**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** or by calling 1-888-849-3681 (TTY 711).

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$250**/person, **$750**/family. Doesn't apply to preventive care. Balance-billed charges, co-payments (inpatient facility and emergency room), and prescription drugs don't count toward deductible. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible 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 deductible. |
| **Are there other deductibles for specific services?** | Yes, prescription drugs: **$100**/person, **$300**/family for Tier 2 and Tier 3 drugs. | You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **Is there an out–of–pocket limit on my expenses?** | Yes.<br>**Medical: $2,000**/person, **$4,000**/family.<br>**Prescription drugs: $2,000**/person (no family limit). | The out-of-pocket limit is the most you could pay to preferred 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 out–of–pocket limit?** | **Medical:** Premiums, balance-billed charges, prescription drug costs, member co-insurance paid to out-of-network providers, services not covered by the plan, and services subject to plan limits or maximums.<br>**Prescription drugs:** 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 out-of-pocket limit. |
| **Does this plan use a network of providers?** | Yes. See **www.hca.wa.gov/ump** or call **1-888-849-3681** for a list of preferred providers. | If you use an in-network doctor or other health care provider, this plan 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 provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting below for how this plan pays different kinds of providers. |

**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** or call 1-888-849-3681 to request a copy. (Plan Administrator: Regence BlueShield)

| | | |
|---|---|---|
| **Do I need a referral to see a specialist?** | No. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services. |

- 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 preferred 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) Preferred Provider | Your cost if you use a(n) Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 15% co-insurance | 40% co-insurance | ——————none—————— |
| | Specialist visit | 15% co-insurance | 40% co-insurance | ——————none—————— |
| | Other practitioner office visit | 15% co-insurance | 40% 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 | 40% 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 15% co-insurance | 40% co-insurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 15% co-insurance | 40% co-insurance | No coverage for routine Computed Tomographic Colonography, upright MRI, and Coronary Artery Calcium Scoring. Discography and Computed Tomographic Angioplasty require preauthorization. |

| Common Medical Event | Services You May Need | Your cost if you use a(n) | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Preferred Provider | Out-of-Network Provider | |
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at **www.hca.wa.gov/ump** 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. Not subject to prescription drug deductible. |
| | 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. Not subject to prescription drug deductible. |
| | Preferred brand drugs (Tier 2) | 30% co-insurance (up to $75/30-day supply or $225/90-day supply) | 30% co-insurance | Subject to prescription drug deductible. Tier 2 also includes some high-cost generic drugs. |
| | Nonpreferred brand drugs (Tier 3) | 50% co-insurance | 50% co-insurance | No individual prescription cost limit for non-specialty Tier 3 drugs. Subject to prescription drug deductible. |
| | 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 plan's 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 | 40% co-insurance | ————none———— |
| | Physician/surgeon fees | 15% co-insurance | 40% co-insurance | Preauthorization may be required. |
| **If you need immediate medical attention** | Emergency room services | $75 copayment/ visit; 15% co-insurance | $75 copayment/ visit; 15% co-insurance | Co-payment 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 | 40% co-insurance | ————none———— |

| Common Medical Event | Services You May Need | Your cost if you use a(n) | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Preferred Provider | Out-of-Network Provider | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $200 co-payment/ day up to $600/yr. | 40% co-insurance | Provider must notify plan on admission. |
| | Physician/surgeon fee | 15% co-insurance | 40% co-insurance | Preauthorization may be required. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 15% co-insurance | 40% co-insurance | Preauthorization may be required. No coverage for marriage/family counseling. |
| | Mental/Behavioral health inpatient services | $200 co-payment/ day up to $600/yr. Professional services: 15% co-insurance | 40% co-insurance | Inpatient admissions must be preauthorized. |
| | Substance use disorder outpatient services | 15% co-insurance | 40% co-insurance | Preauthorization may be required. |
| | Substance use disorder inpatient services | $200 co-payment/ day up to $600/yr. Professional services: 15% co-insurance | 40% co-insurance | Provider must notify the plan for detoxification and partial hospitalization. Inpatient admissions must be preauthorized. |
| **If you are pregnant** | Prenatal and postnatal care | 15% co-insurance | 40% 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 | $200 co-payment/ day up to $600/yr. Professional services: 15% co-insurance | 40% co-insurance | Elective deliveries before 39 weeks gestation covered only if medically necessary. |

| Common Medical Event | Services You May Need | Your cost if you use a(n) | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Preferred Provider | Out-of-Network Provider | |
| **If you need help recovering or have other special health needs** | Home health care | 15% co-insurance | 40% co-insurance | Custodial care, maintenance care, private duty nursing, or continuous care is not covered. |
| | Rehabilitation services | Inpatient: $200 co-payment/day up to $600/yr. Professional services: 15% co-insurance | 40% 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 | Inpatient: $200 co-payment/day up to $600/yr. Professional services: 15% co-insurance | 40% 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 | Inpatient: $200 co-payment/day up to $600/yr. Professional services: 15% co-insurance | 40% co-insurance | Coverage is limited to 150 days/yr. Services must be preauthorized. |
| | Durable medical equipment | 15% co-insurance | 40% 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 deductible is met | 40% 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) Preferred Provider | Your cost if you use a(n) Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If your child needs dental or eye care** | Eye exam | $0 | 40% co-insurance | Eye exams for medical conditions are subject to deductible and co-insurance. Contact fitting fees covered up to $65/yr., member pays additional charges. |
| | Glasses | $0 for one set of glasses/yr. | $0 for one set of glasses/yr. | Not subject to the deductible. 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
- Non-emergency care when traveling outside the U.S.
- 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**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **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**.

## 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, kwiijigo holne' **1-888-849-3681**.

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

# 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** $6,240
- **Patient pays** $1,300

**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 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $300 |
| Copays | $400 |
| Co-insurance | $600 |
| Limits or exclusions | $0 |
| **Total** | **$1,300** |

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

- **Amount owed to providers:** $4,100
- **Plan pays** $3,200
- **Patient pays** $900

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $1,500 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $730 |
| Education | $290 |
| Laboratory tests | $140 |
| Vaccines, other preventive | $140 |
| **Total** | **$4,100** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $300 |
| Copays | $0 |
| Co-insurance | $600 |
| Limits or exclusions | $0 |
| **Total** | **$900** |

# 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.

**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** or call 1-888-849-3681 to request a copy. (Plan Administrator: Regence BlueShield)