

*A Consumer's Guide to:*  
**Health Care  
Coverage**

*Understanding Your Health Insurance Options*



## A message from the Commissioner



Dear Consumer:

Access to affordable health care is a growing concern to many people in our state and across the nation. The health insurance market in Washington state has changed dramatically over the last several years. Many of these changes impact your insurance rights and options.

To help you keep up with the constant changes in the health insurance market, and obtain health care coverage that meets your needs, we've prepared this guide.

It will help you understand:

- what kind of health plan may be best for you and your circumstances;
- how different types of health care plans work, and;
- how to obtain quality care and fair treatment from your health care providers.

I cannot stress enough how important it is for consumers to have adequate health insurance. Uninsured people may avoid getting treated for medical conditions that can escalate into major health and financial problems.

If you have questions or concerns, call our Insurance Consumer Hotline at 1-800-562-6900. We enforce insurance law and can investigate complaints against insurance companies and agents on your behalf. We also offer individual counseling and group education on health care issues in your communities. Our highly trained SHIBA (Statewide Health Insurance Benefits Advisors) HelpLine volunteers can help you understand your rights and options about health care coverage, prescription drugs, governmental programs, and more.

Sincerely,



Mike Kreidler



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# - Section 1 -

## Define your needs and eligibility

Accessing health insurance can be complicated. You must be sure your health care plan meets your needs.

Different types of health insurance plans are available based on your current needs, personal circumstances, and financial resources. This section will help you find out what kind of policy you may need, are eligible for, and can afford.

If you don't have health insurance through your employer, or a spouse, domestic partner or parent, and you are not eligible for Medicare, you might need to buy an individual plan directly from an insurance company.

Before you buy health insurance, check to see if you qualify for lower-cost options. For more information, read Section 3 on "Low-cost health coverage options."

Real-life situations in which you may need to buy individual health insurance or find out if you qualify for lower-cost options include:

- Your employer's health plan does not meet your needs.
- You haven't worked long enough to qualify for your employer's plan.
- You have to wait for an "open enrollment" period.
- You just moved to Washington from another state and need health coverage.
- You will no longer qualify for coverage under your parents' policy.
- The rates for family health insurance through your employer are too costly to cover everyone. If you continue on your employer's plan, you need coverage for your spouse and/or your children.
- Your kids need insurance to play sports at school.
- You work one or more part-time jobs, and none offer benefits.

## Employment-related coverage

If you are currently employed, you might qualify for the following types of health insurance plans:

### Group plans

Your employer may offer health benefits for yourself, your spouse or domestic partner, and your dependents.

If you are enrolling in a group plan, you do not have to take the Standard Health Questionnaire (or health screening). For more information about the questionnaire, see page 6.

Group plans cannot reject you based on your health. You may also be able to enroll a spouse, domestic partner, and other dependents outside of your employer's plan annual enrollment period. For more information, check with the plan's administrator or your human resources department.

It's important to recognize that not all employer group plans are the same. If you recently changed plans, be sure to review all of the plan benefit information before you visit the doctor. Be sure you know which doctors you can visit, what is and isn't covered, and how much you have to pay out-of-pocket.

If you are self-employed and have at least one full-time employee, you may be eligible for a small group plan. Contact an insurance agent or broker for more information on this type of plan.

### Professional organizations and association plans

Sometimes professional organizations offer group health plans, such as the local realtor association or chamber of commerce. Association plans are often available to people in a specific industry, professional group, or business association. You also may qualify for health insurance through a religious or fraternal organization.

Make sure you fully understand the exact level of benefits you are buying. While association plans are offered statewide – often at very competitive rates – you should read the plan's limitations and exclusions before you enroll in it.

If you choose an association plan, also consider buying riders (additional coverage) to the basic coverage to be sure you get all of the benefits you need. It's also important to get benefit information in writing.

## COBRA (Consolidated Omnibus Budget Reconciliation Act)

Under the federal COBRA law, employers with 20 or more employees must extend health plan benefits to their employees who are laid off from their jobs or have their hours reduced.

Small employers (employers with fewer than 20 employees), plus church-related organizations and federal government plans are not required to offer COBRA coverage. But they may offer limited continuation coverage to employees and their dependents. Check your health plan's benefit book to see if you have a continuation coverage benefit.

### How COBRA works

If an employee, spouse, or dependent is covered by the group health plan on the day before a qualifying event, then they may be eligible to continue buying coverage under the group plan for 18-36 months.

