthly Premium Rate Chart** to determine your premium payment. Select the premium indicated for the plan and deductible option you are selecting, based on your age and tobacco use status. If you need assistance, contact Customer Service at 1-800-877-5187.

Please indicate which premium Table you used: Table # _____ Plan _____ Deductible \$ _____

2. If you are applying for a low income discount (for Standard Plan only), you must first submit the undiscounted premium with your application. If you are approved, we will notify you and will credit your account. Full premium is required to be paid until a low income discount is approved.
3. **MAKE CHECKS PAYABLE TO WSHIP.** Submit your premium in the amount applicable to the billing frequency you have selected above. The premiums in our rate chart are monthly; if you choose to pay quarterly, semi-annually or yearly, please multiply the monthly premium by three, six or twelve, respectively.

NOTE: Any changes to your method of payment or automatic withdrawal, including bank information or termination of monthly bank draft, **must be submitted in writing by the 20th of the month** in order for the change to be implemented the first of the following month.

LOW INCOME DISCOUNT INFORMATION

NOTE: This discount is currently available on the Standard Plan only because premiums for our Preferred Provider Plans are already as low as the law allows (and are lower than the Standard Plan Low Income Rates).

Applicants may qualify to receive a low income discount (for Standard Plan only) if the following applies:

- Gross family income is less than 301% of the Federal Poverty Level (FPL) Guidelines (see income tables at <http://aspe.hhs.gov/poverty/index.shtml> or call Customer Service at 1-800-877-5187 for more information); and
- Washington state has funds available to support discounts; and
- Discount does not result in a premium that is less than 110% of the Standard Risk Rate in Washington state for the same benefits.

- Check box if you think you qualify and would like to receive a Low Income Discount Application for the Standard Plan.** (WSHIP will send you this application and notify you of the determination; eligibility is determined by the Washington State Health Care Authority, not WSHIP.)

SECTION 10: EFFECTIVE DATE OF COVERAGE

NOTE: The “**Application Received by WSHIP Date**” is the postmark date of the application that you mailed to WSHIP or the date WSHIP receives a faxed copy of your application, whichever occurs first. The original application must be postmarked and mailed to WSHIP no later than five (5) days following the date you faxed the application to WSHIP. Once the application is approved, your insurance coverage and premiums will begin on the first (1st) of the month based on your choice.

Check one choice below to select your effective date of coverage:

AS SOON AS WSHIP CAN PROCESS MY APPLICATION

I understand that if my application is faxed or postmarked on or before the last day of the month, then I may be eligible for WSHIP coverage effective the 1st of the next month. However, if my application is faxed or postmarked after the last day of the month, my coverage will not start until the 1st of the FOLLOWING month.

Example: If received July 31, will be effective August 1; if received August 1, will be effective September 1.

A FUTURE DATE

This must be on the 1st of the month and can be no more than 60 days later than when your application was faxed or postmarked. (Example: If postmarked May 2, your coverage can be effective no later than July 1.)

What Future Date of Coverage do you want? (month) _____ (year) _____

AN EARLIER DATE

To be eligible for earlier (retroactive) effective date, these two things must be true:

- You applied for individual coverage with a Washington State health carrier no later than the 20th of the month for an effective date of the 1st of the following month, and you were rejected; and,
- You are mailing or faxing this WSHIP application within 15 days of receiving that carriers' Notice of Rejection.

Example: You applied to a health carrier on April 20; you were rejected and received that rejection notice on May 3; you applied to WSHIP on May 15. You may request a WSHIP effective date of May 1.

If both of the above are TRUE, you may select an effective date that your coverage with the individual carrier would have been effective:

Date of the application to the other carrier _____

Requested WSHIP Effective Date: (month) _____ (year) _____

SECTION 11: VOLUNTARY INFORMATION

Completing this section is **voluntary** and will not affect your ability to enroll, but may help us improve our services.

Where did you hear about WSHIP?

- Health carrier (insurance company) sent me materials
 Medical office/hospital/clinic provided WSHIP brochure
 State agency
 Other: _____

Where did you get your WSHIP application?

- Health carrier mailed it to me
 WSHIP website
 Called WSHIP Customer Service
 Other: _____

Are you currently?

- unemployed
 employed
 self-employed
 retired

What is your yearly household income?

