Summary of Benefits

ALERT! Even if a provider orders a test or prescribes a treatment, the plan may not cover it. Please review this *Certificate of Coverage* or call Customer Service at 1-888-849-3681 if you have questions about benefits or limitations.

On the next several pages, you'll find a summary of your plan benefits, a convenient reference to help you find the information you need. For a complete understanding of how a benefit works, it is important that you also read the pages listed in the "For More Information" column.

Not all benefits are listed. For services not listed, see the Table of Contents or call UMP Customer Service at 1-888-849-3681.

In order to be covered, all services must be medically necessary (see the definition on pages 209–211).

If you see an unfamiliar term, see the alphabetical list of definitions on pages 198–225.

This Certificate of Coverage applies only to dates of service between the day your coverage begins (but no earlier than January 1, 2016) and the day your coverage ends (no later than December 31, 2016).

ALERT! If you have coverage under another health plan, see pages 133–140.

Deductibles and Limits

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Medical deductible	$125 per person (maximum of $375 for a family of three or more) See page 26 if you qualified for the 2016 SmartHealth $125 wellness incentive.	▪ You pay toward the medical deductible before the plan pays for covered medical services. ▪ You don't have to pay the medical deductible for some services. ▪ Not all services count toward this deductible.	26–28

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Medical out-of-pocket limit	$2,000 per person (maximum of $4,000 for a family of two or more)	Your medical deductible and all coinsurance and copays for covered in-network services count toward this limit.	30–32
Prescription drug out-of-pocket limit	$2,000 per person (no family maximum)	Your coinsurance counts toward this limit; see page 100 for details.	100
Annual plan payment limit	None	No limit to how much the plan pays per calendar year.	Not applicable
Lifetime plan payment limit	None	No limit to how much the plan pays over a lifetime.	Not applicable

How Much Will I Pay?

The table below describes how much you'll pay for services. Unless otherwise noted, all payment is based on the allowed amount, which is the fee accepted as payment by network and non-network providers, and services are subject to the medical deductible. See the Summary of Benefits table on pages 38–50 for which type of service applies to a specific benefit.

Type of Service	How Much You Pay *See pages 11–20 for descriptions of the provider types listed below.*
Primary Care Services, Office Visits *Naturopaths contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*	▪ **Primary Care Network providers:** You pay $0; the plan pays in full. Services performed during a primary care office visit may be covered under the Standard benefit described below. If you receive primary care office visits from the following providers, services are subject to the medical deductible and the following coinsurance: ▪ **Specialty Network providers:** You pay 15% of the allowed amount. ▪ **Non-network providers:** You pay 50% of the allowed amount; the provider may not balance bill you. ▪ **Out-of-network providers:** You pay 50% of the allowed amount, and the provider may balance bill you (see page 200).

Type of Service	How Much You Pay *See pages 11–20 for descriptions of the provider types listed below.*
Standard **Subject to the medical deductible:** You must pay the first $125 in covered services before the plan begins to pay. Most ancillary providers and services (see page 14) are paid at the standard rate. *Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*	How much you pay (your coinsurance) depends on the provider's network status: ▪ **Primary Care Network and Specialty Network providers:** You pay 15% of the allowed amount. ▪ **Non-network providers:** You pay 50% of the allowed amount, the provider may not balance bill you. ▪ **Out-of-network providers**—You pay 50% of the allowed amount; the provider may balance bill (see page 200).
Preventive Preventive services **are not subject to the medical deductible** (you don't have to pay your deductible before the plan pays).	How much you pay (your coinsurance) depends on the provider's network status: ▪ **Primary Care Network and Specialty Network providers**—You pay $0: the plan pays in full. ▪ **Non-network providers:** You pay 50% of the allowed amount; the provider may not balance bill. ▪ **Out-of-network providers**—You pay 50%; the provider may balance bill.
Outpatient Subject to the medical deductible.	If you receive services at a facility that offers inpatient services but you are not admitted as an inpatient, the services are covered as outpatient. See the specific benefit—for example, diagnostic tests—for how much you will pay.