#### **Temporary COBRA subsidy offers help for laid-off workers**

The 2009 Stimulus Plan offers a temporary COBRA subsidy to workers laid off between Sept. 1, 2008 and Dec. 31, 2009. For more information about this subsidy, go to <http://www.insurance.wa.gov/publications/health/yourrightsunderCOBRA.shtml>.

**A qualifying event for an employee is:** a reduction in hours or losing a job for reasons other than “gross misconduct.”

**A qualifying event for a spouse or dependent includes:** a reduction in hours or termination of the employee (as describe above), or:

- Divorce or legal separation from the employee
- Death of the employee
- Employee becomes eligible for Medicare
- Loss of “dependent child status”

People who experience a qualifying event should check with the employer to find out if they are eligible for COBRA benefits. A qualified person must notify the plan administrator of a qualifying event within 60 days after the divorce or legal separation, or a child's loss of dependent status under the plan.

Employers must notify the plan administrator of a qualifying event within 30 days after the termination, reduction in hours, or death of a covered employee. They must also notify the plan administrator if a covered employee qualifies for Medicare. If declaring bankruptcy, employers must also notify the plan administrator within 30 days.

Each family member or dependent has the right to choose COBRA coverage.

Enrollees generally pay for COBRA coverage themselves. It may cost up to 102 percent of the total cost of the group plan, which includes the portion previously paid by the employer.

A person who already has other coverage (including Medicare) on or before the date he or she becomes eligible for COBRA, may continue that coverage along with COBRA coverage.

But if the person qualifies for an employer plan or Medicare after qualifying for COBRA coverage, the employer may end the COBRA coverage. However, the employer cannot stop coverage if the new plan has a pre-existing condition clause that applies to the person.

Not all plans end COBRA coverage immediately upon Medicare eligibility, so check with the plan administrator. Generally, dependents are able to continue COBRA coverage even if the primary employee (ex-employee) becomes Medicare-eligible.

#### For more information on COBRA:

- Go to “Your Rights Under COBRA” at: <http://www.insurance.wa.gov/publications/health/yourrightsunderCOBRA.shtml>
- Call the U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272
- Check with your employer’s human resources office

## Coverage for individuals and family

If you need health insurance and are not eligible for an employer plan or lower-cost options, there are plans available that you can buy.

Most health insurance sold in Washington state operates as either health maintenance organizations (HMOs) or through preferred provider networks.

**Warning:** If you wait to enroll in Medicare because you have COBRA coverage, you may be subject to penalties and delay Medicare starting. This delay could leave you without health care coverage for up to 15 months, depending upon the date your COBRA coverage expires.

**Bottom line:** Don’t delay enrolling in Medicare! If you want help finding the best coverage that fits your situation, call the Insurance Consumer Hotline at 1-800-562-6900 and ask to speak with a SHIBA (Statewide Health Insurance Benefit Advisors) HelpLine volunteer.



If you choose an HMO, the plan requires that you receive all of your care from a list of providers (except some emergency care). Your plan may require your primary care doctor to provide you with a referral before you can see a specialist or go to the hospital.

If you choose a preferred provider network, you pay less if you get care from doctors or hospitals that contract with the insurance plan. These providers are referred to as “network” providers. It will cost you more if you go to a doctor or hospital not listed in the plan’s network.

Plans may differ greatly from one another. They also may use different copayment systems (an upfront charge the consumer pays for each office visit).

A plan’s premium often covers educational and wellness programs, some preventive exams and routine services, and diagnostic services and treatment.

In addition to the premiums, you may have out-of-pocket copayments, deductibles, or coinsurance for some services. For services not approved or covered by the plan, you pay the full amount.

Ask about the features of any plan before you enroll and make sure you understand how they work.

### **Pre-existing condition waiting periods**

Individual health plans may require a nine-month waiting period for any condition you received medical advice or treatment for during the previous six months.

If you are switching plans, you may receive credit toward the waiting period for a pre-existing condition. If your prior plan is equal or better than the new plan, the insurance company must credit your enrollment time in that plan toward the waiting period for the pre-existing condition.

For example, if you had nine months of coverage under your prior plan, the insurance company would waive your waiting period. If you had four months of coverage, you would have to wait five months for the new insurance to cover a pre-existing condition. Be aware that catastrophic coverage (plans with a \$1,750 or more deductible) may not be considered creditable coverage.

If you switch plans, make sure you submit your application for the new insurance within 63 days of ending your prior plan to receive credit.

Need more help? Call our toll-free Insurance Consumer Hotline at 1-800-562-6900.

