

# UMP Plus–Puget Sound High Value Network

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage Period: 01/01/2016 - 12/31/2016

Coverage for: Individual/Family Plan Type: ACP




**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.hca.wa.gov/ump](http://www.hca.wa.gov/ump) or by calling 1-888-849-3681 (TTY 711).

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$125/person, \$375/family. Doesn't apply to preventive care or primary care services by primary care network providers. Balance-billed charges, <u>co-payments</u> (inpatient facility and emergency room), and prescription drugs don't count toward <u>deductible</u> .	You must pay all the costs up to the <u>deductible</u> amount before this <u>plan</u> begins to pay for covered services you use. Check your policy or <u>plan</u> document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You must pay all the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>Medical:</b> \$2,000/person, \$4,000/family. <b>Prescription drugs:</b> \$2,000/person (no family limit).	The <u>out-of-pocket limit</u> is the most you could pay to network providers during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<b>Medical:</b> <u>Premiums</u> , balance-billed charges, prescription drug costs, member co-insurance paid to non-network and out-of-network <u>providers</u> , services not covered by the <u>plan</u> , and services subject to plan limits or maximums. <b>Prescription drugs:</b> Medical services, premiums, noncovered drugs, balance-billed charges, and costs for other family members' drugs.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this <u>plan</u> use a <u>network of providers</u> ?	Yes. See <a href="http://www.hca.wa.gov/ump">www.hca.wa.gov/ump</a> or call 1-888-849-3681 for a list of <u>in-network providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this <u>plan</u> will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the

**Questions:** Call 1-888-849-3681 (TTY 711) for medical. Call WA State Rx Services at 1-888-361-1611 for pharmacy. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-888-849-3681 to request a copy.

(Plan Administrator: Regence BlueShield)

		term in-network, preferred, or participating for <a href="#">providers</a> in their <a href="#">network</a> . See the chart starting below for how this <a href="#">plan</a> pays different kinds of <a href="#">providers</a> .
<b>Do I need a referral to see a <a href="#">specialist</a>?</b>	No. See <a href="http://www.hca.wa.gov/ump">www.hca.wa.gov/ump</a>	You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</a> .
<b>Are there services this <a href="#">plan</a> doesn't cover?</b>	Yes.	Some of the services this <a href="#">plan</a> doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
  - **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
  - The amount the [plan](#) pays for covered services is based on the **allowed amount**. If an out-of-network [provider](#) charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
  - This [plan](#) may encourage you to use [in-network providers](#) by charging you lower **deductibles**, **copayments**, and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a(n)		Limitations & Exceptions
		In Network Provider	Non-Network or Out-of-Network Provider	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	Primary care network provider 0% co-insurance, no deductible for office visit	50% co-insurance	Must see a primary care network primary care provider affiliated with UW Medicine ACN, or a Regence network naturopath, for primary care office visits to be covered in full with no deductible.
	Specialist visit	15% co-insurance	50% co-insurance	—————none—————
	Other practitioner office visit	15% co-insurance	50% co-insurance	Coverage is limited to 16 visits/yr. for acupuncture, 10 visits/yr. for chiropractic care, and 16 visits/yr. for massage therapy; out-of-network massage therapy is not covered.
	Preventive care/ screening/ immunization	\$0, no deductible	50% co-insurance	Coverage is limited to services with an A or B rating by the U.S Preventive Services Task Force, and immunizations recommended by the Centers for Disease and Prevention. No coverage for vaccines for employment or travel.