Type of Service	How Much You Pay *See pages 11–20 for descriptions of the provider types listed below.*
Inpatient **Subject to the medical deductible.** You pay the inpatient copay and separate charges for professional services, such as doctor consultations and lab tests. See the specific benefit—for example, diagnostic tests—for how the plan covers these related services. ▪ Professional providers may contract separately from a facility. Even if a facility is network, a professional provider may not be. ▪ Most inpatient services require both: • Preauthorization: See page 121 for a description of how this works. • Notification: Your provider must notify the plan upon admission to a facility; see page 122 for a description of how this works.	The inpatient copay is $200 per day at network facilities, $600 maximum per calendar year. **Note:** The inpatient copay counts toward your medical out-of-pocket limit. When you are admitted to a network facility as an inpatient, you will pay: ▪ Any remaining medical deductible; ▪ The inpatient copay; AND ▪ Your coinsurance for professional services; depends on the provider's network status as described under the Standard type of service, listed above. If you receive non-emergency inpatient care at an out-of-network facility, you will pay according to the Standard benefit above. See the table on page 20 for details of coverage of out-of-network facility charges. Services are considered inpatient only when you are admitted as an inpatient to a facility. See definition of "Inpatient Stay" on page 207.
Special Subject to the medical deductible.	These services have unique payment rules, which are described in the "How much will I pay?" column on pages 38–50.

What else do I need to know?

- Some services aren't covered; see pages 126–132 for some of the services not covered by the plan.
- You don't need a referral from the plan to see a specialist for most services. However, you will save money by seeing Primary Care Network and Specialty Network providers, especially for preventive services; see page 13.
- Preexisting conditions: There is no waiting period; medically necessary covered services are eligible for benefits from the effective date of your medical enrollment.

Summary of Benefits

Only certain services are listed in the table. For those not listed, see the alphabetical list of covered benefits on pages 51–96 or call Customer Service at 1-888-849-3681.

Please read the pages listed in the "For more information" column for each benefit. Not all details are included in the table. We recommend that you also review:

- Services that require preauthorization (see page 121 for how this works); see page 122 for how to find the current list at **www.hca.wa.gov/ump** or call 1-888-849-3681.
- Services for which your provider must notify the plan; see the current list at **www.hca.wa.gov/ump** or call 1-888-849-3681.
- Services that aren't covered (exclusions); see pages 126–132.

If you have questions about services that require preauthorization or plan notification, or services not covered by the plan, call Customer Service at 1-888-849-3681.

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Ambulance	**Special:** 20% of the allowed amount Out-of-network providers may balance bill.	53, 126, 131	Covered only for a medical emergency (see definition on page 209).
Applied Behavior Analysis (ABA) Therapy Exception Providers (page 54)	Standard	54	Specific preauthorization requirements; see page 54. Only specified providers are covered; see page 54.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Chemical Dependency Treatment Ancillary providers**			
Inpatient Services	Inpatient	56, 130	See page 56 for preauthorization of inpatient services. Plan notification is required at the time of admission.*
Outpatient Services	Standard	56, 130	See page 56 for services that may require preauthorization.* May be subject to review for medical necessity
Chiropractic Physician Services		88	See *"Spinal and Extremity Manipulations"* on page 47.
Contraceptive Services for Women	Some services and supplies covered as preventive; see benefit description on pages 68–70. Office visits may be covered as primary care services when you see a Primary Care Network provider (page 35).	68–70, 85	