# Health screening and the individual market

## Application requirements

Most people buying individual health insurance in Washington state will need to pass a Standard Health Questionnaire (or health screening). If you fail the health screening, the insurance company you applied with will automatically send you an application for the Washington State Health Insurance Pool (WSHIP).

## People not required to take the health screen

You are not required to fill out the Standard Health Questionnaire when applying for individual coverage if you:

- Will exhaust your COBRA coverage or will lose coverage because your former employer closed its business.
- Have 24 months of continuous coverage through a small employer.
- Have moved out of your existing plan's service area within Washington state.
- Are staying with a primary care doctor who left your existing plan's network to join the network of a new plan.
- Are losing your coverage with the state's Basic Health Plan and you have 24 months of continuous coverage under the plan.
- Are adding a newborn or newly adopted or soon-to-be adopted child to your health plan.

## Washington State Health Insurance Pool (WSHIP)

WSHIP provides health insurance for people who are unable to get individual coverage in the private marketplace. This plan provides comprehensive coverage, including a prescription drug benefit. Its premiums are based on your age and type of plan you select.

Premiums for WSHIP coverage are higher than commercial health plans. However, WSHIP offers some high-deductible plan options with lower premiums.

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There are two WSHIP options available for people who are not on Medicare:

- **Standard Plan (Plan 1):** is a fee-for-service plan, which allows you to go to the doctor of your choice.
- **Network Plan (Plan 3):** uses providers from the First Choice network.

WSHIP provides some discount rates to people who have:

- a low income;
- been continuously insured for 18 months with their previous plan;
- been in WSHIP for more than three years; or
- a combination of more than three years of WSHIP coverage and 18 months of continuous coverage under their prior health plan.

WSHIP also has a separate plan available to Medicare enrollees, called the Basic Plan.



## - Section 2 -

### Shopping for health insurance

This section provides information about how to get the most out of your health insurance coverage. It can also help you determine if you have the right coverage.

#### Tips: Checking out a plan

Make sure the coverage you buy fits your needs, and you receive the best price for the coverage. You should compare benefits and rates. Look at two or three different plans to compare them against your needs and to one another.

**Benefits:** Make sure you understand the plan's benefits. Look at what the contract **will not** cover, not just what it **will** cover.

**Limitations and exclusions:** Find out if there are special requirements to get benefits. For example:

- Do you need prior authorization for some services?
- How do you get that authorization?
- Are there waiting periods before the coverage takes effect?

**Claims:** Before you buy, make sure you understand how to file a claim, where to send it, and how you will receive payment.

**Costs:** Premiums for health insurance vary. When reviewing several companies, look carefully at the benefits they offer.

#### Tips: Checking out an agent

Many people buy health insurance from agents or companies. Agents may represent only one company or a number of companies. Companies can sell their policies by mail, the Internet, or over the phone.

- Agents earn a commission on your business and should do more than just sell you a policy. They should also answer your questions.
- If you need additional information, contact your agent or the company. You are the customer and they should respond to you.
- Never deal with an unlicensed agent. Ask to see his or her license.

You can check on an agent's licensed status by calling the Insurance Consumer Hotline at 1-800-562-6900.

- Never let an insurance agent or broker pressure you. You have the right to look at any policy before you buy it. Never buy because of a threat that “this coverage won't be available tomorrow.” Report any improper behavior to the Office of the Insurance Commissioner at 1-800-562-6900. You can also ask if an agent has received any complaints.
- Never buy an insurance policy you do not understand. Ask to see the benefits explained in writing in simple terms. Keep that document with the policy after you buy it.
- If you need a translator to talk to your agent or company, arrange for an adult translator to accompany you.
- Never give any insurance representative money or a check without a receipt.
- Never give out your bank account or Social Security information over the phone.

## Tips: Checking out an insurance company

Before you buy health coverage, find out about the company selling the plan. Here are some key factors to think about:

**Customer service:** Find out how the company provides service to its members. Does the company have a toll-free customer service number? Do they answer it without a long wait?

**Complaint history:** Does the company have a high number of consumer complaints? Check with our Insurance Consumer Hotline at 1-800-562-6900.

**Licensing status:** Make sure the insurance company is licensed to do business in Washington state. Call our Insurance Consumer Hotline to check a company's status at 1-800-562-6900, or go to [www.insurance.wa.gov](http://www.insurance.wa.gov).

**Financial stability:** Financial stability helps ensure that a company can pay its claims. In addition, Washington state law created requirements that each company must follow. The Office of the Insurance Commissioner continually monitors insurers to make sure they are financially stable. Independent organizations also rate the financial stability of insurance companies. Check your public library's reference desk for published ratings.