Common Medical Event	Services You May Need	Your cost if you use a(n)		Limitations & Exceptions
		In Network Provider	Non-Network or Out-of-Network Provider	
If you have a test	Diagnostic test (x-ray, blood work)	15% co-insurance	50% co-insurance	—————none—————
	Imaging (CT/PET scans, MRIs)	15% co-insurance	50% co-insurance	No coverage for routine Computed Tomographic Colonography, upright MRI, and Coronary Artery Calcium Scoring. Discography and Computed Tomographic Angioplasty require <a href="#">preauthorization</a> .
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.hca.wa.gov/ump">www.hca.wa.gov/ump</a> or 1-888-361-1611.	Generic drugs (Value Tier)	5% co-insurance (up to \$10/30-day supply or \$30/90-day supply)	5% co-insurance	No coverage for prescription drugs with an over-the-counter alternative. Non-network pharmacies may balance bill.
	Generic drugs (Tier 1)	10% co-insurance (up to \$25/30-day supply or \$75/90-day supply)	10% co-insurance	No coverage for prescription drugs with an over-the-counter alternative. Non-network pharmacies may balance bill.
	Preferred brand drugs (Tier 2)	30% co-insurance (up to \$75/30-day supply or \$225/90-day supply)	30% co-insurance	Tier 2 also includes some high-cost generic drugs. Non-network pharmacies may balance bill.
	Nonpreferred brand drugs (Tier 3)	50% co-insurance	50% co-insurance	No individual prescription cost limit for non-specialty Tier 3 drugs. Non-network pharmacies may balance bill.
	Specialty drugs	Tier 1: 10% co-insurance; Tier 2: 30% co-insurance; Tier 3: 50% co-insurance	Not covered	Coverage is limited to a 30-day supply per fill from <a href="#">plan's</a> specialty pharmacy, Ardon Health. You pay no more than \$150/30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% co-insurance	50% co-insurance	—————none—————
	Physician/surgeon fees	15% co-insurance	50% co-insurance	<a href="#">Preauthorization</a> may be required.

Common Medical Event	Services You May Need	Your cost if you use a(n)		Limitations & Exceptions
		In Network Provider	Non-Network or Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	\$75 copayment/visit; 15% co-insurance	\$75 copayment/visit; 15% co-insurance	<a href="#">Co-payment</a> is waived if admitted directly to hospital or facility as inpatient.
	Emergency medical transportation	20% co-insurance	20% co-insurance	Coverage is not provided for air or water ambulance, if ground ambulance would serve the same purpose; or for ambulance services for personal or convenience purposes.
	Urgent care	15% co-insurance <i>Non-network providers covered as network</i>	50% co-insurance	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	15% co-insurance	50% co-insurance	Provider must notify <a href="#">plan</a> on admission.
	Physician/surgeon fee	15% co-insurance	50% co-insurance	<a href="#">Preauthorization</a> may be required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% co-insurance	50% co-insurance	<a href="#">Preauthorization</a> may be required. No coverage for marriage/family counseling.
	Mental/Behavioral health inpatient services	15% co-insurance	50% co-insurance	Inpatient admissions must be preauthorized.
	Substance use disorder outpatient services	15% co-insurance	50% co-insurance	<a href="#">Preauthorization</a> may be required.
	Substance use disorder inpatient services	15% co-insurance	50% co-insurance	Provider must notify the <a href="#">plan</a> for detoxification and partial hospitalization. Inpatient admissions must be preauthorized.

Common Medical Event	Services You May Need	Your cost if you use a(n)		Limitations & Exceptions
		In Network Provider	Non-Network or Out-of-Network Provider	
If you are pregnant	Prenatal and postnatal care	0% co-insurance for office visits to Primary Care Network providers 15% for related tests	50% co-insurance	Ultrasounds during pregnancy are limited to one in week 13 or earlier and one during weeks 16-22 (additional may be covered when medically necessary).
	Delivery and all inpatient services	15% co-insurance	50% co-insurance	Elective deliveries before 39 weeks gestation covered only if medically necessary.
If you need help recovering or have other special health needs	Home health care	15% co-insurance	50% co-insurance	Custodial care, maintenance care, private duty nursing, or continuous care is not covered. Coverage is limited to 130 days/yr.
	Rehabilitation services	15% co-insurance	50% co-insurance	Coverage is limited to 60 days/yr. inpatient and 60 visits/yr. outpatient for all therapies combined. Inpatient admissions for rehabilitation services must be preauthorized.
	Habilitation services	15% co-insurance	50% co-insurance	Coverage includes neurodevelopmental therapy and is limited to 60 days/yr. inpatient and 60 visits/yr. outpatient for all therapies combined.
	Skilled nursing care	15% co-insurance	50% co-insurance	Coverage is limited to 150 days/yr. Services must be preauthorized.
	Durable medical equipment	15% co-insurance	50% co-insurance	Foot orthotics covered only for prevention of diabetic complications. Lost, stolen, or damaged durable medical equipment is not covered.
	Hospice service (including respite care and end-of-life counseling)	\$0 after meeting deductible	50% co-insurance	Coverage for respite care is limited to 14 visits/lifetime.