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Dental Services	**Special:** You pay 20% of the allowed amount. No network dentists; providers may balance bill (see definition on page 200)	58, 127	See "Dental Services" on page 58 for limitations on covered services.
Diabetes Care Supplies	**Special:** Paid under the prescription drug benefit; see pages at right.	60, 138	See "How Are Diabetes Care Supplies Covered When UMP Plus Pays Second?" on page 138 if another plan pays first.
Diabetes Control Program: NOT ME	Preventive	61	Only the NOT ME program is covered.
Diabetes Prevention Program: NOT ME	Preventive	62	Only the NOT ME program is covered.
Diagnostic Tests, Laboratory, and X-Rays Ancillary Providers**	Standard	63, 82, 126, 129, 132	Usually billed separately from related office visits or inpatient services.
Durable Medical Equipment, Supplies, and Prostheses Ancillary Providers**	Standard	64–67, 94, 106, 127, 130, 203	May require preauthorization.* Some breast pumps are covered as preventive; see "Services Covered as Preventive" on page 81.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Emergency Room (ER) *You pay a $75 copay per visit (in addition to coinsurance)* Exception Providers** (page 67)	ER copay ($75), plus you are usually billed separately for: ▪ Facility charges ▪ Professional (physician) services ▪ Lab tests, x-rays, and other imaging tests **Special:** ▪ For services due to a medical emergency (see page 209), you pay 15% for services by all network providers. If you visit a non-network or out-of-network emergency room and are admitted directly to the hospital, your inpatient services are paid at the higher network rate as well. ▪ Out-of-network facilities: You pay 15% of the plan allowed amount and the provider may balance bill (see page 200).	67, 209	If you are admitted as an inpatient directly from the ER, you won't owe the ER copay (but will pay the inpatient copay). Services determined not to be due to a medical emergency (page 209) are not covered in an emergency room setting.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
End-of-Life Counseling	▪ If received as part of hospice: Paid at 100% after meeting medical deductible. ▪ If received outside of hospice services: Standard.	68	Total of 30 visits, all services combined.
Family Planning Services	Some services and supplies covered as preventive; see benefit description on pages 68–70. Office visits may be covered as primary care services when you see a Primary Care Network provider (page 35).	68–70, 128	Not covered: ▪ Infertility services ▪ Reversal of sterilization
Hearing Aids Not subject to medical deductible Ancillary Providers**	**Special:** Plan pays up to $800.	71	Limited to $800 plan payment per three calendar years.
Hearing Exams, Routine Ancillary Providers**	Preventive	71, 85	One per calendar year.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Home Health Care Ancillary Providers**	Standard	72, 90, 128, 202, 206, 208	See page 72 for what is covered. Specific services are not covered; see exclusion 24 on page 128. Maintenance care (page 208) and custodial care (page 202) are not covered.
Hospice Care (Includes respite care) Ancillary Providers**	**Special:** Paid at 100% after meeting medical deductible.	73, 206, 222	Covered for terminally ill members for up to six months. Respite care is limited to 14 visits per lifetime.
Hospital Services			
Inpatient Services **Exception Providers:** Children's Hospitals	Inpatient	74, 80–82, 128	All elective inpatient admissions (except maternity) require preauthorization.* Plan notification is required for all hospital admissions within 24 hours of admission.* Inpatient rehabilitation services require preauthorization.*
Outpatient Services	Standard	74	Some services require preauthorization.*