### “Free Look”

When you receive your new health care policy, read it carefully.

Every individual health care insurance policy sold in Washington state has a 10-day “Free Look” period.

If you are not satisfied for any reason, you may return the policy to the company or agent within 10 days after you receive it. They will void the policy and provide you with a full refund of your premium.

To insure continuous coverage, keep your previous coverage until you have reviewed your new policy.

Information about the “Free Look” period is printed or attached to the face sheet of your policy.

### Questions to ask:

- What does the plan pay for and what does it exclude? Look for:
  - ✓ Preventive care
  - ✓ Immunizations
  - ✓ Well-baby care
  - ✓ Substance abuse
  - ✓ Organ transplants
  - ✓ Durable medical equipment
- Does the plan cover alternative or chiropractic care?
- Does the plan include mental health benefits?
- Will the plan pay for long-term physical therapy?
- How much do I have to pay when I receive health care services, or how much is the copayment or deductible?
- How often do I have to pay the copayment or deductible (per year, per occurrence)?

- Are there limits on how much I must pay for health care services I receive (out-of-pocket maximums), and are there maximums per year, per occurrence?
- Are there limits on the number of times I may receive a service (lifetime maximums, daily, or annual benefit caps)?
- Does the company have a high number of consumer complaints?
- How long does it take to reach a real person when I call the company?
- Will the plan pay for prescriptions, and if it does, what is the maximum benefit?
- Are my prescriptions on the formulary (list of approved drugs)?

- Is my favorite doctor or other health care provider part of the company's network?
- Can I choose my primary care provider (PCP)?
- How will I get access to specialists?
- What does the company consider to be urgent and emergency care?
- What treatments does the company consider "experimental" and, as a result, does not cover?
- How does the company coordinate benefits with other plans?
- What options do I have if I disagree with the treatment plan?

## Complementary and alternative providers

Washington state law requires state-regulated insurers to cover services provided by all of the state's licensed categories of health care providers including, but not limited to:

- Chiropractors
- Medical doctors
- Acupuncturists
- Naturopaths
- Physician assistants
- Registered nurses
- Podiatrists
- Nurse midwives
- Massage therapists

Most health care plans restrict enrollees to using providers in their own network. They may require you to visit your primary care doctor for a referral.

Insurance companies are required to provide adequate networks that contain every type of provider so you have the full range of options the law requires. Also, your plan must cover your condition, and its treatment must fall within a provider's practice.

This law applies to all state-regulated plans. It does not apply to self-funded employer plans or union trusts, which are exempt from state regulation under federal law. If you're not sure what type of plan you have, call our Insurance Consumer Hotline at 1-800-562-6900.

## Getting reimbursed for going to the doctor

### Things to do before you file a claim

Review your policy or employee booklet carefully to make sure the plan covers the service in question. If you think a health care service may not be covered, or that your company disagrees with your understanding of the policy, talk it over first with your provider and the insurance company. Resolving questions first can prevent problems later.

You should never assume your plan will cover a treatment or service. Follow your plan's rules, including pre-certification requirements and using network providers. Your provider may require you to make a copayment or pay your coinsurance at the time of your visit.

Fill out any claim forms the provider or insurance company gives you. Be sure to include your policy number and other identifying information.

### How to submit a claim yourself

- Find out if your provider submits the claim for you, or if you need to do it.
- If you need to do it, review the claim information to make sure it is complete and correct.
- File the claim as soon as you get the bill from the provider.
- Send it to the correct address.
- Keep a copy for your reference.
- Wait for your insurance company's statement before you pay your provider directly.
- Allow reasonable time for your insurance company to process your claim. The company must inform you if it needs any additional information to complete the claim. Sometimes, it will request additional information directly from the providers. In other cases, it will return the claim form to you to get more information.

## If the insurance company denies your claim

- The insurance company should state the reason for denial on your explanation of benefits.
- If you disagree with the reason for denial, check your policy, or benefit book for the company's appeal procedures.
- The company should answer procedural questions about appeals over the phone. Call the company's assistance line (phone numbers should be listed on your statement).
- Submit your appeal in writing. The company may require information from your doctor.
- Keep good notes about whom you speak with and send information to, and keep copies of any information you send.
- Your plan benefit book should also outline how quickly the plan must respond to your appeal. If the plan doesn't respond by the deadline, follow the process.

## What to do if you disagree with your bill

If you don't understand your medical bill or you believe you've been mischarged, consider the following tips:

- If you receive a medical bill that does not show what your insurance paid, call your provider and confirm they have your insurance information, so they can bill your plan.
- Review your Explanation of Benefits (EOB) or Medicare Summary Notice (MSN).

