**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.hca.wa.gov/ump or call 1-888-849-3681 (TRS: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-849-3681 (TRS: 711) to request a copy.

| Important Questions | Answers | Why This Matters |
|---|---|---|
| **What is the overall deductible?** | $250/individual, $750/family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Each person has an individual medical deductible of $250 and the maximum the family pays for medical deductibles is $750. Once a particular individual pays his or her $250 deductible, the plan begins paying for covered services for that person. Once the family deductible has been met, the plan begins paying for covered services for everyone in the family. |
| **Are there services covered before you meet your deductible?** | Yes: Preventive care, hearing aids, sterilization, tobacco cessation, prescription drugs designated as preventive on the UMP Preferred Drug List and vision hardware | This plan covers some items and services even if you haven't yet met the deductible amount. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. But a copayment or coinsurance may apply to some services. For example, deductible and cost sharing may be applied on lab or radiology services during a preventive care visit. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes, for prescription drugs: $100/individual, $300/family for Tier 2 and Tier 3 drugs. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Medical: $2,500/individual, $5,000/family<br>Prescription: $2,000/individual (no family limit) | The out-of-pocket limit is the most you could pay in a year for covered services. For medical, if you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Medical: Premiums, balance billing charges, prescription drug costs, member coinsurance paid to out-of-network providers, health care this plan doesn't cover, amounts paid by the plan, and services that exceed plan limits or | Even though you pay for these services, they don't count toward the out-of-pocket limit. |