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Immunizations (Vaccines)	Preventive (usually)	86, 128, 212	Covered under CDC recommendations; see page 86. *Not covered for travel or employment.*
Mammograms (Diagnostic)	Standard	76	Must be billed as diagnostic by the provider.
Mammograms (Screening) *See "Breast Health Screening Tests" on page 56 for additional services covered.*	Preventive	76	**Women age 40 and older:** Covered every one to two years. **Women under age 40:** Covered as preventive only for women at increased risk; see page 76 for details. For women under age 40 and not at increased risk, see page 76. *See "Breast Health Screening Tests" on page 56 for additional services covered.*
Massage Therapy Ancillary Providers**	Standard	77, 129	Limited to 16 visits per calendar year. Only network massage therapists are covered.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Mastectomy and Breast Reconstruction	Inpatient (Standard for related outpatient visits)	65, 77	All inpatient services require plan notification.*
Mental Health Treatment Ancillary Providers**			
Inpatient Services	Inpatient	78, 130	See page 78 about preauthorization of inpatient services. Plan notification is required at the time of admission.*
Outpatient Services	Standard	78, 129, 130	See page 78 for services that require plan notification.*
Naturopathic Physician Services Primary Care Network Providers	Primary Care	13, 79, 118, 127	Herbs, vitamins, and other supplements are not covered. See "Exceptions Covered" on page 115 for exceptions.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Obstetric and Newborn Care Some Ancillary Providers; see page 14. Examples include Birth Centers and Licensed Midwives.**	Inpatient *Some breast pumps are covered as preventive; see page 81.*	80–82, 132	For non-routine services for a newborn, you may pay toward the baby's medical deductible or inpatient copay; see page 80. See page 80 for coverage of circumcision for males, which is not a preventive service.
Office Visits, Non-Primary Care	Standard	82, 129	
Office Visits, Primary Care	Primary Care, only when you see a Primary Care Network Provider (page 13).	13, 82, 129	See pages 84–86 for routine exams covered as preventive.
Physical, Occupational, Speech, and Neurodevelopmental Therapy Ancillary Providers**	Standard *Charges for inpatient services are not included in the inpatient copay.*	83, 129, 208	**Inpatient:** 60 days maximum per calendar year. **Outpatient:** 60 visits maximum per calendar year.
Prescription Drugs	See "Your Prescription Drug Benefit" on pages 97–120.		See exclusions on pages 126–132, and other limits on pages 108–112.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Preventive Care Includes vaccines, routine exams, some screening tests	Preventive	76, 81, 84–86, 116, 219	Only certain services are covered as preventive; see pages 84–86. See page 81 for contraception covered as preventive.
Primary Care Services Although there is no cost for office visit charges when you see a Primary Care Network provider, other services provided at a primary care visit may be subject to the medical deductible and coinsurance.	Primary Care	Primary Care Network providers: see page 13.	To receive primary care office visits at no cost, you must see a Primary Care Network provider (see description on page 13).
Skilled Nursing Facility Ancillary Providers**	Inpatient *Some services may be billed separately (such as physical therapy).*	87, 129, 131, 222	Maintenance care (page 208) and custodial care (page 202) are not covered.
Spinal and Extremity Manipulations Ancillary Providers**	Standard	88, 129	Limited to 10 visits per calendar year.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Surgery Some Ancillary Providers; see page 14. Examples include Anesthesiologists, Pathologists, and Maxillofacial surgeons.		60, 74, 77, 83, 89, 93, 128 132, 199, 214, 220	See page 55 for coverage of bariatric surgery. See page 93 for coverage of transgender surgery.
Inpatient Services	Inpatient		Some services require preauthorization and/or plan notification.*
Outpatient Services	Standard		Some services require preauthorization.*
Telemedicine Services	Standard	90	
Tobacco Cessation Services	Preventive	90	See page 90 for coverage of drugs and nicotine replacement supplies. See page 92 for tobacco cessation services for members ages 17 and under.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Transgender Services Exception Providers; see page 93.	Standard	93	Some services require preauthorization and/or plan notification. See page 93 for covered services.
Urgent Care You don't pay the ER copay for urgent care services. Exception Providers; see page 94.	**Special:** ▪ **Network providers:** You pay 15% ▪ **Non-network providers:** You pay 15% ▪ **Out-of-network providers:** You pay 50% and the provider may balance bill.	94	
Vision Care (Related to Diseases and Disorders of the Eye)	Standard	94, 126, 128, 129	
Vision Exams, Routine	Preventive	94, 128, 129	One per calendar year. The plan pays $65 per year for contact lens fitting fees; you pay any additional charges.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*

Benefit/Service and Provider Type	How much will I pay? (See pages 35–37 for description of payment types)	For more information See page(s)	Any limitations or exclusions?
Vision Hardware, Adults (Over age 18) Glasses, contact lenses	**Special:** You pay any amount over $150; network status of provider does not matter. No medical deductible.	95	Plan pays up to $150 per two calendar years (resets every even year).
Vision Hardware, Children (Age 18 and under) Glasses, contact lenses	**Special:** No medical deductible. **Eyeglasses:** You pay $0 for one set of standard or deluxe frames and lenses per year. **Contact lenses:** You pay 15% of billed charges.	95	Plan pays for one pair of eyeglasses per year at 100% of billed charges. See page 95 for options that aren't covered. No limit on number of contact lenses covered.
Well-Child Visits Also see "Primary Care Services" on page 47.	Preventive	84–86	See pages 84–86.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 121–123 for how this works.*

***Ancillary providers and services (see page 14). Ancillary providers contracted with Regence but not affiliated with UW Medicine ACN must be within the UMP Plus Service Area to be covered as network; see "Regence Network Providers Must Be Within the UMP Plus Service Area" on page 13 for how this works.*