## How to keep your medical bills from going to collections

- If you can't pay the entire balance at once, work out a payment plan with the doctor or hospital. Some charge no interest; others do.
- Ask the provider to send you the payment terms in writing.

### **What is an Explanation of Benefits (EOB)?**

An Explanation of Benefits is a statement you may receive after you or your doctor files a medical claim with your health plan. It lists the treatment you received, the charges, and the amounts your health plan paid or denied. Note: People with Health Maintenance Organizations (HMOs) may not receive Explanation of Benefits.



- Make sure the payment plan is realistic and something you can afford to pay.
- If your circumstances change, contact your provider and try to negotiate a different payment plan.
- Stick to the plan and pay it on time.

## What to do if your medical bill goes to collections

If your bill goes to a collection agency, you will receive a written notice in the mail. Follow the instructions in the notice. Dodging or avoiding the collector will damage your credit further.

Once your bill goes to collections, you must work directly with the collections agency. If you can't pay, call and tell them. Try to work out some type of payment plan. Make sure you get the terms of the payment plan in writing.

## File a complaint

If you can't resolve a dispute with your health plan and you still believe your plan is in error, call the Insurance Consumer Hotline at 1-800-562-6900. We will investigate your complaint at no cost to you.

### **“I signed a Medicare Advanced Beneficiary Notice (ABN). Can I still appeal?”**

Yes! An Advanced Beneficiary Notice, also known as a “waiver of liability,” is a notice that suppliers and other medical providers must give you when they offer you services or items they know or believe Medicare will not cover.

If you sign an Advanced Beneficiary Notice and the provider does not write down specifically what is not covered and your cost, there is a very good chance you will win an appeal. Note: Medicare Advantage plans may not provide this type of protection. Check your plan benefit book.



# Protect yourself from health care fraud

We all pay a price for health care fraud, abuse and waste. It contributes significantly to rising health care costs, including higher health care premiums, deductibles, and co-payments. In fact, it contributes to billions of dollars wasted on Medicare and Medicaid.

Most health care providers are honest, but some intentionally misrepresent or bill health plans or Medicare for services they never provided. When fraud occurs, someone is using you to steal health care dollars. Trust your instincts and learn how to protect yourself from fraud.

## Watch out if:

- Someone offers you gifts or money to receive medical services or supplies.
- Someone offers you free testing or screening in exchange for your Medicare number or your health insurance subscriber number.
- Your provider bills you or your insurance for services or supplies you did not receive or order.
- Your provider performs services beyond what is medically necessary.

Treat your Medicare and health insurance cards like a credit card. Protect them. Do not give them out, except to providers you know and trust.

## If you suspect health care or Medicare fraud

To report possible fraud, call the Insurance Consumer Hotline at 1-800-562-6900.

## Getting help

As a health insurance consumer, you should understand what your rights are and how to exercise them.

## Patient Bill of Rights

The Patient Bill of Rights is a state law created to ensure that you receive quality health care. This includes sufficient and timely access to care, an adequate choice of health care providers, and a process by which you may appeal a health care decision made by your insurance company.

## Under the Patient Bill of Rights, you:

- Are guaranteed that health-care decisions providers make are based on medical standards.
- Have better access to information about your health insurance plans.
- Have access to a quick and impartial process for appealing claim denials.
- Have the right to independent third-party reviews when your insurer denies coverage.
- Are protected from unnecessary invasions of privacy.
- Can ask for damages that result when managed care insurers withhold or deny you appropriate care.

For more information about this law, read the Patient Bill of Rights fact sheet at [http://www.insurance.wa.gov/archives/pbor/documents/bill\\_of\\_rights.pdf](http://www.insurance.wa.gov/archives/pbor/documents/bill_of_rights.pdf) or call our Insurance Consumer Hotline at 1-800-562-6900 to request a copy.

## Other rights

**Employer plans:** If your health plan is a “self-funded” plan offered by an employer or by a union trust under a union contract, the federal government regulates your plan.

**Self-funded plans:** These are health plans developed and managed by your employer or union. If you have issues with your plan, you may file a complaint with the U.S. Department of Labor (DOL) Employee Benefits Security Administration toll free at 1-866-444-3272. DOL may investigate your complaint. In some disputes, DOL may suggest personal legal advice as your best option.

**Government/Church organization plans:** If your health plan is self-funded, but offered through a government or church organization, follow the appeals process outlined in your benefit book to resolve issues. In most cases, final responsibility for resolving disputes rests with the governing body of the organization sponsoring the plan, such as a school board.

