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?	**$1,400**/person, **$2,800**/family for medical and prescription drug costs. Doesn't apply to preventive care. Family deductible must be met before plan pays for benefits not exempt from deductible. Charges above plan's allowed amount do not 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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$4,200** person/**$8,400** family. Family out-of-pocket limit must be met before plan pays 100% for covered benefits from a preferred provider. Out-of-pocket expenses for a single member under a family account not to exceed $6,850.	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?	Premiums, balance-billed charges, services not covered by the plan, and services subject to plan limits or maximums.	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 on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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)

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.

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 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.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.hca.wa.gov/ump** or 1-888-361-1611	Generic drugs	15% co-insurance	15% co-insurance	No coverage for prescription drugs with an over-the-counter alternative.
	Preferred drugs	15% co-insurance	15% co-insurance	No coverage for prescription drugs with an over-the-counter alternative.
	Nonpreferred drugs	15% co-insurance	15% co-insurance	No coverage for prescription drugs with an over-the-counter alternative.
	Specialty drugs	15% co-insurance	Not covered	Coverage is limited to a 30-day supply per fill from plan's specialty pharmacy, Ardon Health.
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	15% co-insurance	15% co-insurance	——————none——————
	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——————
If you have a hospital stay	Facility fee (e.g., hospital room)	15% co-insurance	40% co-insurance	Provider must notify plan on admission.
	Physician/surgeon fee	15% co-insurance	40% co-insurance	Preauthorization may be required.

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 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	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	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 ultrasound(s) may be covered when medically necessary).
	Delivery and all inpatient 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	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 require preauthorization.
	Habilitation 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	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.
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** $5,140
- **Patient pays** $2,400

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	$1,400*
Copays	$0
Co-insurance	$1,000
Limits or exclusions	$0
Total	**$2,400**

*Assumes single account for mother only.

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

- **Amount owed to providers:** $4,100
- **Plan pays** $2,300
- **Patient pays** $1,800

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	$1,400*
Copays	$0
Co-insurance	$400
Limits or exclusions	$0
Total	**$1,800**

*Assumes single person on the account.

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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