| | | |
|---|---|---|
| | maximums<br>Prescription drugs: Medical services, premiums, noncovered drugs, balance billed charges, amounts paid by the plan, amounts exceeding the allowed amount for drugs, and costs paid for other enrolled family members' drugs and products | |
| **Will you pay less if you use a network provider?** | Yes. See www.hca.wa.gov/ump or call 1-888-849-3681 (TRS: 711) for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 15% coinsurance | 40% coinsurance | Not applicable |
| | Specialist visit | 15% coinsurance | 40% coinsurance | Not applicable |
| | Preventive care/screening/ immunization | $0 | 40% coinsurance | This plan covers some items and services even if you haven't met the deductible amount. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. But a copayment or coinsurance may apply to some services. For example, deductible and cost share may be applied on lab or radiology services during a preventive care visit. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 15% coinsurance | 40% coinsurance | Not applicable |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance | 40% coinsurance | No coverage for routine Computed Tomographic Colonography, upright MRI, Carotid Intima Media Thickness testing, and Coronary Artery Calcium Scoring. Discography and Computed Tomographic Angioplasty require preauthorization. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.hca.wa.gov/ump-drugs-classic | Preventive Value Tier and Tier 1 drugs | **Preventive:** 0%<br><br>**Value Tier:** 5% coinsurance. Prescription cost limit: $10 up to a 30-day supply, $20 per 31-60 day supply, or $30 per 61-90 day supply<br><br>**Tier 1:** 10% coinsurance. Prescription cost limit: $25 up to a 30-day supply, $50 per 31-60 day supply, or $75 per 61-90 day supply | Value Tier: 5% coinsurance<br><br>Tier 1: 10% coinsurance | No coverage for prescription drugs with an over-the-counter alternative. Not subject to prescription drug deductible. Tier 1 does not include high-cost generic drugs. Preauthorization may be required. Mail order at exclusive mail order pharmacy, Postal Prescription Services (PPS). |
| | Tier 2 drugs | 30% coinsurance Prescription cost limit: $75 up to a 30-day supply, $150 per 31-60 days' supply, or $225 per 61-90 days' supply | 30% coinsurance | No coverage for prescription drugs with an over-the-counter alternative. Subject to prescription drug deductible. Tier 2 also includes some high-cost generic drugs. Preauthorization may be required. Mail order at exclusive mail order pharmacy, Postal Prescription Services (PPS). |
| | Tier 3 drugs | 50% coinsurance No prescription cost limit for non-specialty drugs | 50% coinsurance | No coverage for prescription drugs with an over-the-counter alternative. Subject to prescription drug deductible. Preauthorization may be required. Mail order at exclusive mail |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | order pharmacy, Postal Prescription Services (PPS). |
| | Specialty drugs | **Tier 1:** 10% coinsurance Prescription cost limit: $25 up to a 30-day supply<br><br>**Tier 2:** 30% coinsurance; Prescription cost limit: $75 up to a 30-day<br><br>**Tier 3:** 50% coinsurance Prescription cost limit: $150 per 30-day supply | Not covered | Coverage is limited to up to a 30-day supply per prescription or refill from the plan's specialty pharmacy, Ardon Health. No prescription drug deductible for Tier 1. Prescription drug deductible applies to Tier 2 and Tier 3. Preauthorization is required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 40% coinsurance | Not applicable |
| | Physician/surgeon fees | 15% coinsurance | 40% coinsurance | Preauthorization may be required. |
| **If you need immediate medical attention** | Emergency room care | $75 copayment per visit; 15% coinsurance | $75 copayment per visit; 15% coinsurance | Emergency room copayment is waived if admitted directly to hospital or facility as inpatient from the emergency room (but you will pay inpatient copayment). |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Coverage is not provided for air or water ambulance if ground ambulance would serve the same purpose. Ambulance services for personal or convenience purposes are not covered. |
| | Urgent care | 15% coinsurance | 40% coinsurance | Not applicable |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $200 copayment per day up to $600 per | 40% coinsurance | Provider must notify plan on admission. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | individual per admission | | |
| | Physician/surgeon fees | 15% coinsurance | 40% coinsurance | Preauthorization may be required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 15% coinsurance | 40% coinsurance | Preauthorization may be required. No coverage for marriage or family counseling. |
| | Inpatient services | $200 copayment per day up to $600 per individual per admission<br>Professional services: 15% coinsurance | 40% coinsurance | Preauthorization required for inpatient admissions. Provider must notify the plan for detoxification, intensive outpatient program, and partial hospitalization. |
| **If you are pregnant** | Office visits | 15% coinsurance | 40% coinsurance | 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). |
| | Childbirth/delivery professional services | 15% coinsurance | 40% coinsurance | Elective deliveries before 39 weeks gestation covered only if medically necessary. |
| | Childbirth/delivery facility services | $200 copayment per day up to $600 per admission. | 40% coinsurance | 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% coinsurance | 40% coinsurance | Custodial care, maintenance care, and private duty nursing or continuous care are not covered. |
| | Rehabilitation services | Inpatient: $200 copayment per day up to $600 per individual per admission<br>Professional services: 15% coinsurance | 40% coinsurance | Coverage is limited to 60 inpatient days per calendar year for all therapies combined and 60 outpatient visits per calendar year for all therapies combined. Inpatient admissions for rehabilitation services must be preauthorized. |
| | Habilitation services | Inpatient: $200 copayment per day up | 40% coinsurance | Coverage includes neurodevelopmental therapy. Coverage is limited to 60 inpatient |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | to $600 per individual per admission<br>Professional services: 15% coinsurance | | days per calendar year for all therapies combined and 60 outpatient visits per calendar year for all therapies combined. |
| | Skilled nursing care | Inpatient: $200 copayment per day up to $600 per individual per admission<br>Professional services: 15% coinsurance | 40% coinsurance | Coverage is limited to 150 days per calendar year. Services must be preauthorized. |
| | Durable medical equipment | 15% coinsurance | 40% coinsurance | Foot orthotics are covered only for prevention of diabetic complications. Lost, stolen, or damaged durable medical equipment is not covered. |
| | Hospice services | $0 after deductible is met | 40% coinsurance | Hospice coverage is limited to 6 months. Coverage for respite care is limited to 14 visits per the patient's lifetime. |
| **If your child needs dental or eye care** | Children's eye exam | $0 | 40% coinsurance | Eye exams for medical conditions are subject to deductible and coinsurance. Contact fitting fees covered up to $65 per year, and member may pay charges exceeding that amount. |
| | Children's glasses or contact lenses | $0 for one pair of glasses per calendar year; or $0 for a one-year supply of contact lenses in lieu of glasses | $0 for one set of glasses per calendar year; or $0 for a one-year supply of contact lenses in lieu of glasses up to the allowed amount. Providers may balance bill you for charges that exceed the allowed amount. | Not subject to the deductible. Coverage for children ages 0-18 years only. |
| | Children's dental check-up | Not covered | Not covered | Not applicable |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Coronary or cardiac artery calcium scoring
- Cosmetic Surgery
- Custodial care
- Dental care
- Immunizations for travel or employment
- Infertility treatment after initial diagnosis
- Lost, stolen, or damaged durable medical equipment
- Maintenance care
- Marriage or family counseling
- MRI, upright
- Out-of-network massage therapy
- Private duty nursing and continuous care
- Computed Tomographic Colonography for routine colorectal cancer screening
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing Aids
- Long Term Care
- 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:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: UMP Customer Service at 1-888-849-3681 (medical benefits) (TRS: 711); 1-888-361-1611 (prescription benefits); or (TRS: 711) or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **Yes.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards?** **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-849-3681 (TRS: 711).]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-849-3681 (TRS: 711).]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-888-849-3681 (TRS: 711).]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-849-3681 (TRS: 711).]

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

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is having a baby
(9 months of in-network prenatal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist coinsurance | 15% |
| Hospital (facility) copayment | $400 |
| Other coinsurance | 15% |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery professional services
Childbirth/Delivery facility services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,840** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $400 |
| Coinsurance | $550 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,260** |

### Managing Joe's type 2 diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist coinsurance | 15% |
| Hospital (facility) copayment | $0 |
| Other coinsurance | 15% |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,460** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $0 |
| Coinsurance | $1,550 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,860** |

### Mia's simple fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist coinsurance | 15% |
| Hospital (facility) copayment | $75 |
| Other coinsurance | 15% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,010** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $75 |
| Coinsurance | $330 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$655** |

The plan would be responsible for the other costs of these EXAMPLE covered services.