**People with disabilities:** If you have a disability, you may have special protections available under the Americans with Disabilities Act (ADA) that apply specifically to self-funded coverage.

For more information, call the ADA Technical Assistance Center at 1-800-949-4232 or the U.S. Department of Justice at 1-800-514-0301 (TDD users: 1-800-514-0383).

For more information about health care options, read our publication “Health insurance options for people with disabilities,” at [http://www.insurance.wa.gov/publications/health/Options\\_for\\_People\\_with\\_Disabilities.pdf](http://www.insurance.wa.gov/publications/health/Options_for_People_with_Disabilities.pdf) or call our Insurance Consumer Hotline at 1-800-562-6900 to request a copy.

## Filing a complaint with the Office of the Insurance Commissioner

If you're unable to resolve a dispute with your company or agent, and still believe you've been treated unfairly, contact our Insurance Consumer Hotline at 1-800-562-6900. We investigate consumer complaints at no cost. To speed processing of your inquiry or complaint:

Call the Insurance Consumer Hotline first to talk to a health insurance expert about your problem. You can also ask us to mail you a complaint form or you can access the form online at <https://fortress.wa.gov/oic/complaints/>.

Use the form to briefly state your case, but provide complete information. **Be sure to include the:**

- Name of your insurance company
- Policy number
- Name of the agent or adjuster
- Name of your employer, if the plan is offered through your employer

Also, make sure you sign the medical release on the back of the form.

Include photocopies (do not send originals) of any documents that support your case.

Provide the details of your dispute, including who you talked to and what they told you.

We will investigate your complaint and inform you of what happens. If the company is wrong, we will work on your behalf to correct the situation.

## - Section 3 -

### Low-cost health coverage options

In general, these programs help people who cannot afford insurance in the individual market. Some programs help people with disabilities or who have limited income and assets. Often, people are not aware they qualify for these programs. Following are several health coverage programs for individuals and families, pregnant women, children, and veterans and active military personnel.

#### Individuals and families

**Alien Emergency Medical (AEM)** – AEM is a program for non-U.S. citizens with a serious medical condition(s). It helps you pay for medical treatment and bills. Non-citizens, qualified and non-qualified aliens, and visitors may apply for it. You must meet income and asset requirements. For more information, call the Department of Social and Health Services (DSHS) at 1-800-865-7801 or go to [www.dshs.wa.gov](http://www.dshs.wa.gov).

**Basic Health Plan (BHP)** – The state of Washington offers the Basic Health Plan to Washington state limited-income residents. People who are eligible for Medicare, institutionalized at the time of enrollment, and those who attend school full-time in the U.S. on a student visa are NOT eligible for this plan.

Private insurance companies manage the Basic Health Plan. They provide comprehensive health plans that cover:

- Prescription drugs
- Maternity
- Preventive care
- Major medical costs

However, the plan does not cover:

- Eye exams
- Dental and hearing exams
- Artificial limbs or medical equipment (such as wheelchairs or back braces)

Physical therapy and chiropractic care is limited to specific circumstances.

The Basic Health Plan requires you to use a network of providers in your area. Besides paying a monthly premium, you must meet the \$150 deductible each year and make a small copayment each time you visit your health care provider. On some services, it also requires a 20 percent coinsurance payment.

People enrolled in the Basic Health Plan pay on a sliding scale, with premiums based on income, age, family size, county they live in, and choice of insurer.

The Basic Health Plan may be available for children. For more information, see “Basic Health Plus” on page 22.

You can get benefits, rates, and other details by calling the plan at 1-800-660-9840, or go to [www.basichealth.hca.wa.gov](http://www.basichealth.hca.wa.gov).

**Breast and Cervical Cancer Treatment Coverage** – This program provides screening, diagnosis, and access to treatment for women with breast or cervical cancer, or a related pre-cancerous condition. You must meet income and asset requirements. There are no citizenship requirements. For more information, call the Breast and Cervical Health Program toll free at 1-888-438-2247.

**Community Health Clinics** – These clinics offer health services for the entire community on a sliding-fee scale. For information, call the Association of Community and Migrant Health Centers at 360-786-9722 or go to [www.wacmhc.org/chcswashington.html](http://www.wacmhc.org/chcswashington.html).

**Early Intervention Program (EIP)** – If you have HIV (Human Immunodeficiency Virus), this program can provide financial help for medical and dental coverage, and prescription drugs. If you are eligible, the program also provides help with paying insurance premiums. For more information, call the Washington State Department of Health at 1-800-272-2437.

