

# 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, the Index at the back of the book, 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 124–125).

*If you see an unfamiliar term, see the alphabetical list of definitions on pages 117–132.*

*This Certificate of Coverage applies only to dates of service between the day your coverage begins (but no earlier than January 1, 2015) and the day your coverage ends (no later than December 31, 2015).*



**ALERT!** If you have coverage under another health plan, see pages 66–71. If your other coverage is Medicare, see pages 72–78.

## 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	\$250 per person (maximum of \$750 for a family of three or more) See page 8 if you qualified for the SmartHealth \$125 wellness incentive.	<ul style="list-style-type: none"> <li>▪ You pay toward this deductible before the plan pays for covered services.</li> <li>▪ You don't have to pay the deductible for some services.</li> <li>▪ Not all services count toward this deductible.</li> </ul>	8–9
Prescription drug deductible	\$100 per person (maximum of \$300 for a family of three or more)	<ul style="list-style-type: none"> <li>▪ You pay the costs for Tier 2 and Tier 3 drugs until you reach this amount.</li> <li>▪ The plan pays its share for Value Tier and Tier 1 drugs right away; you don't pay the deductible.</li> </ul>	44–45
Medical out-of-pocket limit	\$2,000 per person (maximum of \$4,000 for a family of two or more) For Medicare-primary members: \$2,500/\$5,000	Your medical deductible and all coinsurance and copays for covered in-network services count toward this limit.	11–12

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## Deductibles and Limits *(continued)*

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Prescription drug out-of-pocket limit	\$2,000 per person (no family maximum)	Your prescription drug deductible and coinsurance count toward this limit; see page 45 for details.	45
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 a preferred provider, and services are subject to the medical deductible. See the Summary of Benefits table on pages 16–20 for which type of service applies to a specific benefit.

Type of Service	How Much You Pay
<p><b>Standard</b></p> <p>Subject to the medical deductible: You must pay the first \$250 in covered services before the plan begins to pay.</p>	<p>How much you pay (your coinsurance) depends on the provider's network status:</p> <ul style="list-style-type: none"> <li>▪ <b>Preferred providers</b> — You pay 15% of the allowed amount.</li> <li>▪ <b>Out-of-network providers</b> — You pay 40% of the allowed amount; the provider may balance bill (see page 118).</li> <li>▪ <b>Participating providers</b> — You pay 40% of the allowed amount; the provider may not balance bill. Indicated by \$\$ in the provider directory on <a href="http://regence.com">regence.com</a>.</li> </ul>
<p><b>Preventive</b></p> <p>Preventive services are <b>not subject to the medical deductible</b> (you don't have to pay your deductible before the plan pays).</p>	<p>How much you pay (your coinsurance) depends on the provider's network status:</p> <ul style="list-style-type: none"> <li>▪ <b>Preferred and participating providers</b> — You pay \$0; the plan pays in full.</li> <li>▪ <b>Out-of-network providers</b> — You pay 40%; the provider may balance bill.</li> </ul>
<p><b>Outpatient</b></p> <p>Subject to the medical deductible.</p>	<p>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.</p>

## How Much Will I Pay? *(continued)*

Type of Service	How Much You Pay
<p><b>Inpatient</b>  <b>Subject to the medical deductible.</b>            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.</p> <ul style="list-style-type: none"> <li>▪ Professional providers may contract separately from a facility. Even if a facility is preferred, a professional provider may not be.</li> <li>▪ Most inpatient services require:               <ul style="list-style-type: none"> <li>▪ <b>Preauthorization:</b> See page 58 for a description of how this works.*</li> <li>▪ <b>Notification:</b> Your provider must notify the plan upon admission to a facility; see page 59 for a description of how this works.*</li> </ul> </li> </ul> <p>Note that most inpatient services require both preauthorization and plan notification.</p>	<p><b>The inpatient copay is \$200 per day at preferred facilities</b></p> <ul style="list-style-type: none"> <li>▪ Employees and retirees not enrolled in Medicare: <b>\$600 maximum per calendar year.</b></li> <li>▪ Retirees enrolled in Medicare: <b>\$600 maximum per admission up to the medical out-of-pocket limit.</b></li> </ul> <p><b>Note:</b> The inpatient copay counts toward your medical out-of-pocket limit.</p> <p>When you are admitted to a preferred facility as an inpatient, you will pay:</p> <ul style="list-style-type: none"> <li>▪ Any remaining deductible;</li> <li>▪ The inpatient copay; AND</li> <li>▪ Your coinsurance for professional services; depends on the provider's network status as described under the Standard type of service, listed above.</li> </ul> <p><i>If you receive non-emergency inpatient care at an out-of-network facility, you will pay according to the Standard benefit above. See page 4 and page 7 for details of coverage of out-of-network facility charges.</i></p> <p>Services are considered inpatient only when you are admitted as an inpatient to a facility. See definition of "Inpatient Stay" on page 122.</p>
<p><b>Special</b>            Subject to the medical deductible.</p>	<p>These services have unique payment rules, which are described in the "How much will I pay?" column on pages 16–20.</p>

### What else do I need to know?

- ◆ Some services aren't covered; see pages 61–65 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 preferred providers, especially for preventive services; see page 4.
- ◆ Preexisting conditions: There is no waiting period; medically necessary services are covered from the effective date of your medical coverage.