Common Medical Event	Services You May Need	Your cost if you use a(n)		Limitations & Exceptions
		In Network Provider	Non-Network or Out-of-Network Provider	
If your child needs dental or eye care	Eye exam	\$0	50% co-insurance	Eye exams for medical conditions are subject to <b>deductible</b> and <b>co-insurance</b> . Contact fitting fees covered up to \$65/yr., member pays excess.
	Glasses	\$0 for one set of glasses/yr.	\$0 for one set of glasses/yr.	Not subject to the <b>deductible</b> . Coverage for children ages 0-18 only. 15% co-insurance for contact lenses, no limit.
	Dental check-up	Not covered	Not covered	—————none—————

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or [plan](#) document for other [excluded services](#).)

- Coronary Artery Calcium Scoring
- Cosmetic surgery
- Custodial and/or continuous care
- Dental care (Adult)
- Immunizations for travel or employment
- Long-term care
- Lost, stolen, or damaged durable medical equipment
- Maintenance care
- Marriage/family counseling
- MRI, upright
- Out-of-network massage therapy
- Private duty nursing
- Routine Computed Tomographic Colonography
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or [plan](#) document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)
- Routine foot care for certain medical conditions

## Your Rights to Continue Coverage:

If you lose coverage under the [plan](#), then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a [premium](#), which may be significantly higher than the [premium](#) you pay while covered under the [plan](#). Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the [plan](#) at 1-888-849-3681. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your [plan](#), you may be able to [appeal](#) or file a [grievance](#). For questions about your rights, this notice, or assistance, you can contact the [plan](#) at 1-888-849-3681, or the TTY line for the hearing impaired at 711. Additionally, a consumer assistance program can help you file your appeal. Contact the Washington State Office of the Insurance Commissioner's Consumer Advocacy Program at 1-800-562-6900 or [www.insurance.wa.gov](http://www.insurance.wa.gov).

## Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This [plan](#) or policy does provide minimum essential coverage.**

## Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health [plan](#). The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-888-849-3681**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-849-3681**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-888-849-3681**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' **1-888-849-3681**.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About These Coverage Examples:

These examples show how this [plan](#) might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this [plan](#). The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,290
- Patient pays \$1,250

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$125
Copays	\$0
Co-insurance	\$1125
Limits or exclusions	\$0
<b>Total</b>	<b>\$1,250</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$4,110
- Plan pays \$3,714
- Patient pays \$396

#### Sample care costs:

Prescriptions	\$1,500
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$730
Education	\$300
Laboratory tests	\$140
Vaccines, other preventive	\$140
<b>Total</b>	<b>\$4,110</b>

#### Patient pays:

Deductibles	\$125
Copays	\$0
Co-insurance	\$271
Limits or exclusions	\$0
<b>Total</b>	<b>\$396</b>



## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include [premiums](#).
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health [plan](#).
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this [plan](#).
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network [providers](#). If the patient had received care from out-of-network [providers](#), costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how [deductibles](#), [copayments](#), and [co-insurance](#) can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your [providers](#) charge, and the reimbursement your health [plan](#) allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other [plans](#), you'll find the same Coverage Examples. When you compare [plans](#), check the "Patient Pays" box in each example. The smaller that number, the more coverage the [plan](#) provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the [premium](#) you pay. Generally, the lower your [premium](#), the more you'll pay in out-of-pocket costs, such as [copayments](#), [deductibles](#), and [co-insurance](#). You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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