**Evergreen Health Insurance Program (EHIP)** – If you have AIDS (Acquired Immune Deficiency Syndrome), this program may help you pay your insurance premiums. For information, call EHIP at 1-800-945-4256 or go to [www.ehip.org](http://www.ehip.org).

**General Assistance Unemployable (GAU)** – GAU provides cash and medical benefits to people who are physically and/or mentally incapacitated and unemployable for 90 days from the date of application. Medical care is limited. Immigrants can also apply for this program. You must meet disability, income, and asset requirements. For more information, call DSHS at 1-800-865-7801 or go to [www.dshs.wa.gov](http://www.dshs.wa.gov).

**For more information on income levels**

Refer to the federal poverty level chart at [http://www.insurance.wa.gov/publications/consumer/FINAL\\_FPL\\_chart.pdf](http://www.insurance.wa.gov/publications/consumer/FINAL_FPL_chart.pdf), or call the Insurance Consumer Hotline at 1-800-562-6900 to request a copy.



**Healthcare for Workers with Disabilities Program** – This program is for people with disabilities age 16 through 24. You must be working and have a monthly net income at or below 220 percent of the federal poverty level. For income levels, refer to the federal poverty level chart at [http://www.insurance.wa.gov/publications/consumer/FINAL\\_FPL\\_chart.pdf](http://www.insurance.wa.gov/publications/consumer/FINAL_FPL_chart.pdf). Or call the Insurance Consumer Hotline to request a copy. To apply for the Healthcare for Workers with Disabilities Program, call 1-800-337-1835 or 206-341-7433 (both phone numbers also work for TTY users). Choose option 2 for “family or adult medical” and tell the customer service specialist you are calling about the Healthcare for Workers with Disabilities Program.

**Hospital Charity Care** – All hospitals in Washington state offer this program to people who cannot pay their medical bills. They provide either free care or at-reduced prices to limited income people. Also, many hospitals offer financial assistance programs. You must meet income requirements. For more information, talk to the hospital billing staff.

**Indian Health Services (IHS)** – This is a federal program for American Indians and Alaska natives. IHS may provide services to Indians of Canadian or Mexican origin, or to non-Indian women pregnant with an eligible American Indian child. For more information and to find the nearest IHS office, call the Portland service area office at 503-326-2020. This office services Washington, Oregon, and Idaho.

**Medicaid** – This is a publicly-funded program that provides health insurance to specific people who meet financial and citizenship requirements.

Medicaid is a complex system of programs, requirements, and benefits. There are many different Medicaid programs available for specific eligibility groups. In Washington state, those groups include:

- Pregnant women
- Infants
- Children
- Low-income families
- People with disabilities
- Blind people
- People over age 65
- Aliens and refugees

Due to the variety of eligibility requirements for different programs, DSHS recommends that you review your eligibility online at <http://fortress.wa.gov/dshs/maa/eligibility/index.html>. You can also talk to a customer service

representative. Call DSHS at 1-800-562-3022 to find the nearest Community Service Office.

**Medicare** – Medicare is a health insurance program for people age 65 and older, some younger people with disabilities, and people with End Stage Renal Disease (ESRD) or Lou Gehrig’s Disease (Amyotrophic Lateral Sclerosis), also referred to as kidney failure. It helps you pay for many health care expenses, but not all of them. For more information, call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board, call 1-800-808-0772.

**Medicare Savings Programs** – These are programs to help people with limited income and assets pay for Medicare premiums, deductibles, and coinsurance. You must meet income and asset requirements. For more information, call DSHS at 1-800-865-7801 or go to [www.dshs.wa.gov](http://www.dshs.wa.gov). You can also call the Medical Assistance Customer Service Office at 1-800-562-3022.

**Take Charge** – This program offers free family planning and birth control methods for one year for men and women. You must meet income, and citizenship or alien status requirements. For more information, call the Family Planning Hotline at 1-800-770-4334.

**Tuberculosis Care** – If you have tuberculosis, contact your local health department. To find the nearest office, go to <http://www.doh.wa.gov/LHJMap/LHJMap.htm>. You can also look under “county” in the blue government listing pages of your phone book.

## Children

**Basic Health Plus** – This is a Medicaid program for children in low-income households. There are no copayments for services and no monthly premiums. The Department of Social and Health Services (DSHS) pays the cost of coverage. It offers added benefits and services for children, including vision and dental benefits, and transportation to medical services.

If you are on Basic Health, your children may be eligible for Basic Health Plus. They must be under age 19, a U.S. citizen, or a permanent legal resident who’s lived in the U.S. for five consecutive years immediately prior to applying for this benefit. You can enroll children not living in your household in Basic Health (see page 19), but not Basic Health Plus.