- Less than \$18,000
 \$18,000 - \$36,000
 Over \$36,000

of people in household _____

Is English your first language? Yes No

If no, what is?

Do you have Internet access? Yes No

What is your occupation?

WASHINGTON STATE HEALTH INSURANCE POOL

**BANK SERVICE PLAN
AUTHORIZATION FORM**

TO: The financial institution named on the Request for Bank Service Plan – Authorization Form

So that you may comply with your depositor's request, the Washington State Health Insurance Pool (WSHIP) agrees:

- a) To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, order or direction to debit an account purporting to be executed by WSHIP and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- b) In the event that any such check, draft, order or direction shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in forfeiture of insurance.
- c) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your action taken pursuant to the foregoing request or in any manner arising by reason of your participating in the foregoing plan of premium collection.



Washington State Health Insurance Pool • PO Box 1090 • Great Bend, KS 67530



WASHINGTON STATE HEALTH
INSURANCE POOL

REQUEST FOR BANK SERVICE PLAN – AUTHORIZATION FORM (Optional)

For Monthly Premium Payments Only

TO: Washington State Health Insurance Pool

Please use your Bank Service Plan to make my premium payments by withdrawing funds by automatic debit entry from the account below.

WSHIP will withdraw from your account the first Friday of each month except when it falls on the 1st, 2nd, or 3rd. In that case, we will then withdraw on the second Friday of the month. If you have any questions, call WSHIP Customer Service at 1-800-877-5187.

Name as shown on Account Insured / Applicant

Insured / Applicant Identification Number (if you are a NEW Applicant, leave blank)

Name of Financial Institution Branch

City State ZIP

Transit/ABA No. _____ Account No. _____

Please indicate below the type of account to be debited:

Checking

Savings

As a convenience to me, I authorize WSHIP to pay and charge to my account automatic debit entries made upon my account by, and payable to, the order of Washington State Health Insurance Pool. I agree that WSHIP's rights with respect to each such charge will be the same as if it were personally executed by me. **This authorization is to remain in effect until WSHIP receives written notice from me to revoke it.** Any changes to your method of payment or automatic withdrawal, including bank information or termination of monthly bank draft, **must be submitted in writing by the 20th of the month** in order for the change to be implemented the first of the following month.

X _____ / /
Authorized signature as shown on account Date

ATTACH A VOIDED CHECK HERE:

Please return the Bank Service Plan to:

Washington State Health Insurance Pool
PO Box 1090
Great Bend, KS 67530



WASHINGTON STATE HEALTH
INSURANCE POOL

PERSONAL REPRESENTATIVE FORM (Optional)

Include this form with your application if you wish to designate someone as your Personal Representative(s) for discussion and disclosure of Personal Health Information and Personal Financial Information with WSHIP or its health plan administrator(s). This designation will not affect benefits, claims processing and payment, or eligibility status.

Type of Information

WSHIP and its health plan administrator(s) may discuss or release Personal Health Information (PHI) and Personal Financial Information (PFI) to my Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through the Washington State Health Insurance Pool (WSHIP), and or its health plan administrator(s).

Authorized Use and/or Disclosure

I authorize WSHIP and or its health plan administrator(s) to release PHI and PFI to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider, or other person subject to federal privacy laws, my PHI and PFI may no longer be protected by those privacy laws and may be subject to re-disclosure by my Personal Representative. WSHIP and or its health plan administrator(s) are not responsible should my Personal Representative further disclose my protected PHI and PFI information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating no limitation on disclosure of PHI of PFI.

Disclosure Limitations: _____

Expiration and Revocation

The authorization to release information to my Personal Representative(s) will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan administrator. Revocation will not affect any action that WSHIP or its health plan administrator(s) has taken, or any information that has already been released based upon prior authorizations.

Designation of Personal Representative(s)

Name of Authorized Person	Phone Number ()	*Privacy Password
Name of Authorized Person	Phone Number ()	*Privacy Password

**Privacy Password – such as mother’s maiden name, your elementary school, birth city, etc.*

Signature and Authorization

I, the undersigned, do hereby swear that I am the above-mentioned member or an authorized legal representative of the above-mentioned member. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

X _____ / /
Signature of Member/Legal Representative Date

Printed Name of Legal Representative Description of Legal Representative’s Relationship to Member