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# Summary of Benefits

Only certain services are listed in the table. For those not listed, see the alphabetical list of covered benefits on pages 21–42, check the Index, 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 58 for how this works); see the current list at [www.hca.wa.gov/ump](http://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](http://www.hca.wa.gov/ump) or call 1-888-849-3681.
- ♦ Services that aren’t covered (exclusions); see pages 61–65.

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.

<b>Benefit/Service</b>	<b>How much will I pay? (See pages 14–15 for description of payment types)</b>	<b>For more information: See page(s)</b>	<b>Any limitations or exclusions?</b>
<b>Ambulance</b>	<b>Special:</b> 20% of the allowed amount for preferred or out-of-network providers.  Out-of-network providers may balance bill.	22, 61, 65	Covered only for a medical emergency (see definition on page 123).
<b>Applied Behavior Analysis (ABA) Therapy</b>	Standard	22	Specific preauthorization requirements; see page 22.
<b>Chemical Dependency Treatment</b>			
<i>Inpatient Services</i>	Inpatient	24, 63, 75	Inpatient admission and some other services require plan notification.*  Treatment in residential facilities requires preauthorization.*
<i>Outpatient Services</i>	Standard	24, 63, 75	May be subject to review for medical necessity.  Some services require plan notification.*
<b>Chiropractic Physician Services</b>		39	See “Spinal and Extremity Manipulations” on page 20.
<b>Contraceptive Services for Women</b>	Preventive or Standard	29–30, 38	See pages 29–30 for services that are covered as preventive. Some contraceptive services may be covered as Standard.

\*For services requiring preauthorization or plan notification: See the list of services at [www.hca.wa.gov/ump](http://www.hca.wa.gov/ump) or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 58-59 for how this works.

<b>Benefit/Service</b>	<b>How much will I pay?</b> <i>(See pages 14–15 for description of payment types)</i>	<b>For more information:</b> See page(s)	<b>Any limitations or exclusions?</b>
<b>Diabetes Care Supplies</b>	<b>Special:</b> Paid under the prescription drug benefit; see pages at right.	26, 70, 74	See page 74 if Medicare is your primary coverage.
<b>Diabetes Control Program: NOT ME</b>	Preventive	26	Only the NOT ME program is covered.
<b>Diabetes Prevention Program: NOT ME</b>	Preventive	26-27	Only the NOT ME program is covered.
<b>Diagnostic Tests, Laboratory, and X-Rays</b>	Standard	27, 36, 61, 63, 65	Usually billed separately from related office visits or inpatient services.
<b>Durable Medical Equipment, Supplies, and Protheses</b>	Standard	27–29, 42, 48, 62, 63, 120	May require preauthorization.* Some breast pumps are covered as preventive; see page 36.
<b>Emergency Room (ER)</b> <i>You pay a \$75 copay per visit (in addition to coinsurance)</i>	Standard plus the ER copay (\$75) You are usually billed separately for: <ul style="list-style-type: none"> <li>▪ Facility charges</li> <li>▪ Professional (physician) services</li> <li>▪ Lab tests, x-rays, and other imaging tests</li> </ul>	29, 123	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 123) are not covered in an emergency room setting.
<b>Family Planning Services</b>	Standard <i>Some contraceptive services are covered as preventive; see pages 29–30.</i>	29–30, 62	Not covered: <ul style="list-style-type: none"> <li>▪ Infertility services</li> <li>▪ Reversal of sterilization</li> </ul>
<b>Hearing Aids</b> <i>Not subject to medical deductible</i>	<b>Special:</b> Plan pays up to \$800.	31, 75	Limited to \$800 plan payment per three calendar years.
<b>Hearing Exams, Routine</b>	Preventive	31, 38, 75	One per calendar year.
<b>Home Health Care</b>	Standard	32, 40, 62, 122, 123	See page 32 for what is covered. Specific services are not covered; see exclusion 24 on page 62. Maintenance care (page 123) and custodial care (page 119) are not covered.