For more information, call 1-800-660-9840, or go to the Basic Health Web site at [www.basichealth.hca.wa.gov](http://www.basichealth.hca.wa.gov).

**State Children’s Health Insurance Program (SCHIP)** – This is a federal and state program that covers children under age 19 in families with limited income. Many children who don’t qualify for Basic Health are eligible for SCHIP. A family must meet income limits for children to qualify for SCHIP. These income limits represent gross monthly household income minus childcare and other approved deductions.

When you apply for SCHIP, DSHS considers the children for Medicaid first. If the children are not eligible for Medicaid due to income, DSHS will then check to see if the family income fits within the SCHIP income guidelines. If children are eligible for Medicaid, they are not eligible for SCHIP.

**Children’s Health Program (CHP)** – This program provides medical coverage to:

- Non-citizen children, including visitors or students from another country
- Undocumented children (people not legally admitted into the U.S.)
- Qualified alien children under age 18 in limited-income families

You must meet income requirements.

Children’s medical programs have no asset limits. Remember, you must apply for children’s medical programs and Alien Emergency Medical (see page 19) at the same time.

For more information about children’s medical programs, go to <http://fortress.wa.gov/dshs/maa/chip> or call toll free 1-877-543-7669.

## Pregnant women and infants

**Pregnancy Medical** – This program offers medical coverage for pregnant women regardless of their citizenship. You must meet income requirements, but there are no asset limits. Your newborn baby automatically receives full medical benefits for the first year. Call the Department of Social and Health Services (DSHS) at 1-800-562-3022 to find the nearest Community Service Office.

## Active military and veterans

**TRICARE military insurance** – This insurance covers:

- Active duty and retired service members
- Some reserve members

- Spouses and unmarried children
- Widows and widowers
- Unmarried children of deceased active duty or retired service members

For more information, call TRICARE toll free at 1-888-TRIWEST (1-888-874-9378) or go to [www.tricare.osd.mil](http://www.tricare.osd.mil).

**Veterans’ Assistance** – If you are a veteran, you may qualify for care and prescription drug coverage through a Department of Veteran Affairs (VA) medical facility. To find out if you are eligible, call the VA Health Benefits Service Center at 1-877-222-VETS (1-877-8387) or go to [www.va.gov](http://www.va.gov).

### Resources

<p><b>Washington State Office of the Insurance Commissioner</b></p> <p>If you need information on your rights, have questions about insurance or need help accessing health care, call the Insurance Consumer Hotline or go to <a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a></p>	<p><b>Federal Department of Labor - Employee Benefits Security Administration</b></p> <p><b>Benefit advisors and publication hotline:</b> 1-866-444-3272 or go to <a href="http://www.dol.gov">www.dol.gov</a></p>
<p><b>Centers for Medicare and Medicaid Services (CMS)</b></p> <p><b>Medicare Hotline</b> 1.800-MEDICARE: 1-800-633-4227</p> <p><b>Local customer service:</b> (206) 615-2306</p> <p><b>Local service for Medicare Managed Care:</b> (206) 615-2351 or <a href="http://www.medicare.gov">www.medicare.gov</a></p>	<p><b>Washington State Health Care Authority</b></p> <p><b>Public Employees Benefits Board (PEBB)</b> <a href="http://www.pebb.hca.wa.gov">www.pebb.hca.wa.gov</a></p> <p><b>Employee customer service:</b> 1-800-700-1555</p> <p><b>Retiree customer service:</b> 1-800-200-1004</p> <p><b>Basic Health customer service:</b> 1-800-660-9840 or go to <a href="http://www.basichealth.hca.wa.gov">www.basichealth.hca.wa.gov</a></p>
<p><b>Federal Department of Health and Human Services</b></p> <p><b>National Elder Care Locator Service:</b> 1-800-677-1116 or go to <a href="http://www.eldercare.gov">www.eldercare.gov</a></p>	<p><b>Federal Social Security Administration</b></p> <p>Customer service: 1-800-772-1213 or go to <a href="http://www.socialsecurity.gov">www.socialsecurity.gov</a></p>

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# Need more help?

Call our Insurance Consumer Hotline!

# 1-800-562-6900

We enforce insurance law and can investigate complaints against insurance companies and agents on your behalf.

We also offer individual counseling and group education on health care issues in your communities. Our highly trained Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine volunteers can help you understand your rights and options about health care coverage, prescription drugs, long-term care options, government programs, and more.

