

 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 (TTY: 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 (TTY: 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. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of the deductible expenses paid by all family members meets the overall family deductible .
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: \$2,000/individual, \$4,000/family 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, and services that	Even though you pay these services, they don't count toward the out-of-pocket limit .

	<p>exceed plan limits or maximums.</p> <p>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.</p>	
Will you pay less if you use a network provider ?	Yes. See www.hca.wa.gov/ump_or_call_1-888-849-3681 (TTY: 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .

* For more information about limitations and exceptions, see the plan or policy document at www.hca.wa.gov/ump.

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 .
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.hca.wa.gov/ump-drugs-classic.</p>	Value Tier and Generic drugs(Tier 1)	Preventive: 0% Value Tier: 5% coinsurance . Prescription Cost Limit: \$10 up to a 30-day supply, \$20 per 31-60 days' supply, or \$30 per 61-90days' supply Generic drugs (Tier 1): 10% coinsurance . Prescription cost limit: \$25 up to a 30-day supply, \$50 per 31-60 days' supply, or \$75 per 61-90 days' supply	Value Tier: 5% coinsurance Generic Drugs (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. Prior authorization may be required. Mail order at exclusive mail order pharmacy, Postal Prescription Services (PPS).
	Preferred brand drugs (Tier 2)	30% coinsurance Prescription cost limit: \$75 up to a 30-day supply, \$150 per 31-60 days' supply, or \$225 per61-90days' 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. Prior authorization may be required. Mail order at exclusive mail order pharmacy, Postal Prescription Services (PPS).
	Non-preferred brand drugs (Tier 3)	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 . Prior authorization may be required. Mail order at exclusive mail order pharmacy, Postal Prescription Services (PPS).
	Specialty drugs	Tier 1: 10%	Not covered	Coverage is limited to up to a 30-day supply

* For more information about limitations and exceptions, see the plan or policy document at www.hca.wa.gov/ump.

		coinsurance Prescription cost limit: \$25 up to a 30-day Tier 2: 30% coinsurance ; Prescription cost limit: \$75 up to a 30-day Tier 3: 50% coinsurance Prescription cost limit: \$150 per 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. Prior authorization 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 ER (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 individual per calendar year.	40% coinsurance	Provider must notify plan on admission.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	Preauthorization may be required.

* For more information about limitations and exceptions, see the plan or policy document at www.hca.wa.gov/ump.

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 calendar year. 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 calendar year	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 calendar year. 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 to \$600 per individual per calendar year. Professional services: 15% coinsurance	40% coinsurance	Coverage includes neurodevelopmental therapy. 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.

* For more information about limitations and exceptions, see the plan or policy document at www.hca.wa.gov/ump.

	Skilled nursing care	Inpatient: \$200 copayment per day up to \$600 per individual per calendar year 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	\$0 for one set of glasses per calendar year.	\$0 for one set of glasses per calendar year.	Not subject to the deductible . Coverage for children ages 0-18 only. 15% coinsurance for contact lenses, and no limit to number purchased.
	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](#).)

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|---|--|---|
| <ul style="list-style-type: none"> • Coronary or cardiac artery calcium scoring • Cosmetic Surgery • Custodial care • Dental care • Immunizations for travel or employment | <ul style="list-style-type: none"> • Infertility treatment after initial diagnosis • Lost, stolen, or damaged durable medical equipment • Maintenance care • Marriage or family counseling • MRI, upright | <ul style="list-style-type: none"> • Out-of-network massage therapy • Private duty nursing and continuous care • Computed Tomographic Colonography for routine colorectal cancer screening • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Hearing Aids • Long Term Care • Non-emergency care if traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care for certain medical conditions |
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* For more information about limitations and exceptions, see the plan or policy document at www.hca.wa.gov/ump.

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 will 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) (TTY: 711); 1-888-361-1611 (prescription benefits) (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 (TTY: 711).]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-849-3681 (TTY: 711).]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-849-3681 (TTY: 711).]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-849-3681 (TTY: 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 pre-natal 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$400
Coinsurance	\$550
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,550
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$75
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$655