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## Summary of Benefits, continued

<b>Benefit/Service</b>	<b>How much will I pay? (See pages 14–15 for description of payment types)</b>	<b>For more information: See page(s)</b>	<b>Any limitations or exclusions?</b>
<b>Hospice Care</b> (Includes respite care)	<b>Special:</b> Paid at 100% after meeting deductible.	32, 122, 131	Covered for terminally ill members for up to six months. Respite care is limited to 14 visits per lifetime.
<b>Hospital Services</b>			
<b>Inpatient Services</b>	Inpatient	32-33, 34, 35, 62, 75	All elective inpatient admissions (except maternity) require preauthorization.* Plan notification is required for all hospital admissions within 24 hours of admission.* Some services require preauthorization.*
<b>Outpatient Services</b>	Standard	33	Some services require preauthorization.*
<b>Immunizations (Vaccines)</b>	Preventive (usually)	38-39, 62, 125	Covered under CDC recommendations; see pages 38–39. <i>Not covered for travel or employment.</i>
<b>Mammograms (Diagnostic)</b>	Standard	34	Must be billed as diagnostic by the provider.
<b>Mammograms (Screening)</b>	Preventive	33-34	<b>Women age 40 and older:</b> Covered every one to two years. <b>Women under age 40:</b> Covered as preventive only for women at increased risk; see page 33 for details. For women under age 40 and not at increased risk, see pages 33–34.
<b>Massage Therapy</b>	Standard	34, 63	Limited to 16 visits per calendar year. Only preferred massage therapists are covered.
<b>Mastectomy and Breast Reconstruction</b>	Inpatient (Standard for related outpatient visits)	28, 34	All inpatient services require plan notification.*

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<b>Benefit/Service</b>	<b>How much will I pay?</b> <i>(See pages 14–15 for description of payment types)</i>	<b>For more information:</b> See page(s)	<b>Any limitations or exclusions?</b>
<b>Mental Health Treatment</b>			
<i>Inpatient Services</i>	Inpatient	34-35, 63, 75	Inpatient admission and some other services require plan notification.* Treatment in residential facilities requires preauthorization.
<i>Outpatient Services</i>	Standard	35, 63, 75	Some services require plan notification.*
<b>Naturopathic Physician Services</b>	Standard	6, 35, 55, 61, 75	Herbs, vitamins, and other supplements are not covered. See page 54 for exceptions.
<b>Obstetric and Newborn Care</b>	Inpatient (Standard for related outpatient visits) <i>Some breast pumps are covered as preventive; see page 36.</i>	35-36	For non-routine services for a newborn, you may pay toward the baby's medical deductible or inpatient copay; see page 35. See page 35 for coverage of circumcision, which is not a preventive service..
<b>Office Visits</b>	Standard	37, 63	See pages 37–38 for routine exams covered as preventive.
<b>Physical, Occupational, Speech, and Neurodevelopmental Therapy</b>	Standard <i>Charges for inpatient services are not included in the inpatient copay.</i>	37, 63, 123	<b>Inpatient:</b> 60 days maximum per calendar year. <b>Outpatient:</b> 60 visits maximum per calendar year.
<b>Prescription Drugs</b>	See "Your Prescription Drug Benefit" on pages 43–57.	43–57	See exclusions on pages 61–65, and other limits on pages 50–53.
<b>Preventive Care</b> <i>Includes vaccines, routine exams, some screening tests</i>	Preventive	33-34, 36, 37–39, 55, 75, 130	Only certain services are covered as preventive; see pages 37–39. See pages 29–30 for contraception covered as preventive.
<b>Skilled Nursing Facility</b>	Inpatient <i>Some services may be billed separately (such as physical therapy).</i>	39, 63, 64, 131	Maintenance care (page 123) and custodial care (page 119) are not covered.

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## Summary of Benefits, continued

<b>Benefit/Service</b>	<b>How much will I pay? (See pages 14–15 for description of payment types)</b>	<b>For more information: See page(s)</b>	<b>Any limitations or exclusions?</b>
<b>Spinal and Extremity Manipulations</b>	Standard	39, 63	Limited to 10 visits per calendar year.
<b>Surgery</b>		25, 33, 34, 37, 40, 41, 62, 65, 118, 126, 130	See page 23 for coverage of bariatric surgery.
<i>Inpatient Services</i>	Inpatient		Some services require preauthorization and/or plan notification.*
<i>Outpatient Services</i>	Standard		Some services require preauthorization.*
<b>Tobacco Cessation Program</b>	Preventive	41, 64	Only the <i>Quit for Life</i> program is covered for ages 18 and above. See page 41 for drugs and nicotine replacement supplies covered. See page 41 for tobacco cessation services for members ages 17 and under.
<b>Vision Care</b> (Related to Diseases and Disorders of the Eye)	Standard	42, 61, 62, 63	
<b>Vision Exams, Routine</b>	Preventive	42, 62, 63	One per calendar year. \$65 annual limit on contact lens fitting fees.
<b>Vision Hardware, Adults</b> (Over age 18) Glasses, contact lenses	<b>Special:</b> You pay any amount over \$150; network status of provider does not matter. No medical deductible.	42	Plan pays up to \$150 per two calendar years (resets every even year).
<b>Vision Hardware, Children</b> (Age 18 and under) Glasses, contact lenses	<b>Special:</b> No medical deductible. <b>Eyeglasses:</b> You pay \$0 for one set of standard or deluxe frames and lenses per year. <b>Contact lenses:</b> You pay 15% of billed charges.	42	Plan pays for one pair of eyeglasses per year at 100% of billed charges. See page 42 for options that aren't covered. No limit on number of contact lenses covered.
<b>Well-Child Visits</b>	Preventive	37–39	See pages 37–39.

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